

# ONETIME PARENT CONSENT TO ACCESS PUBLIC BENEFITS (MEDICAID)

(For SchoolBased Medicaid Reimbursement — IDEA & FERPA Compliant)

School District:

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Why You Are Receiving This Form

Your school district is allowed to request Medicaid reimbursement for certain health related services provided to your child at school. These services may include nursing services, therapies (speech, OT, PT), counseling, behavioral health services, and other medically necessary supports your child receives in school.

Before the district can bill Medicaid for the first time, **federal law requires the district to obtain your onetime written consent**. After you sign, the district must provide you with **annual written notification**, but you will **not** be asked to sign again.

## Information That May Be Shared with Medicaid

To submit Medicaid claims, the district may share the minimum information required, including:

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- Student name
- Date of birth
- Gender
- Medicaid ID (if applicable)
- Type of service provided
- Date/time of service
- Name/title of the provider delivering the service

No other information will be shared without your permission.

## Important Protections for You and Your Child

Federal regulations guarantee the following protections:

### No Cost to You

You **cannot** be charged:

- 
- Deductibles
- Copays
- Premium increases
- Any out-of-pocket expenses

If a cost occurs, the district must pay it.

## No Impact on Your Child's Medicaid Benefits

Allowing the district to bill Medicaid will **NOT**:

- 
- Reduce your child's lifetime coverage
- Limit the number of services your child can receive
- Affect your child's eligibility for Medicaid
- Affect your family's use of Medicaid outside school

**No Impact on School Services**

Your child will continue to receive all required services at **no cost to you**, even if:

- You refuse to give consent
- You later withdraw consent

**You May Withdraw Consent at Any Time**

You may revoke consent at any time without penalty. Billing must stop immediately after you withdraw consent.

**Consent Is Voluntary**

You are **not required** to sign up for Medicaid, nor are you required to provide consent for your child to receive IEP or other school-based services.

**Parent/Guardian Consent (Select One)**

**YES, I give consent** for the school district to share the information listed above and to access my child's Medicaid benefits to receive reimbursement for school-based health services.

**NO, I do not give consent.** I understand that my child will still receive all required services at no cost to me.

**Your Rights**

By signing this form, you acknowledge:

- You understand what information will be shared.
- You understand your rights and protections under federal law.
- You understand consent is voluntary and may be revoked at any time.
- You understand your child's services will not be impacted by your decision.

**Parent/Guardian Information**

**Parent/Guardian Name (Printed):**

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**Parent/Guardian Signature:**

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**Effective Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Phone/Email (optional):**

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