



## Ionia County Intermediate School District

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[www.ioniaisd.org](http://www.ioniaisd.org)

### Medicaid Authorization & Consent Form

Student's Name:           DOB:

Resident District:       Primary Disability:

School Building:

#### Medicaid School-Based Services:

The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover services that are included in the student's IEP or IFSP pursuant to the Individuals with Disabilities Education Act (IDEA). The program identifies medically necessary services already provided to schools e.g. speech therapy, social work, nursing, occupational therapy, physical therapy, and psychological services, and allows the school, as a service provider, to bill under Medicaid, thus ensuring federal participation in the cost of providing these services. All special education students who are Medicaid eligible are included under this act. Enrollment by a school district for Medicaid billing is not expected to result in any change in the student's program or services provided by the school district or any other agency.

According to your child's IEP dated,           s/he will receive services that are eligible for reimbursement under the state's Medicaid program as specified in the IEP.

#### **Consent to Bill Medicaid** (*Parent to read, sign, & date*)

*Effective October 13, 2006, local school districts must obtain parent consent to access the Medicaid benefits for reimbursement of school-based special education related services [34 CFR §300.154(d)]. In addition, school districts must also notify parents that if they refuse to grant consent for Medicaid service reimbursement that all special education services will continue to be provided at no cost to the parents [34 CFR §300.9(B)].*

I authorize the           (school district) to disclose to *Public Consulting Group, Inc. (PCG)* the following information: my child's name, date of birth, assigned unique student number, eligibility as a student with a disability, the type(s) and number of services provided, the service date(s), and name of the provider(s). This information may be disclosed for the purpose of processing a claim to the Medical Services Administration in the Michigan Department of Community Health for Medicaid reimbursement for these services.

I agree to allow the school district to seek Medicaid reimbursement for special education related services for my child (as applicable) and I understand that personally identifiable student information is needed to submit a claim which will be kept confidential. I understand that my consent and authorization is voluntary and may be revoked at any time. I understand that if I refuse to allow access, the district is not relieved of its responsibility to ensure that these services are provided at no cost to me.

I also give my consent for ICISD to exchange records with my child's physician for the purpose of obtaining a prescription for services (i.e., OT, PT, and/or Speech).

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*