Bandon SD	**Brookings SD**	**Gold Beach SD**	**Coos Bay SD**	**Coquille SD**
Myrtle Point SD	**North Bend SD**	**Port-Orford SD**	**Powers SD**	**Reedsport SD**

(Circle one)

WRITTEN CONSENT *to* **ACCESS PUBLIC INSURANCE (MEDICAID) and**
RELEASE PERSONALLY IDENTIFIABLE INFORMATION *for* **MEDICAID BILLING PURPOSES**
For Ages 0 – 21

Last Name: _____ First Name: _____

Birth Date: _____ Medicaid ID#: _____

SSID #: _____ Date of Initial Written Notification of Change: _____

Resident District: _____ Attending School: _____

I understand that– _____ **(School District)**

1. My informed written consent is required before *the* **School District** may access my public insurance (such as Medicaid) or release my child's personally identifiable information to State agencies (such as Department of Human Services or Oregon Health Authority) for purposes of billing Medicaid**.**
2. My consent is voluntary. If I refuse to give consent, the **School District** must still provide the special education and related services needed to provide a Free Appropriate Public Education (FAPE)**.**
3. The **School District** must give me a written notification that explains consent *before* it asks for my consent.
4. The **School District** *will* only ask for my informed written consent the *first time* it requests access to my public insurance (e.g. Medicaid) and requests permission to release personally identifiable information from my child's education records for purposes of Medicaid billing. After that, I will receive annual notices about this information.
5. I may revoke my consent at any time by notifying the **School District** in writing. Revoking consent for the use of my public benefits or insurance means my public insurance benefits will not be accessed and my child's personally identifiable information will not be released on or after the date revocation is effective.
6. If I revoke my consent my child will still receive the special education and related services needed to provide a Free Appropriate Public Education (FAPE) at no cost to me.

By giving consent I understand and agree that the **School District**

1. May access my public insurance benefits (Medicaid) to pay for special education and related services provided as part of the Individuals with Disabilities Education Act (IDEA);
2. May disclose personally identifiable information from my child's education records to the following agency(ies) only for the purpose of Medicaid billing: Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA)
3. May disclose the types of personally identifiable information indicated below:
   a. Name and address of my child, my child's parent, or other family member;
   b. A personal identifier, including the child's social security number; the child's date of birth; gender; diagnosis and procedure codes for billing Medicaid;
   c. Records of special education and related services provided under the Individuals with Disabilities Education Act (IDEA). (Examples: evaluation and assessment reports from special education service providers and educators, eligibility statements, educational plans (IEP/IFSP), IEP progress reports; health records that are considered student education records under the Individuals with Disabilities Education Act (IDEA) and the Family Educational Rights and Privacy Act (FERPA)); and
   d. Other (List):

I GIVE MY CONSENT to access my public insurance (Medicaid) and to disclose, for billing purposes, my child's personally identifiable information listed above.

_____ _____
Signature of Parent/Guardian *Date*

I DO NOT GIVE CONSENT to access my public insurance (Medicaid) or to disclose, for billing purposes, my child's personally identifiable information listed above**.**

_____ _____
Signature of Parent/Guardian *Date*

For more information, contact: South Coast ESD Medicaid Biller 541-266-4022

Revised 9-2019

Medicaid Biller
Date Received: _____ Notified Program of Eligibility
_____ _____
Date Signature

Related Service Providers
(Circle all that apply)
OT/ PT Nursing K-12 Speech Aug Com
Return to SCESD Medicaid Biller

Directions – Use of Form

Authority
This form complies with the February 14, 2013 revisions of IDEA 2004 regulations, effective March 18, 2013, related to the parental consent use of a parent or child's public insurance benefits and release of personally identifiable information to the State Medicaid agencies 34 CFR §300.154(d). These requirements apply to children ages 3-21.

Purpose
Districts and ECSE programs that propose to use a parent/child's Medicaid benefits use this form to implement the new consent regulations. 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(-ies), the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA).

When Is this Form Used?

This form is to be used for children ages 0-21.

Use this form *only after* the district or ECSE program has provided *written notification* to the parent that explains the proposal to use their public benefits and the IDEA safeguards related to use of public benefits.

It is used the first time that there is a change in the type or amount of the 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 and AFTER the district or ECSE program has provided written notification to the parent that explains the proposal to use their public benefits and the IDEA safeguards related to use of public benefits.

Once the public agency obtains this one-time consent, the public agency 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

Heading - Enter the District/Agency information in the heading to adapt form for local use.

Enter the child/student's identifying information:
Full legal name, last name first, including middle name.
Date of birth (month/day/year).
SSID number.
Enter date the District provided Initial Written Notification in accordance with March 2013 federal revisions of federal law.

Throughout the document enter the name of the District or ECSE program (for preschool children ages 3-5) where indicated:

- Ask parent to sign and enter date of signature in the appropriate blank (either giving consent or refusing consent).
- Provide a copy to the parent/guardian and place a copy in the student's file.