ORANGEVILLE CUSD #203

PARENTAL NOTICE FOR RELEASE OF INFO
ONE-TIME CONSENT TO BILL MEDICAID

Date: 2023-24 School Year	Serving School: Orangeville School District
School/ District Contact Name:	Abigail Schroeder
Title:	Speech and Language Pathologist
Contact Information:	aschroeder@orangevillecusd.com / 815-789-4450 x209

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share records and information about your child with Medicaid. The school district needs to share information with Medicaid pertaining to your child, including name, date of birth, gender and type of services provided.

With your permission, the school district will be able to seek partial reimbursement for services provided by Medicaid. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

Under Federal law, the school district cannot share with Medicaid information about your child without your permission (34 CFR 99.30(b);34 CFR 300.154(d)(2)(iv)(A)-(B)). As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for Medicaid for your child to receive the health-related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge Medicaid for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.
3. If you give the school district permission to share information with and request reimbursement from Medicaid:
   a. This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of Medicaid benefits outside of school.
   b. Your permission will not affect your child's special education services or IEP/IFSP rights in any way, if your child is eligible to receive them.
   c. Your permission will not lead to changes in your child's Medicaid rights; and
   d. Your permission will not lead to any risk of losing eligibility for other Medicaid or Medicare funded programs.
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with Medicaid for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with services, at no cost to you.

ONCE YOU HAVE READ THIS INFORMATION, PLEASE CHOOSE YES OR NO ON THE APPLICATION. **Yes** if you give permission to the School to share with Medicaid records and information concerning your child and their health-related services, as necessary; **No** if you do not give permission to the School to release information for Medicaid billing purposes, and do not give consent for the School to access/bill Medicaid insurance for the provided services.