Medicaid Annual Parent Notification Letter

Today's Date: _____

Student's Name: _____ Current School: _____

Dear _____,

The _____ School District is pleased to provide your child with special education and related services as stated in his or her Individual Education Program (IEP). Your child is entitled to a free appropriate public education, which means at no cost to you.

State and federal laws allow school districts to be Medicaid service providers for children with disabilities who are eligible under the Individuals with Disabilities Education Act (IDEA) and the Medicaid program. This means that our school district can bill the Department of Medicaid for related health services stated in your child's IEP.

Our school district is approved by the Department for Medicaid Services to take part in the Medicaid School-Based Health Services Program. School claims for Medicaid payment for these services will not affect your child's receipt of health services from your family physician or other health providers in any way.

Our school district cannot submit claims to Medicaid for your child's services if you do not want us to do so. Our district's billing Medicaid for these services will not change your child's IEP services or your right to receive Medicaid services as long as your son or daughter continues to be eligible for Medicaid services.

If you wish to deny the district's access to reimbursement from Medicaid for health services in your child's IEP, you should do so in writing. Our school district will continue to bill Medicaid for special services unless you notify us in writing that you wish us to stop. We will remind you once a year. If you wish to stop the district from submitting claims to Medicaid for your child, send a written statement to the district's Medicaid Liaison.

If you have any questions or concerns about your child's Medicaid coverage, please contact _____ at _____.

If we do not hear from you we will begin or continue to submit claims to Medicaid for your child's IEP health services. I want to thank you for your support of our efforts.

Sincerely,

Medicaid Liaison

File copy of notice maintained in student folder

Notice of Parent Consent for School District's Use of Public Benefits or Insurance (Medicaid) under 34 CFR §300.154(d)(2)(iv)

I hereby authorize the release of _____ educational records as listed below to Medicaid, for the purpose of processing Medicaid claims or for agency review of records.

Medicaid's examination of records for program audit purposes shall take place in my child's school district. No copies of my child's records will be provided to Medicaid.

Please mark statement, sign and date at the bottom:

___ I give my permission for _____ to allow the Department of
Name of Local Educational Agency
Medicaid Services to examine information in my child's educational files which is needed to bill the Kentucky Medicaid program for services provided through my child's Individual Education Program (IEP). My signature does not give permission to bill my private insurance company. This information to be released may include:

- My child's name and Social Security Number;
- My child's date of birth;
- My child's referral and evaluation information and reports pertaining to the billing of Medicaid services.
- The dates and times that service is provided to my child at school;
- My child's IEP goals that relate to these services; and
- Progress notes pertaining to the billing of Medicaid services

___ I do not give my permission for this information to be released.

___ I understand that services provided by _____ special education
Name of Local Educational Agency
program will not count against limits for Medicaid programs.

This consent form gives the school system listed above permission to release information needed to recover costs from Medicaid for eligible school-based services provided as outlined within the IEP.

Child's full name: _____ Medicaid Number: _____

Child's Date of Birth: _____

Parent's or guardian's name (printed):_____

Parent or guardian's signature:_____

Date signed:____/____/_____

Release is given to the following agencies or their designated representatives, for the sole purpose of billing Medicaid services or for auditing of the school districts School-Based Health Services program:

X Kentucky Department for Medicaid Services
X Kentucky Department for Public Health/Local Health Departments
X Centers for Medicare and Medicaid Services (CMS)
X Any agency commissioned to audit this program
X Contractual Third-party Billing Agency (Agency performing billing and related services for the school district)

I understand that the records will remain confidential and will only be used for the purposes listed above. The above agencies have been advised that they are bound by FERPA and cannot release the information they have obtained from the child's records without informed parent consent.

Your consent is voluntary. If you have any questions or concerns, please contact your school principal or the district's Medicaid Liaison at _____.