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| **PURPOSE:** This form asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with the Washington State Health Care Authority (HCA). When the district verifies Medicaid eligibility or bills HCA for school-based services based on you or your child’s eligibility for public benefits, it does not affect either of your individual benefits under Medicaid.  |

CONSENT TO VERIFY ELIGIBILITY AND BILL FOR SCHOOL-BASED MEDICAID REIMBURSEMENT

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| Student Name: |  | SSID (if known): |  |
| Current School: |  | Date of Birth: |  |

A school district is required to obtain your consent to verify eligibility for Medicaid and submit claims for reimbursable school-based services provided on behalf of your child. The types of services that can be reimbursed by Medicaid include physical therapy, occupation therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluations. These types of services which may be provided to your child through an individualized education program (IEP), may also be reimbursed by Medicaid if your child is eligible to receive Medicaid benefits. With your permission, (Insert SCHOOL DISTRICT) will submit your student’s name and birth date to the Washington State Health Care Authority (HCA) to verify Medicaid eligibility. The submission of this information will not change the services provided in your child’s IEP. With your consent, (Insert SCHOOL DISTRICT) will also share necessary information from your child’s education record to obtain reimbursement from the HCA if the services provided to your child can be reimbursed because of your child’s eligibility for Medicaid benefits.

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| I authorize |  | to share any necessary identifying information from my |
| child’s educational record to verify Medicaid eligibility with the HCA, and to access my or my child’s public benefits to obtain Medicaid reimbursement for school-based health services from the HCA. If my child is no longer served by this school district, I understand that this consent will not transfer to a new school district. This authorization will begin on the date that I sign and give consent below.  |

By giving consent, I acknowledge that: (1) I have been fully informed of all information relevant to accessing my or my child’s Medicaid benefits and informed of the reasons I have been asked to provide consent to release relevant information from my child’s education records to verify eligibility and to obtain reimbursement from HCA; (2) I also understand that the granting of consent is voluntary on my part and I may revoke consent at any time; and (3) if I revoke consent, the revocation is not retroactive; which means that it does not undo any verification or billing through HCA that has already taken place, but it will stop any future verification or billing.

[ ]  I give my consent to verify my child’s Medicaid eligibility with HCA and to submit claims for allowable services.

[ ]  I do not give consent. I understand that my refusal to consent means that the district cannot verify eligibility or make a claim for reimbursement for services that might otherwise be covered by HCA. I also understand that my refusal does not affect my child’s access to special education services under his or her IEP.

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| *Parent/guardian signature* |  | *Date* |

If you have questions about this consent please call or email your school district for an explanation as to why the request is being made at INSERT DISTRICT CONTACT INFORMATION.

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