Date:

_____

Region IX Education Cooperative
237 Service Road. Ruidoso. NM 88345 575-257-2368

CONSENT TO ACCESS MEDICAID AND RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

School District (Distrito Escola)_____
Student Name(Nombre del Estudiante)_____
Date of Birth (Fecha de Nacimiento)_____ SS# (De Seguro)_____
Address (Domicillio)_____Phone(Telefono)_____

TO THE PARENT: Enclosed with this CONSENT is a WRITTEN NOTIFICATION.

The school district must obtain your informed consent before it may access for the first time your child's Medicaid benefits to pay for Medicaid-Eligible IEP services and discloses necessary information from your child's school records to complete the billing process. If you indicate **YES** in response to all of the statements below and sign at the bottom, you will be giving your consent for the school district, now and in the future, to access your child's Medicaid benefits to pay for Medicaid-Eligible IEP services and to disclose confidential information from your child's education records to obtain prior authorization from your child's Primary Care Provider (PCP) to complete the billing process.

Once the school district obtains your one-time consent, unless you subsequently revoke your consent, the school district will not be required to obtain any further parental consent to release and exchange confidential information with your child's PCP and Medicaid for purposes of billing Medicaid, and to bill Medicaid even when there is a change in the type, amount, or cost of services to be billed to Medicaid. However, the school district must annually provide you with written notification to ensure that you understand your rights.

This consent for disclosure (release and exchange of confidential information) is for the release and exchange of your child's record(s)/confidential information between the school district, your child's Primary Care Provider (PCP) and the Medicaid agency.

Confidential Education Record Information to be Released to your Child's Primary Care Provider (PCP) and Medicaid:

- Billing information such as your child's name, date of birth, Medicaid number.
- A current copy of your child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) reflecting the Medicaid services to be billed.
- Any evaluations conducted or maintained by the School District as part of your child's education records that demonstrate the medical necessisity of the services specified in the IEP or IFSP.
- Other information from your child's education records as may be necessary to clarify the nature and need for the services specified in the IEP or IFSP.
- The dates and frequency of the billed services provided.

Confidential Medical Information to be Released by your Child's Primary Care Provider (PCP):

- The Primary Care Provider (PCP) shall be asked to sign and return the individualized treatment plan (ITP) portion of the IEP or IFSP.
- Other information from your child's medical records as may be necessary to clarify the nature and need for the services specified in the IEP or IFSP so that the PCP may order or authorize such services.

State the purpose of the disclosure (if any) by the school district:

- In order to bill Medicaid for those services under the IDEA specified in your child's IEP that may be paid for by Medicaid (Medicaid-Eligible IEP services). To bill Medicaid:
  - Services must be medically necessary, must be ordered or authorized by the child's Primary Care Provider (PCP), and must meet the needs specified in the IEP or the IFSPl
  - Services require prior authorization by the Primary Care Provider (PCP). The requirement for prior authorization is met when the PCP signs the ITP portion of the IEP or IFSP.
  - Complete copies of the IEPs or IFSPs, with the ITP portions of the IEPs or IFSPs signed by the primary care provider (PCP), must be maintained as part of the required records.

If consent is granted, the Primary Care Provider to whom the School District discloses information may not disclose the information to any other party without the prior consent of the parent or eligible student.

Please respond to each statement with a **YES** or **NO** and sign at the bottom.

☐ Yes ☐ No I understand and give my consent for the school district to access my child's Medicaid benefits to pay for Medicaid-Eligible IEP services and to disclose confidential student information to the Medicaid agency as necessary to complete the billing process.

☐ Yes ☐ No I have been fully informed of the records and confidential information to be released and exchanged, the purpose of the release/exchange, and that the release/exchange will be between the school district, my child's Primary Care Provider (PCP), and the Medicaid agency.

☐ Yes ☐ No I understand that my consent is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ Yes ☐ No The information provided to me has been provided in my native language or other mode of communication. If other than English, specify: _____.

_____ _____

Signature of Parent Date

_____ _____

Signature of Interpreter, if used Date

Please return this page to Region IX Education Cooperative, 237 Service Road, Ruidoso, NM, 88345.
Phone (575) 257-2368 Fax (575) 257-2141
Favor de regresar esta forma al domicilio de arriba