ONE-TIME CONSENT TO ACCESS PUBLIC BENEFITS AND RELEASE PERSONALLY IDENTIFIABLE INFORMATION TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS), ARIZONA'S MEDICAID AGENCY

Student's Name: _____ Current School: _____
Student's SAIS ID: _____ Date of Birth: _____

Federal special education law, the Individuals with Disabilities Education Act (IDEA), requires schools to obtain your consent to verify eligibility for Medicaid and submit claims for reimbursable school-based services provided on behalf of your child. The types of services that can be reimbursed by Medicaid include physical therapy, occupation therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluations. These services may be provided to your child through an individualized education program (IEP) and the school may be reimbursed by Medicaid if your child is eligible to receive Medicaid benefits.

Under the Family Educational Rights and Privacy Act (FERPA), your consent is required for the school to release information about your child to AHCCCS (or their authorized agency) in order to access your or your child's public benefits. With your permission, _____ *will submit your child's name and birth date to AHCCCS (or their authorized agency) to verify eligibility. The submission of this information will not change the services provided in your child's IEP. With your consent,* _____ *will also share necessary information from your child's education record to obtain reimbursement from AHCCCS if the services provided to your child can be reimbursed because of your child's eligibility for Medicaid benefits.*

I authorize _____ to share any necessary identifying information from my child's educational records (including records about the services that may be provided to your child) to verify Medicaid eligibility with AHCCCS and to access my or my child's public benefits to obtain Medicaid reimbursement for school-based services from AHCCCS. If my child is no longer served by this school system, I understand that this consent will not transfer to a new school. This authorization will begin on the date that I sign and give consent below.

By giving consent, I acknowledge that:

(1) I have been fully informed of all information relevant to accessing my or my child's Medicaid benefits and informed of the reasons I have been asked to provide consent to release relevant information from my child's education records to verify eligibility and to obtain reimbursement from AHCCCS or their authorized agency;
(2) I may request and receive a copy of the records disclosed;
(3) My child will continue to receive special education services at no cost to me;
(4) Reimbursed services provided by _____ will not count against funding limits in Medicaid programs in which my child is enrolled;
(5) I understand that the granting of consent is voluntary on my part and I may revoke consent at any time;
(6) If I revoke consent, the revocation is not retroactive, which means that it does not undo any verification or billing through AHCCCS that has already taken place, but it will stop any future verification or billing.

☐ I give my consent to verify my child's Medicaid eligibility with AHCCCS (or their authorized agency) **and** to submit claims for allowable services.

☐ I do not give consent. I understand that my refusal to consent means that the school system cannot verify eligibility or make a claim for reimbursement for services that might otherwise be covered by AHCCCS. I also understand that my refusal does not affect my child's access to special education services under his or her IEP.

_____ _____
Parent/Guardian Signature *Date*

If you have questions about this consent, please call or e-mail your school for an explanation of the reason for this request:

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