# Consent for Sharing Information with Medicaid for Reimbursement for the Provision of School-Based Skills Development Services

(USBE Rules VIII.L.7.)

Dear Parent or Student who is an Adult,

 (local education agency or LEA) has the opportunity to receive federal reimbursement from Medicaid for school-based skills development services provided to special education students. Prior to submitting reimbursement requests to Medicaid for such services, LEA is required under federal regulations to obtain written consent from parent, guardian, or adult student to share a student’s information.

If (Student) currently or could in the future receive any school-based skills development services and/or qualifies for Medicaid benefits, LEA requests your permission to bill Medicaid insurance to receive reimbursement. The reimbursement is for school-based skills development services included in Student’s individualized education program (IEP).

1. Services must meet the requirements of the State’s Medicaid program and be provided in accordance with Student’s IEP. Reimbursable school-based skills development services may include evaluation and assessment services and/or related services, such as speech language therapy, vision and hearing adaptation services, occupational therapy, physical therapy, personal care services, nursing, and/or behavior health services.
2. We request your permission to share Student’s first name, last name, and date of birth with Medicaid. This information will be shared with Medicaid for billing purposes. LEA and the State Medicaid agency will share information through a secure-file transfer system. When LEA shares this information, LEA is provided with the information necessary to process reimbursement claims. Student’s social security number will not be disclosed by LEA with Medicaid for any purpose.
3. LEA’s participation in this reimbursement program DOES NOT in any way affect or impact health insurance or other Medicaid covered services that are provided to Student outside of school. LEA’s participation in this reimbursement program will not result in costs to the family now or in the future. If you do not provide consent, LEA will still provide the same services as defined by Student’s IEP, but LEA will not pursue Medicaid reimbursement for these services.
4. This consent will be valid for the duration of Student’s attendance in LEA; or until this consent is changed at your direction; or until Student’s IEP services change to the extent that Student does not meet the criterion for reimbursement.

Please indicate whether you consent to LEA sharing Student’s information with Medicaid for reimbursement for the provision of school-based skills development services and return this form as soon as possible. If you have questions about Medicaid reimbursement or this consent, please call LEA at[phone]:

I **give** LEA permission to disclose Student’s first name, last name, and date of birth with the State’s Medicaid agency for billing purposes in order to be reimbursed for school-based skills development services.

I **do not give** LEA permission to disclose Student’s first name, last name, and date of birth with the State’s Medicaid agency for billing purposes in order to be reimbursed for school-based skills development services.

Student’s Full Name Date of Birth

Parent/Guardian Name (print) Name of School

Parent/Guardian/Student who is an Adult Signature Date