GROTON PUBLIC SCHOOLS
ADMINISTRATION OFFICES
P.O. Box K, Groton, Connecticut 06340 • 1300 Flanders Road, Mystic, Connecticut 06355
PHONE (860) 572-2100 • FAX (860) 572-2107

CONSENT FORM FOR ACCESSING STUDENT'S PUBLIC BENEFITS (HUSKY) FOR HEALTH-RELATED SERVICES IN STUDENT'S IEP/504 PLAN

District Name: Groton

Student Name: _____

Student Date of Birth: _____

SASID#: _____

School Location (not required):

Groton Public Schools participates in the Connecticut Medicaid School-Based Child Health Program (SBCH). The SBCH program allows school districts to receive state and federal funding for services that are provided to eligible students who receive special education related health services listed in their IEP or 504 plan and qualify for Medicaid (HUSKY) benefits.

This one-time consent form allows the school district to seek reimbursement from the state for eligible students who have a covered health-related service as part of the student's IEP or 504 plan.

- Examples of these services are: Occupational Therapy, Physical Therapy, Speech-Language, Hearing services, Psychological Services, Social Work, Nursing, and Individual Assessments/Evaluations as recommended by the Planning and Placement Team.
- If your child receives any of the above services and qualifies for Medicaid (HUSKY) benefits at any time during the school year, **we request your permission to release information to access school-based Medicaid (HUSKY) reimbursement for the school district.**
- Information to the state Medicaid agency may include student's name, date of birth, Medicaid ID, as well as dates and services provided.
- Any reimbursement received from the Medicaid program does not affect or impact other benefits to which my child is entitled, including any eligible services outside of school, other state programs and/or Medicaid waivers. **There is NO cost to the family, now or in the future.**
- The school district will provide all services to your child whether you provide written consent. Consent is voluntary and you have the right to withdraw this consent at any time.

☐ I GIVE MY CONSENT to allow the school district to access and seek reimbursement for SBCH eligible services prescribed in my student's IEP/504 plan.

☐ I DO NOT give my permission to allow the school district to access and seek reimbursement for SBCH eligible services prescribed in my student's IEP/504 plan.

_____ _____
Signature Date Signed