GEM PREP ONLINE

One Time Medicaid Consent Form

ONE-TIME AUTHORIZATION FOR DISCLOSURE OF IDENTIFYING EDUCATION RECORD INFORMATION FOR SCHOOL-BASED MEDICAID REIMBURSEMENT FOR SPECIAL EDUCATION EVALUATIONS, ASSESSMENTS, AND IEP HEALTH–RELATED SERVICES

Student's Name:		Birth Date:	Sex:
School:	Grade:		
Parent/Guardian Name:		Home Phone:	

34 CFR. 300.154D (d) (2) (D) (iv) (A)-(B) requires the District to obtain a one-time parental consent to access public benefits or insurance as such access requires the sharing of identifiable information from the student's education record pursuant to the Family Educational Rights and Privacy Act (FERPA).

I authorize Gem Prep Nampa to share necessary identifying information from my child's education record to access federal Medicaid reimbursement for _____ (Student's name) when conducting evaluations and assessments to determine Special Education eligibility and if found eligible for Special Education, provide for the health-related services identified on _____'s IEP.
Student's name

_____ The student is not Medicaid eligible. Please initial

Below, please indicate your receipt of the "IDEA Part B Written Notification Regarding Use of Public Benefits or Insurance" by **"providing your initials below"**.

_____ The School District has provided me with a copy of "IDEA Part B Written Notification Regarding Use of Public Benefits or Insurance." I understand that at any time I can withdraw my consent in writing to share identifying information from my child's education record to access federal Medicaid reimbursement.

I understand that this consent is not transferable to a different school district. (Please **INITIAL** either option.)

_____ I **give** my continuing permission for my child's evaluations, assessments and health related services to be submitted to Medicaid for federal reimbursement each time evaluations and assessments are completed and services are provided. I understand that to submit the billing to Medicaid to be reimbursed that identifying information about my child will be shared with Medicaid.

_____ I **give** my consent to Gem Prep Nampa to release information from my child's educational records to their Primary Care Physician, if requested. I understand that I can revoke this permission at any time.

_____I **do not give** my permission for my child's evaluations, assessments, and health related services to be submitted to Medicaid for federal reimbursement at this time.

I understand that my refusal to allow the district to submit the billing for related services to Medicaid precludes the School District from accessing my child's Medicaid benefit and that my denial of permission for such disclosure of information from my child's education record will not impact my child's access to a Free and Appropriate Public Education and/or required health-related services.

Parent/Personal Representative/Adult Student's Name: _____
Signature: _____
Date: _____

March 2014
Form 560
Copy to the confidential folder, electronic file, each service provider, and the parent or adult student.