CONSENT TO RELEASE INFORMATION FROM EDUCATIONAL RECORDS FOR MEDICAID BILLING

Student's Full Name_____ **Birthdate**_____

The county school district wishes to periodically apply for reimbursement for certain services provided to eligible children during the year by accessing Medicaid or other publicly funded benefits. This access will not result in any decrease in available lifetime coverage or any other insured benefit; will not result in any cost to the child or the child's family; will not increase any premium or lead to the discontinuation of the child's benefits or insurance; and will not create any risk of loss of the child's eligibility for West Virginia's Title XIX MR/DD Waiver Program based on aggregate health-related expenditures.

The county school system is providing the following Medicaid covered services to your child:

TYPE OF SERVICE	FREQUENCY (per week/month/year)	Is the service also provided outside the school system?
Audiology Services		
Occupational Therapy Services		
Physical Therapy Services		
Psychological Services		
Speech Therapy Services		
Nursing (RN) Specialized Procedures		
Personal Care Aide (direct 1:1)		
Specialized Transportation (vehicle)		
Specialized Transportation (aide)		
IEP-Development (Initial or Annual/Triennial Update)	**1-4 per year**	
Care Coordination	**One per month**	

If your child is receiving audiological, occupational therapy, physical therapy, psychological and/or speech services from a provider(s) **outside** the school system, please list the name of the provider(s) in the box(es) provided so that the school system does not duplicate the outside provider's Medicaid billing.

Medicaid reimbursement to districts is authorized by West Virginia Code 18-2-5b, effective March 15, 1990. These funds provide additional financial resources for the county's educational services. Regardless of the status of the consent, the school district will continue to provide your child's IEP services with available federal, state and/or local school district dollars.

I give my consent to release information from my child's educational records for the purpose of Medicaid billing for the duration of services.

Parent Signature: X_____

Child's Medicaid Number: X_____

Family Physician (optional): _____