# NOTICE TO PARENTS
## Regarding Consent to Bill Medicaid

*Background:*
The Anchorage School District provides special education services at no cost to the parents. Services may include occupational therapy, physical therapy, speech-language services, hearing services and behavioral health services. Services provided to students who are eligible for Medicaid or Denali Kid Care may be partially reimbursed by Medicaid. Prior to accessing a child's or parent's public benefits or insurance for the first time, and annually thereafter, school districts must provide written notification consistent with the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) §300.154(d)(2)(v) and the Family Educational Rights and Privacy Act (FERPA).

*Notice Regarding Consent to Bill Medicaid:*

- Anchorage School District is required to obtain parental consent prior to disclosing information for the first time from a child's education records to outside parties, such as the Medicaid or another public health insurance agency.

- Consent is voluntary. If the parent refuses to provide Consent to Bill Medicaid or revokes previous consent, the child will still receive the services on his/her IEP at no cost to the parent.

- Consent may be revoked in writing at any time.

- Once written Consent to Bill Medicaid is obtained, Anchorage School District is required to provide parents with annual written notice regarding Consent to Bill Medicaid; the written notice may be:
  - Mailed to the parents, or
  - E-mailed if requested by the parents, and if consistent with State or public agency policies, or
  - Provided at an IEP Team meeting if the meeting occurs prior to the first time ASD accesses the child's or parent's public benefits or insurance, or

- Anchorage School District may not use a child's benefits if that use would:
  - Decrease available lifetime coverage or any other insured benefit;
  - Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;
  - Increase premiums or lead to the discontinuation of benefits or insurance; or
  - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

# PARENT PERMISSION
## For Medicaid School-Based Services

**Student Name:** _____ **Birth Date:** _____

**Attending School Building:** _____

Anchorage School District will participate in the Alaska Medicaid School-based Services Program. This program allows school districts to bill Medicaid for partial reimbursement of health services provided in schools to Medicaid-eligible students who receive special education services. Medicaid School-based services include occupational therapy, physical therapy, speech-language, hearing services and behavioral health services.

If your child receives any of the above services and qualifies for Medicaid benefits at any time during the school year, **we request your permission to bill your child's Medicaid insurance to receive reimbursement for services.** In releasing the billing information, school-based service treatment information about your child may also be released to Medicaid. You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid. If you do not provide consent, the district will still provide the services but the district will not receive any Medicaid reimbursement for these services.

The funds received from the Medicaid School-based Services Program will be used to reimburse Anchorage School District for its staff costs in providing health-related IEP services.

**Billing the Medicaid program for your child's School-Based Services will not affect any other Medicaid benefits that your child may receive.**

I understand and agree that ASD may access my child's Medicaid insurance to pay for services.

I give permission for Anchorage School District to bill my child's Medicaid insurance for reimbursement of School-based Services.

**Parent/Guardian Signature:** _____ **Date:** _____

**Relationship to Student:** _____

**Child's Medicaid I.D. #:** _____ *(if known)*

**Please return this form to the Anchorage School District, Attn: Medicaid Office, 5530 E. Northern Lights Blvd., Anchorage, AK 99504**

Revised 8/1/16