Initial Notice and Consent
Regarding Medicaid Reimbursement

NOTICE

The Louisiana Department of Health and Hospitals (DHH) Medicaid program allows school districts to request reimbursement for costs associated with provision of certain IEP related services. These services include occupational and physical therapy, speech pathology, behavioral health services, nursing services, and special transportation. Schools are required to provide notice and to obtain consent from a parent before accessing a child's Medicaid benefits.

_____ seeks your consent to disclose personally identifiable information about your child to Louisiana Medicaid to access reimbursement for the IEP/Medicaid covered health services that are provided at school. In order to submit claims for IEP/Medicaid covered services, the following types of records may be required: child's full name, address, date of birth, Medicaid ID, disabilities, types of services and dates of services delivered. This disclosure of information to Louisiana Medicaid and its affiliates and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime Medicaid coverage, result in any cost to you or your family, increase any premiums or lead to the discontinuation of your child's benefits or insurance or create any risk of loss of your child's eligibility for home and community-based waivers based on total health- related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to your child.

CONSENT

I hereby authorize _____ to disclose necessary information to Louisiana Medicaid in order to seek reimbursement for the IEP/Medicaid-covered health services provided to my child.

_____ _____

Name of Student Date

_____ _____

Parent(s)/Guardian(s) Signature Relationship to Student

Annual Notice
Regarding Medicaid Reimbursements

_____
Date

_____
Student's Name

You have authorized the _____ to share personally identifiable information about your child with Louisiana Medicaid and to seek reimbursement for the IEP/Medicaid covered health services that are provided at school.

This disclosure of personally identifiable information to Louisiana Medicaid and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime coverage, shall not result in any cost to you or your family, shall not increase any premiums or lead to the discontinuation of your child's benefits or insurance, and shall not create any risk of loss of your child's eligibility for home and community-based waivers based on total health-related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to your child.

For assistance in this area, please contact: _____at _____