School District or Intermediate Unit Name

MEDICAL ASSISTANCE PROGRAM BILLING CONSENT

I understand that the school district or intermediate unit identified above may charge the School-Based Access Program ("SBAP")—or any public benefit or insurance program that replaces or supplements the SBAP—the cost of certain special education and related services described in my child's IEP. To make these charges to the SBAP, the school district or intermediate unit will release to the administrator of that program the name, age, and address of my child, verification of Medicaid eligibility for my child, a copy of my child's IEP, a description of the services provided and the times and dates during which such services were provided to my child, and the identity of the provider of such services. I understand that such information will not be disclosed, and such charges will not be made, unless I consent to the disclosure. ***I understand and agree that the school district or intermediate unit may disclose the information identified above and may access the my child's public benefits or insurance to pay for services under the Individuals with Disabilities Education Act ("IDEA")***.

My agreement is subject to the following understandings:

I understand that my consent is ongoing from year-to-year unless and until I withdraw it. I can withdraw my consent in writing, or orally if I am unable to write, at any time. My refusal to consent or my withdrawal of consent will not relieve the school of the obligation to provide, at no cost to me or my family, any service or program to which my child is entitled under the IDEA or that is necessary to enable my child to receive a free appropriate public education as described in my child's IEP.

I understand that the school cannot—

Require me or my family to sign up for or enroll in any public benefits or insurance program, such as Medicaid, as a condition of receiving a free appropriate public education for my child;

Require me or my family to incur any expense for the provision of a free appropriate public education to my child, including co-payments and deductibles, unless it agrees to pay such expenses on my or my family's behalf;

Cause a decrease in available lifetime coverage or any other insured benefit;

Cause me or my family to pay for services that would otherwise be covered by a public benefits or insurance program and that are required for my child outside the time that he or she is in school;

Risk the loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

I received a copy of this notice on the date indicated next to my signature below.

_____

Student Full Name Student ID Date of Birth

____ I have read the Notice and I give consent for the LEA to share my child's education and health-related information and bill Medical Assistance.

_____

Parent/Guardian/Surrogate Signature Printed Name Date