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 *(child's name)* ______________________________ 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 *Montgomery County Schools* to allow the Department of 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 *Montgomery County School District* special education 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:____

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 _______________497-8760______________.