ANCHORAGE SCHOOL DISTRICT SCHOOL-BASED MEDICAID
PARENT INITIAL NOTIFICATION AND CONSENT TO BILL

Student Name: _____Birth Date: _____

The Anchorage School District (ASD) participates in the Alaska Medicaid School-Based Services (SBS) Medicaid Program.

The School-Based Services (SBS) Medicaid program*:

- **DOES:**
  - Allow schools to receive federal Medicaid funds as partial reimbursement for qualifying medically necessary and educationally necessary health-related services provided to students, such as but not limited to: Occupational Therapy, Physical Therapy, Speech/Language Therapy, Audiology, Nursing Services, Psychological Services, Counseling, or Behavior Health Services.
  - Help schools offset some of the costs of the services provided to students.
  - Require a one-time, signed parent/guardian Medicaid Consent allowing release of relevant student information, such as demographic, diagnostic, and service provision records with Alaska Medicaid and their contracted billing agency to pursue reimbursement for services rendered to your child.
  - Require schools to provide written, annual notice to families informing them of their SBS Medicaid rights for signed Medicaid consents.
- **DOES NOT:**
  - Impact the student's access to academic and support services they need;
  - Require students to enroll in Medicaid;
  - Cost the family anything; or
  - Affect the student or family's Medicaid insurance eligibility, benefits, or lifetime limits.

☐ YES, I authorize the SBS Medicaid office of the ASD to release information for my child, to verify Alaska Medicaid eligibility and bill Alaska Medicaid for reimbursements for eligible services provided to my child.

☐ NO, I do not authorize the ASD SBS Medicaid office to release information for my child to Alaska Medicaid.

By granting authorization I acknowledge that:

- I have been informed of my rights concerning the release of relevant education record information in order for ASD to verify Medicaid eligibility and obtain reimbursement for eligible services;
- I understand that this consent is voluntary and I have the right to revoke consent at any time;
- Should I revoke consent, it is valid from the date of revocation forward and is not applied retroactively--meaning that the revocation will not undo verifications or claim already submitted to Alaska Medicaid for periods covered by a prior consent.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

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

----------FOR OFFICE USE ONLY----------

Please return all forms to the ASD Medicaid department by either inter-district mail or scan to schoolbasedmedicaid@asdk12.org.

*In compliance with the Individuals with Disability Education Act (IDEA), 34 CFR part 300.154(d), and Federal Education Rights and Privacy Act (FERPA), 34 CFR part 99.

Please contact the ASD SBS Medicaid Office at 907-742-6068 or email schoolbasedmedicaid@asdk12.org with questions or concerns.
ASD SBS Medicaid Office, 5530 E. Northern Lights Blvd., Anchorage, AK 99504
2.2023