Schenectady City Schools

PUPIL SERVICES AND SPECIAL EDUCATION

STEINMETZ EDUCATIONAL CENTER
900 OAKWOOD AVE.
SCHENECTADY, NEW YORK 12303
(518) 370-8101 Ext. 114

PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

STUDENT NAME:____**DOB:**___________
LAST FIRST M.I.

By signing this form, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.

- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.

- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program

- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, __________________________________, as parent/guardian of ______________________________
(Print name of parent/guardian) Student Name

give permission to the Schenectady City School District to use Medicaid to pay for IEP services, and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependant on my granting consent.

Signature: __________________________________ Date: ______________