Please fill in your and your child's names & sign the bottom of the form even if you DO NOT have MEDICAID. This form will stay in your child's file, and will only be used if/when your child receives special education services.

Solvay Union Free School District
Committee on Special Education
Committee on Special Education
PO Box 980/299 Bury Dr.
Syracuse, NY 13209 (315-484-1412)

Medicaid Consent

Dear

RE:
DOB:
Client Identification Number (CIN):

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____,
(print name of parent/guardian) ***(please print name of child)***

have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Medicaid CIN # ☐☐☐☐☐☐☐☐☐☐ **Or Initial here: _____ My Child is NOT Eligible for Medicaid.**

Parent/Guardian Signature: _____

Print Name: _____ Date: _____