NOTIFICATION AND CONSENT TO SEEK REIMBURSEMENT FOR HEALTH-RELATED SERVICES AND FOR RELEASE OF RECORDS

***This notification is being provided to all district families regardless of MA (Medicaid) or Special Education eligibility**

Dear Parent/Guardian:

Introduction: Minnesota school districts must seek reimbursement from insurers and similar third parties for school-based health-related evaluation and services. Health-related evaluation and services may include assessments and services for nursing, speech/language therapy/audiology, occupational therapy, physical therapy, personal care assistance, assistive technology devices, interpreter services, special transportation, and/or mental health. This notification and consent for reimbursement will apply to health-related services received by students either with or without an IEP (Individual Education Plan), IFSP (Individual Family Service Plan). The District must obtain your consent to seek reimbursement for health-related services from insurers and similar third parties.

The purpose of this notice form is:

- To provide notification that the district will seek reimbursement from insurers and similar third parties for school-based health-related evaluation and services, and to obtain your initial consent for reimbursement of health-related services and release of records.
- To provide annual written notification that the district will seek reimbursement from Medical Assistance/Minnesota Care for billable services.

Notification:

- The district will seek reimbursement from insurers and similar third parties (Medical Assistance (MA) or MinnesotaCare (MC)) for school-based health-related services that your child receives (with or without an IEP/IFSP).
- The district will provide you annual notification of our intent to seek reimbursement for health-related services.
- There will be NO cost to your family, and this will NOT affect your insurance coverage (including MA/MC coverage, TEFRA, waivered programs, service limits or thresholds).
- The District may not require you to sign up for MA/MC.
- You have the right to receive a copy of the education records the district shares with any third party (for example: Minnesota Department of Human Services (DHS) and the United States Department of Health and Human Services (DHHS)).
- After initial consent, if you wish to revoke your consent, you may do so in writing by sending an email to: **steph.reichert@rockford883.org** at any time without affecting your child's services. Revocation is not retroactive.

Additional information:

- For children age 3 and older, consent may be obtained through either this school district form, or (when applicable) the Minnesota Health Care Program (MHCP) enrollment/re-enrollment form for medical assistance or MinnesotaCare, provided that

(1) you have completed the MHCP enrollment/re-enrollment form for MA or MC; (2) the District has provided you with an annual written notice; and (3) one year has passed since both (1) and (2) have occurred.

- The district will not bill your private insurance. If you have a combination of MA/MC and private insurance, we will receive a denial from your insurance company before billing MA/MC.

By selecting yes below:

- I agree that the district may access MA/MC for reimbursement of health-related services.
- I agree that the district may release health-related service records and other education records about my child to the Minnesota Department of Human Services (DHS) and the United States Department of Health and Human Services (DHHS), and their agents and contractors for billing or audit purposes. Records that may be released include, but are not limited to, IEP/IFSP plans, evaluation reports, and other IEP/IFSP-related documents, diagnostic assessments, medical orders, diagnosis/health conditions, service logs, and attendance records.
- I understand that, except as allowed by law, these records may not be re-disclosed without my authorization on this consent form or the MHCP enrollment/re-enrollment form, as detailed above. This consent is retroactive one year from the date of the signature below.
- For children with an IFSP: My child has an IFSP, and I have received a copy of the state system of payments policy, which includes (1) Consent to Share Data and Seek Payment for IFSP Health Related Services; and (2) Written Annual Notice Related to Third Party Billing for IFSP Health Related Services. This policy will be provided to me each time my consent is required.