One-Time Consent for
Medicaid School-Services Program

Student	Last:	First:	M:	ID:
Attending Building:		Grade:		Birth Date:

The district is delivering this notice via:_____On: _____

The Medicaid School Services Program in Michigan:

- Provides partial reimbursement to school districts for services such as Evaluations, Occupational Therapy, Physical Therapy, Speech Therapy, Audiology, Psychological Services, Social Work, Orientation and Mobility, Transportation, Nursing, Personal Care, Case Management and Assistive Technology Services.

- Does NOT affect a family's Medicaid insurance benefits and there is NO cost to the family, now or in the future.

- Helps school districts to offset some of the costs of health care provided to children.

- Is voluntary and requires a parent or guardian to provide written consent to release information about their child to the Michigan Medicaid agency and its affiliates to obtain reimbursement. This may include name, address, date of birth, student ID, Medicaid ID, disability/diagnosis, dates and services delivered.

If your child receives any of the services listed above and qualifies for Medicaid benefits at any time, we request your permission to release information to enable your school district to access School-Services Medicaid Reimbursement. **You will have to sign this consent <u>one time</u>; however, you will be informed annually of your right to withdraw this consent at any time via the Medicaid Annual Notification Regarding Parental Consent form.** If you do not provide consent, the district will still provide the services.

☐ I have received a copy of the Medicaid Annual Notification Regarding Parental Consent form.

☐ I understand and agree that _____ and _____
School District ISD Name

may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed in the Plan of Care (IEP, IFSP, Behavior Plan, Individualized Health Plan, Medical Management Plan or other).

☐ I do not give permission for _____ and _____
School District ISD Name

to seek reimbursement for services rendered as listed in Plan of Care (IEP, IFSP, Behavior Plan, Individualized Health Plan, Medical Management Plan or other).

_____ _____
Signature of Parent/Guardian Date:

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