MEDICAID PARENT NOTIFICATION and CONSENT to TREAT and BILL

STUDENT NAME (first and last) *

DATE OF BIRTH *

STUDENT'S ATTENDING DISTRICT *

Attending Districts Served by Washtenaw ISD: *Ann Arbor, Chelsea, Dexter, Lincoln, Manchester, Milan, Saline, Whitmore Lake, Ypsilanti.*

If your child requires medical or social-emotional services listed below and has a Plan of Care, IEP (Individualized Education Program), IFSP (Individualized Family Service Plan), 504 Plan, health care plan, or needs crisis support services and is eligible for Medicaid at any time during the school year, we request your permission to treat/intervene with your child and bill the State Medicaid program to receive funding to help support the services your child received.

Supported Services include Speech/Language Therapy, Occupational Therapy, Physical Therapy, Social Work Services, Psychological Services, Nursing Services, Orientation and Mobility, Assistive Technology Services, Case Management, Personal Care, Evaluations and Transportation.

Billing the State Medicaid program for your child's School-Based Services does NOT affect your family's Medicaid insurance benefits and is at NO cost to your family now or in the future.
We are simply asking your permission to provide medical and/or social-emotional intervention and claim funds reserved by the State to help schools provide the services listed on your child's plan.

Billing the State's Medicaid program requires that we disclose information from your child's education records to the State, which could include school, date of birth, gender, disability, date of service, type of service. If your student receives Special Education Services, you will receive annual notification about information released in the Parent Handbook with Procedural Safeguards.

You have the right to refuse to consent to bill the State Medicaid system, and you have the right to revoke this consent at any time. If you check 'no' below, the district will still provide the services, but the district will not receive funding from the State Medicaid system for these services.

CONSENT: I understand and agree that the ISD and its local school districts may: *****

☐ Yes, provide treatment as needed for medically necessary services.

Please choose one of the following options: *

☐ Yes, bill the State Medicaid insurance program for reimbursement of School-Based Services provided to my child and disclose personally identifiable information from my child's education records (including school, date of birth, gender, disability, date of service, type of service) to Michigan Medicaid and its billing agencies for Medicaid reimbursement of services provided on or after my signature date. I understand I may revoke this consent in writing at any time.

☐ No, I do not give permission for the ISD and its local school districts to bill the State Medicaid system for reimbursement of School-Based Services provided to my child.

PARENT or GUARDIAN SIGNATURE * **DATE SIGNED ***

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