St. Johns County School District
40 Orange Street
St. Augustine, FL 32080

Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

Student name: _____ ID# _____ DOB: _____ School: _____

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. Medicaid reimbursement helps the school district fund costs of providing special education, related services and any other services allowable by Medicaid.

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, then sign and date at the bottom):**
(Signature on this consent is a one-time requirement and will not be necessary again unless the consent choice is changed.)

☐ **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 If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.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), Social Security number, 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 services, occupational therapy services, speech therapy services, hearing and language therapy services, behavioral services, transportation services, and nursing services.

The records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records and logs, 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.

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https://registration.powerschool.com/resources/2620/files/Parental Consent for Release of Student Info.docx

Parent/Guardian Signature _____ Date signed _____

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Parent/Guard Name (printed)

Medicaid reimbursement for schools is a federal program and will not impact services a student receives under his/her managed care plan. If you have any questions about this information, please contact Toni Dendler, Medicaid Specialist, 904-547-7686.