PLEASE RETURN THIS FORM TO:
Classroom teacher who will send to Special Services Department

One-Time Parent/Guardian Consent to Access Public Benefits and Release Personally Identifiable Information

With your consent, your school district is allowed to seek reimbursement from the MO HealthNet (Medicaid) Division for the purpose of payment for some services provided through an individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA) by accessing your or your child's public benefits.

School District Name: Galena R-II Schools
Student's Full Name: ___________________________________Date of Birth:___________

The MO HealthNet (Medicaid) School-Based Services Program in Missouri:

- Provides partial reimbursement to school districts for services such as occupational therapy, physical therapy, speech/language therapy, behavioral health services, audiology/hearing services, private-duty nursing, personal care services and transportation.
- Does not affect a family's MO HealthNet (Medicaid) insurance benefits.
- Helps school districts offset some of the costs of healthcare provided to children.
- Is voluntary and requires parents/guardians to provide written consent for a school district to release information about their child and seek reimbursement from MO HealthNet to help pay for services in an IEP under the IDEA.

If your child receives any of the services listed above and qualifies for MO HealthNet benefits at any time during a school year, we request your permission to release information to allow the school district to access MO HealthNet (Medicaid) to help pay for school-based services.

By signing below, you are indicating the following:

- I understand and give the school district permission to access my or my child's public insurance and release my child's education records and information about the services my child receives through the IEP in order to access MO HealthNet (Medicaid) to help pay for services under the IDEA.
- I understand this may include sharing information with the MO HealthNet Division (MHD), their contracted billing agent, and/or a physician to obtain necessary documentation (e.g., physician scripts, referrals) to receive partial reimbursement for services provided through an IEP.
- I understand information to be released may include: the child's name, date of birth, Social Security number (if provided), Medicaid ID or other identification, disability type, IEP and evaluations, types of services, times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child unless revoked by me and that I may revoke my consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice telling me more about parental consent and the purpose of this form.
- My consent authorizes the school district to access benefits beginning August 1, 2020.

APPROVE

____ ___________
Parent/Guardian Name (Printed or Typed) Date

____
Parent/Guardian Signature

DECLINE

____
Please initial