

*****Parent or guardian: Complete, sign and date this form, whether or not the child is currently eligible for Medicaid*****

School District: _____ School: _____

2008-2009 School District Medicaid Consent Form for Registration

The Department of Health and Human Services sponsors a program allowing our school district to seek reimbursement for health-related services we provide to children with Medicaid health insurance. Such services include, but are not limited to: assessments and evaluations, nursing services, speech, occupational and physical therapy, psychological, social work and counseling services as part of an individual student's education or health plan. This program helps us maximize federal funds for support of additional health services in our schools. Your child will continue to receive services at no cost to you under this program. Granting the district permission to receive these federal funds in no way limits any other MEDICAID benefits your child can receive outside of school. By giving your consent, which will be considered valid for the entirety of the school year indicated above, you help our school district expand health and health-related services for all children. The students truly benefit from the success of this program.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SERVICES

PARENT/GUARDIAN _____
(Name of parent or person in parental relationship-PLEASE PRINT.)

CHILD'S NAME _____
(First Name-Middle Initial-Last Name-PLEASE PRINT.)

CHILD'S DATE OF BIRTH ___/___/___
 month/day/year

CHILD'S SOCIAL SECURITY NUMBER ___ - ___ - ____

CHILD'S MEDICAID NUMBER _____ (If currently eligible.)

CHILD IS NOT CURRENTLY ELIGIBLE _____ (Please check here if child is not currently eligible.)

As parent/guardian of the child named above, I give the school district permission to release information related to health services he/she has received at school to state and/or federal Medicaid representatives for the sole purpose of allowing the school district to seek reimbursement from Medicaid for those health services.

Signature: _____ **Date:** _____
(Signature of Parent or person in parental relationship) (month/day/year)

If at some time you wish to withdraw this permission, please contact the school building nurse