Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: ID#: Date of Birth:

Age: Grade: Local Education Agency:

Primary Care Physician's Name (Optional):

Medicaid Number:

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are Identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may indude: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of servlce(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district Is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this fonn.

Parent or Guardian Signature: Date:

Is your child covered by private Insurance? ◯ Yes ◯ No
(If yes, please complete Third Party Liability Section)

Name:

Parental Consent to Release Personally Identifiable Information Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Information Related to Billing Third Party Insurance:

Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

- ◯ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.
- ◯ I give permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:
Insurance Company:
Address:
Phone:
Name of Policy Holder:
Policy Holder Date of Birth:
Social Security Number:
Policy Number:
Group Number:

Parent or Guardian Signature: Date:

Clear Form