**Prairie Hills Elementary School District 144**

**Consent for Medicaid School-Based Services**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Medicaid School-Based Services Program in Illinois:

* Provides partial reimbursement to school districts for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work, Transportation, Nursing, Personal Care, and Medical screenings.
* 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 Illinois Medicaid agency and its affiliates to obtain reimbursement. This may include name, and date of birth, Medicaid ID, disability, dates and services delivered.

If your child receives any of the services listed above and qualifies for Medicaid benefits at any time during the school year, we request your permission to release information to enable your school district to access School-Based Medicaid Reimbursement. You have the right to withdraw this consent at any time. 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.
* I understand and agree that Prairie Hills Elementary School District 144 may access my child’s public benefits in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), or as part of required medical screenings.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_