## **Parent Consent to**

**Access Public Insurance (Medicaid) and**

**Release Personally Identifiable Information for****Medicaid Billing Purposes**

**For Ages 3 - 21**

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission, also known as consent, to share information about your child with the Oregon Health Authority (OHA), Oregon’s State Medicaid Agency, in order to access Medicaid reimbursement for covered health services provided in the school setting. School districts and Early Childhood Special Education (ECSE) programs may receive partial reimbursement from the OHA for the costs of Medicaid covered health services provided to Medicaid-enrolled children with disabilities. In order to access Medicaid reimbursement, your child’s school district or ECSE program needs your consent to share information about your child with the OHA. The following type of information about your child may need to be shared with the OHA: name; date of birth; type of services provided, the date(s) services are provided, and by whom; attendance records, and State Student Identification Number (SSID).

**Parental Notification**

School districts and ECSE programs cannot share information about your child without your permission. As you consider giving your permission, please know that you have the following rights:

1. The school district cannot require you to sign up for the Oregon Health Plan (Medicaid) in order for your child to receive the school health services to which your child is entitled.
2. The school district cannot ask you to pay anything for your child's health-related services provided in the school setting. This means that they cannot ask you for a co-pay or deductible in order to bill the OHA for the services provided.
3. If you give the school district permission to share information with the OHA in order to bill Medicaid:
   1. This will not affect your child’s available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family’s use of Medicaid benefits outside of school.
   2. Your permission will not affect your child’s special education services or Individualized Education Program (IEP) or Section 504 rights in any way, if your child is eligible to receive them.
   3. Your permission will not lead to any changes in your child’s Medicaid rights.
   4. Your permission will not lead to any risk of losing eligibility for other Medicaid or OHA funded programs.
4. If you give permission, you have the right to change your mind and withdraw your permission at any time. You must let the school district know ***in writing*** that your permission is withdrawn.
5. If you withdraw your permission or refuse to allow the school district to share your child’s records and information with the OHA for the purpose of seeking Medicaid reimbursement for the cost of covered school health services, the school district will continue to be responsible for providing your child with the health services, at no cost to you.

**Parental Consent**

I have read the notice and understand it. Any questions I had were answered. I give permission to the school district or ECSE program to share with the OHA records and information concerning my child and their Medicaid covered health services, as necessary. I understand that this will help the school district or ECSE program seek partial reimbursement for the cost of Medicaid covered services provided to my child.

Date of Initial Written Notification to Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Child’s Name | Date of Birth | SSID |
| --- | --- | --- |
|  |  |  |

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directions to Education Agency - Use of Form**

**Authority**

This form is intended to comply with the February 14, 2013 revisions of the Individuals with Disabilities Education Act (IDEA) 2004 regulations related to the parental consent use of a child’s public insurance benefits and release of personally identifiable information to the State Medicaid agency per 34 CFR §300.154(d) and the Family Educational Rights and Privacy Act (FERPA).

**Purpose**

School districts and ECSE programs that propose to use a child’s Medicaid benefits use this form to comply with written notification requirements. It replaces existing consent to access Medicaid benefits forms on file for a child/student. This notice must be written in language that is understandable to the general public. The individual receiving this form has the right to receive this notice in their native language or other method of communication unless it’s clearly not feasible to do so.

Specifically, the form is used to document parent’s written informed consent, or refusal to consent, 1) to use the parent’s or child’s public insurance benefits (Medicaid) and 2) to release personally identifiable information about the child to the State Medicaid agency, the Oregon Health Authority (OHA).

**When Is this Form Used?**

This form is to be used for children ages 3-21. Use this form ***only*** after the school district or ECSE program has provided ***written notification*** to the parent that explains the proposal to use their public benefits and the rights that they are entitled to.

Once the school district or ECSE program obtains this one-time consent, the school district or ECSE program is not required to obtain parental consent before it accesses the child’s or parent’s public benefits or insurance in the future, regardless of whether there is a change in the type or amount of services to be provided to the child or a change in the cost of the services to be charged to the public benefits or insurance program (e.g., Medicaid).

**Completing the Form**

* Enter the school district/ECSE program information in the heading to adapt form for local use
* Enter the date the school district/ECSE program provided Initial Written Notification
* Enter the child/student’s:
  + Full legal name including middle name
  + Date of birth (month/day/year)
  + SSID number
* Ask parent to print name, sign the document, and enter date of signature
* Provide a copy to the parent/guardian and place a copy in the student’s file

**NOTE: District should consult with its legal counsel regarding any questions related to the requirements of state or federal regulations.**