MEDICAID PARENTAL CONSENT INFORMATION

Why is this important to McCormick County School District?

South Carolina school districts have the opportunity to receive federal funding through the School-Based Medicaid program. This important program helps fund and support the District's services provided to students. It offers a financial benefit to the District and helps South Carolina taxpayers by taking advantage of available federal funding instead of relying 100% on state funding.

Why is my consent needed?

Your consent is needed so that if your child is eligible for Medicaid, now or in the future, and is evaluated for and/or receives certain health-related services, the federal government can reimburse the District for those services. Your consent is needed to allow our district to receive funding to improve its programs.

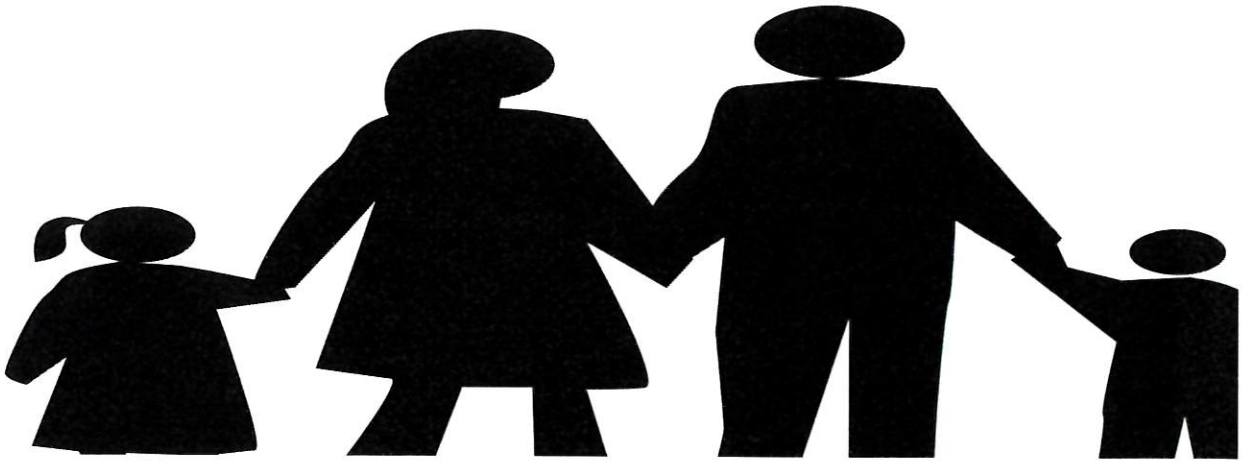
Will this affect my child's private medical/clinical services or insurance?

The reimbursement from this program should have no impact on medical insurance or existing benefits that you or your family receive, whether provided by private medical insurance or Medicaid. We work with our Medicaid billing vendor to take several precautions to help prevent private provider services from being impacted and you can revoke your consent at any time.

Thank you for your support!

Please know that the reimbursement received through the School-Based Medicaid program has a significant impact on the services provided to students. We appreciate your attention to this request and willingness to return the enclosed consent form so that our district can seek federal reimbursement for our services!

If you have questions about the form, or any of the information presented on this handout, please contact our Medicaid coordinator, Wendy Gable, via email, wgable@mccormick.k12.sc.us, or by phone at 864-852-2435.



MCCORMICK COUNTY SCHOOL DISTRICT
821 N. MINE STREET MCCORMICK, SOUTH CAROLINA 29835 TEL 864-852-2435 FAX 864-852-2883

Medicaid General Consent

The McCormick County School District and the South Carolina Department of Education (SCDE) have my permission to provide services to my child and release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services (SCDHHS) and any applicable third-party insurer regarding billable services provided to my child. I understand the purpose of this consent is to bill Medicaid and/or private third-party insurer for services under the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the SCDE my permission to bill and receive payment from Medicaid and any third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an individualized education program (IEP). The District provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to my signing this consent to release information to bill Medicaid or any third-party insurer and prior to accessing Medicaid or my child's third-party insurance benefits.

I further understand that the District must provide me annual written notification of my rights (attached) relative to Medicaid or any third-party insurer accessing my child's information and before the District and the SCDE access my benefits to pay for services under the IDEA. This consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually thereafter, unless there is a change in the type or amount of services to be provided to my child or a change in the cost of the services to be charged to Medicaid or a third-party insurer. I understand that Medicaid and third-party insurance reimbursement for billable services provided by the District and the SCDE will **not** affect any other Medicaid services or insurance benefits for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether my child is covered by public or private insurance programs and regardless of whether I provide consent to access those benefits. I understand that my refusal to consent to the SCDHHS or any third-party insurer accessing my child's personally-identifiable information does not relieve the District of its responsibility to ensure that all required services in my child's IEP are provided at no cost to me.

I understand that this consent is voluntary on my part and may be revoked at anytime. If I later revoke consent, the revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).
I also understand that the District and the SCDE will operate under the guidelines of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of services.

Student's Name: _____ DOB: _____ Medicaid #: _____

_____ _____
Signature of Parent/Guardian Date