



RICHLAND ONE

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CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND FOR MEDICAID REIMBURSEMENT

PURPOSE: *This is an updated Medicaid Form that asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with Richland County School District One. When the district verifies Medicaid eligibility or bills for school-based services based on your child's eligibility for public benefits, it DOES NOT affect or impact health insurance or other Medicaid covered services that are provided to your child or family outside of school. Please review, sign and return to school with your child within three days of receipt of this form.*

Richland County School District One (the District) and the South Carolina Department of Education have my permission to provide health-related services to my child and to release and exchange medical, psychological, and other personal identifiable confidential information, as necessary, to the Department of Health and Human Services and any third party insurance carrier regarding health-related services provided to my child. I understand that the purpose of this consent is to bill Medicaid or other health insurance for services under Part B of the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the South Carolina Department of Education my permission to bill Medicaid and any third party insurance and receive payment from Medicaid or any third party insurer for health-related services set forth in my child's individualized education program (IEP), and for psychological evaluation services, nursing services, and other health-related treatment services billable to Medicaid without the requirement of an IEP. I understand that the District and the South Carolina Department of Education have provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to accessing Medicaid or any third party insurance benefits and prior to this consent for release of information to bill Medicaid.

I further understand that the District and the South Carolina Department of Education will provide me annual written notification of my rights before Medicaid accesses my child's benefits to pay for services under the IDEA and that this consent for release of information to bill Medicaid is a one-time consent and is not required annually thereafter regardless of whether there is a change in the type or amount of services to be provided to the child or a change in the cost of the services to be charged to Medicaid or a third party insurance.

I understand that Medicaid reimbursement for health-related services provided by the District and the South Carolina Department of Education will not affect any other Medicaid services for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public or private benefits or insurance programs. I also understand that my refusal to allow access to the Department of Health and Human Services or any third party insurance carrier does not relieve the District of its responsibility to ensure that all required services are provided at no cost to me.

I understand that the granting of consent is voluntary on my part and may be revoked at anytime.

If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

I also understand that the District and the South Carolina Department of Education will operate under the guidelines of Part B of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of health-related services.

Student's Name

Student's Date of Birth

Medicaid #

Social Security #

Signature of Parent/Guardian

Date