JOHNSTON PUBLIC SCHOOLS

Special Services

PARENT/GUARDIAN CONSENT TO ACCESS MEDICAID FUNDS

Student Name: _____ DOB: _____

Background:

The Johnston School Department provides special education & related services to eligible students at no cost to the parent(s). The school department can be partially reimbursed through Medicaid for a portion of some of these services which may include personal care, assistive technology services, day program treatment, residential program treatment, child outreach screening, transportation, and services and/or evaluations provided by physical therapists, occupational therapists, speech, hearing and language therapists, licensed psychologists, social workers and nurses.

All funds received through this program directly support education in our district.

We need your written consent to share information on your child with the state Medicaid Agency, (the Department of Human Services).

We also need your consent to authorize the school department to use your or your child's public benefits or insurance to pay for services under 34 CFR Part 300, which are special education and related services under IDEA.

Parental Consent:

I understand that billing for these services by the district **will not impact** my ability to access these services for my child outside the school setting, nor will any cost be incurred by my family, including: co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

I understand that my consent is voluntary and I may revoke this consent in writing at any time.
If consent is revoked, the school department will no longer bill Medicaid from that date forward.
I understand that IEP services will continue to be provided by the school department as long as my child remains eligible for special education.

YES—I give my consent.

_____ I give permission to the district to share information about my child with DHS, EDS and the district's Medicaid billing agent in order for the district to participate in this reimbursement program, I also consent to the district's use of my child's public benefits or insurance to pay for services under 34 CFR part 300, which are special education and related services under IDEA.

Thank you for your assistance and cooperation. ***All funds received through Medicaid for students directly support education in our district.***

No—I do not give my consent

_____ I do not give permission to the district to share information about my child with DHS, EDS and the district's Medicaid billing agent. I do not give my consent for the district to participate in this reimbursement program

Parent/Guardian Signature Date

Parent/Guardian Printed Name