



PARENTAL CONSENT FOR RELEASE OF INFORMATION FOR MEDICAID FUNDING

Student ID: _____

School: _____

Dear Parent/ Guardian:

To complete this form electronically, scan this QR code:



(You do not need to complete this paper form if you use this code)

We would like to request your consent to bill Medicaid for any eligible reimbursable services that are on your child's individualized education program (IEP). Schools in New York State routinely access Medicaid funding to help meet the costs of providing these special education services. Please read and complete the following information:

I, _____ as the parent or guardian

of _____, give permission for the Rochester City School
(Print child's name)

District to access Medicaid funds to pay for any Medicaid eligible services listed on my child's IEP and hereby give my consent for the District to release any necessary information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are related to my child's IEP. In addition, I hereby authorize the Monroe County Division of Social Services to release Medicaid information including Medicaid Member Client Identification (CIN) to the District to accomplish this purpose.

I understand:

- Providing consent **will not** impact my child's or my Medicaid coverage;
- I **will not** incur any out-of-pocket expense such as payment of a deductible or co-pay amount;
- Upon request, I may review copies of records disclosed pursuant to this authorization; and
- The school district must give me annual written notification of my rights regarding this consent.

I give my consent voluntarily and understand that I may withdraw my consent at any time by notifying the parties in writing. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependent on my granting this consent and that, regardless of my decision to provide this consent; all the required services on my child's IEP will be provided to him or her at no cost to me.

Parent/Guardian Signature: _____ Date: _____



Mike Sausa
Medicaid Compliance Officer
Rochester City School District
131 West Broad Street
Rochester, New York 14614
Phone: (585) 262-8444

Dear Parent/Guardian:

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA). This notice will help you to make an informed decision about Parental Consent for the release of information for Medicaid funding, which allows the Rochester City School District to access available public benefits to help fund special education related services. Under the IDEA, the District is required to provide these services at no cost to you and your child.

By providing consent, you acknowledge that:

- Providing consent will not impact your child's or your family's Medicaid coverage.
- Upon request, you may review copies of records disclosed pursuant to this authorization.
- Services listed in your child's IEP must be provided at no cost to you, whether or not you give consent to bill Medicaid and/or provide your child's CIN.
- You have the right to withdraw consent at any time.
- The District must provide you with annual written notification of your rights regarding this consent.

Signed consent will not:

- Reduce your family's insured benefits under the Medicaid program.
- Decrease the available lifetime coverage under the Medicaid program.
- Lead to discontinuation of benefits.
- Result in you paying for required services for your child outside of school that would otherwise be covered by Medicaid.

We hope this information is helpful to you in making an informed decision. For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services, please visit [US Department of Education IDEA Part B Sec. 300.154 \(d\)](https://sites.ed.gov/idea/regs/b/b/300.154/d) (<https://sites.ed.gov/idea/regs/b/b/300.154/d>)

If you have any questions, please contact me at (585) 262-8444 or mike.sausa@rcsdk12.org. Thank you for helping our District meet these new requirements.

Sincerely,

Mike Sausa
Medicaid Compliance Officer



Dear Parent/Guardian,

This is a friendly reminder that the Rochester City School District does not have a signed one-time Medicaid Parental Consent Form on file for your child. This consent form allows RCSD to access Federal funding for health-related services provided to students. Signing the consent form will not impact your Medicaid benefits or IEP-related services in any way. RCSD requests that all parents or guardians sign the consent form, regardless of Medicaid eligibility.

What is the purpose of signing a Parental Consent form for Medicaid?

The Consent form allows the Rochester City School District to access Federal funding for Health-Related Services provided to students.

How does signing this Consent form impact my current Medicaid insurance?

Signing this consent form has NO impact on your current Medicaid insurance or Medicaid status. You will see no changes to your Medicaid coverage or status.

If I do not receive Medicaid benefits, should I still sign the consent form?

Yes. We request that all parents of students receiving health related services sign this form regardless of Medicaid eligibility. Signing this form will have NO impact on your current medical insurance or status.

Should you have any questions or concerns about the Medicaid Parental Consent form, please contact the RCSD Medicaid Compliance Officer at (585) 262-8444.

Sincerely,

Mike Sausa
Medicaid Compliance Officer
Rochester City School District
Medicaid Compliance and Reimbursement Department