

**CONSENT FORM FOR ACCESSING A PARENT OR STUDENT'S MEDICAID INSURANCE TO  
PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S  
INDIVIDUALIZED EDUCATION PROGRAM (IEP)**

DEAR PARENT/GUARDIAN OF \_\_\_\_\_ :  
(print name of student)

\*\*\* NUMBER FROM STUDENT'S MEDICAID CARD: \_\_\_\_\_ \*\*\*  
(CIN – Child's Identification Number)

This is to ask your permission (consent) for \_\_\_\_\_ to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, (name of parent/guardian), \_\_\_\_\_ as the parent/guardian of (print name of student) \_\_\_\_\_ have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact your child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared:

- IEP and related service reports
- Script(s) for related service – Speech Therapy, Occupational Therapy, Physical Therapy
- Session / progress note listing date, time, and progress of student for related services listed above.
- Attendance record of student.

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

PARENT/GUARDIAN NAME AND SIGNATURE:

Signature: \_\_\_\_\_  
(signature of parent/guardian)

Print Name \_\_\_\_\_ Date \_\_\_\_\_