MEDICAID PARENTAL CONSENT

As you may know, the Prince George's County School system provides service coordination and health-related services outlined in your child's Individualized Education Program (IFSP). Parent consent must be obtained before Prince George's County School system can disclose, for billing purposes, your child's personally identifiable information to the Maryland Department of Health and Mental Hygiene (DHMH). DHMH is the State agency responsible for the administration of the Medical Assistance (MA) Program, consistent with the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Act (IDEA).

Your consent to release the information in order to bill Medicaid, will allow Prince George's County School system to receive the maximum Medicaid reimbursement for services provided rather than covering the costs solely from your local tax dollars. Medicaid funding will help Prince George's County Public Schools expand and enhance the services to your child.

In order to provide a free and appropriate public education (FAPE) to your child Prince George's School system may not:

- Require you to sign up for or enroll in State's Medicaid Assistance in order for your child to receive FAPE under IDEA.
- Require you to incur an out of pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services,
- Use your child's benefits under Medical Assistance if that use would:
  - Decrease available lifetime coverage or any other insured benefit;
  - Result in your family paying for services that would otherwise be covered by Medical Assistance and that are required for your child outside of the time your child is school;
  - Increase premiums or lead to the discontinuation of benefits or insurances; or
  - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

- ✓ I give my consent for Prince George's County School system to disclose my child's personally identifiable information to the State's Medical Assistance Program in order to access Medical Assistance Benefits.
- ✓ I give permission to the Prince George's County School system to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's IFSP goals.
- ✓ I understand that if I refuse to allow the provider agency access to MA funds, it does not relieve the public agency of its responsibility to ensure that all required services are provided to my child at no cost to the parent.
- ✓ I understand that this service does not restrict or otherwise affect my child's eligibility for other Medical Assistance benefits. I also understand that my child may not receive a similar type of case management service under Medical Assistance if he/she qualifies for more than one type.
- ✓ I understand that the Prince George's County School System will submit information that will be used for the Special Services Information System. This system will be used by the MSDE and other State Agencies, as appropriate; to enable funding of programs and to assure my child's rights to any needed assessment.
- ✓ I hereby authorize Prince George's County Public Schools to share information with the MD State Department of Health and Mental Hygiene (DHMH) and for purposes of billing Medicaid for Medicaid covered case management and health related services that are identified in my child's Individualized Education Program (IFSP).
- ✓ I understand that the use of my Medicaid insurance to recover costs for special education services does not restrict or otherwise affect my child's eligibility for other Medicaid insurance benefits.
- ✓ I also understand if I choose to deny consent, Prince George's County Schools is obligated to provide all required special education services at no cost to me.
- ✓ I give my consent voluntarily and I understand that I may withdraw that consent at any time. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependent on my granting consent.

Parent/ Guardian Signature: _____ Date: _____

Student's Name _____ Student # _____ Date of Birth _____

School Name: _____ Medical Assistance# _____