



Date of Report: _____

Individualized Education Program

Student:	STN:
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Date of Birth: _____ **Age:** _____ **Current Grade:** _____ **Gender:** _____

Written notice before requesting your consent

Before the school corporation asks for your consent to bill Medicaid (public benefits) for services in your child’s Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), the school must give you this written notice about your rights and protections under federal law. And, before the school may disclose your child’s health-related educational service records to the State Medicaid agency for claiming purposes, the school must have your written consent.

Federal Special Education funds cover some but not all of the costs for services that the school is required to provide at no cost to you. Public benefits such as Medicaid may also be used to help fund these costs, but only if you choose to give your consent.

Your Rights and Protections

- If you choose not to give consent or later withdraw your consent, the school must continue to provide your child all required IEP or IFSP services at no cost to you.
- If you give consent, you have the right to withdraw that consent at any time.
- The school may not require you to enroll in Medicaid or other public health coverage program as a condition of providing IEP or IFSP services that it is required to provide at no cost to you.
- The school may not use your public benefits (Medicaid) if doing so would:
 - exhaust the plan benefit limitations (for example, decrease the number of covered visits or cause you to pay for services outside of school that would otherwise be covered);
 - cause you to pay a deductible, co-payment or other out-of-pocket expense;
 - increase your premium or lead to cancellation of benefits; or
 - jeopardize your child’s eligibility for Medicaid home and community based waiver services.

Written Consent to Bill Medicaid

Your signature on this form allows the school corporation to bill Medicaid for health-related educational services provided to this student. Medicaid reimbursement helps fund state and local costs for providing Special Education and related services, specialized equipment and training.

Student Name: _____ **Student Date of Birth:** _____

I give consent for South Bend Community Sch Corp to bill Medicaid for covered services in this student’s education program. My signature authorizes the school to release health-related educational services records to Medicaid as necessary for eligibility verification, billing and auditing.

I understand that:

- Giving, refusing or withdrawing consent will not impact my child’s/my Medicaid eligibility or benefits.
- I have the right to withdraw my consent at any time.
- The school corporation must provide required IEP or IFSP services even if I refuse or withdraw consent.
- Services in the IEP or IFSP must be provided at no cost to me even if I refuse or withdraw consent.
- Upon request, I may receive copies of any records the school disclosed to Medicaid.
- The school must give me written notice of my rights and protections under federal law one time each year.

Signature of Parent/Guardian or Student who is 18 years old or older with no legal guardian:

Name	[please print]	Signature	Date

This completed form must be retained and available for audit purposes.

