PARENT/GUARDIAN CONSENT TO ACCESS MEDICAID FUNDS

Today's Date:		
Student's Name:	**DOB:**	**Grade:**
Parent/Guardian Name:		
Parent/Guardian Address:		
City:	**State:**	**Zip Code:**

Background:
The Barrington Public Schools provides special education and related services as a free and appropriate public education (FAPE), **at no cost to the parents**, in the least restrictive environment (LRE). The [LEA] can seek reimbursement through Medicaid for some special education services for students who are eligible for Medicaid benefits. Section 300.154 of the Rhode Island Board of Education's Regulations Governing the Education of Children with Disabilities Education requires that the [insert LEA] receive your **written informed consent** in order to seek Medicaid reimbursement for certain special education services. Before you give or deny consent, please read the following:

Please check all of the following (this is informed consent):

☐ **I understand** that giving my consent to the district to access Medicaid reimbursement for services provided to my child **will not impact** my ability to access these services for my child outside the school setting.

☐ **I understand** this consent **does not include consent for assistive technology devices.** The district needs a **separate consent form** when accessing reimbursement for any assistive technology device.

☐ **I understand** that services in my child's IEP must be provided at **no cost** to me, whether or not I give consent to bill Medicaid. [If I refuse consent or if I revoke (withdraw) this consent, the school district is still responsible to provide special education and any related services identified for my child through the special education eligibility processes and these services will be provided at **no cost** to me. This includes no costs for co-pays, deductibles, loss of eligibility or impact on lifetime benefits.]

☐ **I understand that my consent is <u>voluntary</u>** and I may revoke (withdraw) my consent **in writing** at anytime after it is given. If I revoke (withdraw) my consent, the school department will no longer bill Medicaid from the date the written revocation (withdrawal) of consent is received by the district.

☐ **I understand** that the district follows both the Health Insurance Portability and Accountability Act (HIPAA -- the federal health privacy act) and the Family Educational Rights and Privacy Act (FERPA -- the federal education privacy act) requirements to protect my confidential information and that Medicaid funds received by the district directly support education in our district.

Permission given or denied (please check one):

☐ **I give permission** to the district to share information about my child with the state Medicaid Agency, its fiscal agent, and the district's Medicaid billing agent. The information shared may include my child's name, date of birth, address, primary special education disability, Medical Assistance Identification number (MID), and the type and amount of health services provided. Services 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.

☐ **I do not give permission** to the district to share information about my child in order to seek Medicaid reimbursement for services provided to my child.

Parent/Guardian Signature **Date**

<u>PLEASE PRINT</u> Parent/Guardian Name