



BREVARD PUBLIC SCHOOLS
**Parent Consent to Release Personal Student Information
for Medicaid Reimbursement**

Medicaid reimbursement helps the school district fund costs of providing special education, related services, and any other services allowable by Medicaid. Our school district wishes to seek reimbursement for certain services provided to your child by accessing Medicaid. We must obtain your written informed consent for the purpose of releasing certain information related to seeking Medicaid reimbursement.

Individual Educational Plan (IEP) Services

The Individuals with Disabilities Education Act of 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school (Title 34, section 300.154(d)(2)(iv)(A)-(B), Code of Federal Regulations [CFR]).

Non-IEP Services

School districts are also allowed to seek reimbursement from Medicaid for services provided under the Florida Administrative Code Medicaid rule for school-based services (Rule 59G-4.035).

Consent given or denied (please read, initial, sign and date at the bottom):

I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary to receive an appropriate education at no charge to my child in accordance with 34 CFR § 300.154(d)(2)(v)(D) or other services provided outside of the IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

The information shared may include my child's name, date of birth, address, primary special education disability (if applicable), Florida Medicaid identification number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, physical therapy, occupational therapy, speech therapy, hearing and language therapy, behavioral services which includes counseling & social work, transportation services, and nursing services.

The records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records, transportation logs, progress notes, and nursing reports or records.

I understand and do NOT give my consent to the school district to share information about my child in order for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

Parent/Guardian's Signature: _____ **Date signed:** ____/____/____

Parent/Guardian's Name (printed): _____

Student's Name (printed): _____

Student ID _____ **Student's Date of Birth (printed):** _____