Parent Consent for Release of Information and Medicaid Reimbursement

_____ _____
(Student's Name) (Student's Date of Birth)

_____ _____
(Parent's name) (Student's ID Number)

By signing this form, I give consent for the _____ (LEA) to disclose information concerning my child with the Kansas Health Policy Authority (KHPA) for the purpose of accessing my, or my child's, Medicaid benefits for covered health-related assessment and /or IEP service costs; and with _____ (qualified health professional) for the purpose of obtaining a physician's prescription for some/all of the health-related services in my child's IEP in order to access Medicaid benefits for covered health-related assessment and /or IEP service costs.

The records to be disclosed are:

- ☐ the student's Individualized Education Program (IEP), or portions of it
- ☐ evaluations and determinations of assessments and/or services needed
- ☐ _____
- ☐ _____

By signing this form, I give consent for the _____ (LEA) to access my, or my child's, Medicaid benefits for the following services:

- ☐ Speech therapy for _____ (frequency) for _____ (duration)
- ☐ Physical therapy _____ (frequency) for _____ (duration)
- ☐ Occupational therapy _____ (frequency) for _____ (duration)
- ☐ Psychological Services _____ (frequency) for _____ (duration)
- ☐ Social Work Services _____ (frequency) for _____ (duration)
- ☐ Nursing Services _____ (frequency) for _____ (duration)
- ☐ _____
- ☐ _____

Consent

- I understand that the LEA is required to provide certain health-related services to any student who has an IEP at no additional cost to the student's parent(s) and that my refusal to sign this form will not affect whether services are provided to the student at no cost.
- I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that my child's Medicaid benefits will not be used if the use will: decrease available lifetime coverage or any other insured benefit; result in your family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school; increase premiums or lead to the discontinuation of benefits of insurance; or risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- I also understand that the granting of consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).

_____ _____
PARENT(S)/GUARDIAN(S) SIGNATURE(S) DATE