

**Consent for Medicaid School-Based Services**

 3.18.2013

**Student Name:**

**Date of Birth: ­­­­­­­­­­­­­­­­**

**School District:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The Medicaid School-Based Services Program in Michigan:**

* Provides partial reimbursement to school districts for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work, Orientation and Mobility, Transportation, Nursing, Case Management and Assistive Technology Services.
* Does NOT affect a family’s Medicaid insurance benefits and there is NO cost to the family, now or in the future.
* Helps school districts to offset some of the costs of health care provided to children.
* Is voluntary and requires a parent or guardian to provide written consent to release information about their child to the Michigan Medicaid agency and its affiliates to obtain reimbursement. This may include name, address, and date of birth, along with student ID, Medicaid ID, disability, dates and services delivered.

If your child receives any of the services listed above and qualifies for Medicaid benefits at any time during the school year, we request your permission to submit claims on behalf of your child to enable your school district to access School-Based Medicaid reimbursement. You have the right to refuse consent to bill Medicaid, and you have the right to withdraw this consent at any time. If you do not provide consent, the district will still provide the services.

[ ] I have received a copy of the Medicaid Prior Written Notification Regarding Parental Consent.

**CHOOSE ONE OF THE FOLLOWING:**

[ ] I understand and agree that      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (District) and Monroe County Intermediate School District may access my child’s public benefits or insurance information in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

**OR**

[ ] I do not agree to the disclosure of information for purposes of gaining reimbursement from the

Medicaid School‐Based Services program for medical services listed on the Individualized

Education Program (IEP) or Individualized Family Service Plan (IFSP) and provided to my child by      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (District) and Monroe County Intermediate School District.

DATE:

Signature of Parent/Guardian