Notice of Parental Rights Concerning the Use of Public Benefits or Insurance

Dear Parent or Guardian:

The District School Board of Pasco County may request the use of Medicaid or other public benefits or insurance programs in which your child participates to provide or pay for services required under the Individuals with Disabilities Education Act (IDEA), section 300.154(d)(2)(v) of Title 34, Code of Federal Regulations, as permitted under the public benefits or insurance program. The IDEA requires that your school district obtain a one-time parental consent before accessing your child's or your public benefits or insurance for the first time. The one-time parent consent must specify:

1. The personally identifiable information that may be disclosed,
2. The purpose of the disclosure,
3. The agency to which the disclosure may be made, and
4. That you understand and agree that the school district may access your child's or your public benefits or insurance to pay for services under Part B of the IDEA.

The District School Board of Pasco County must also provide written notification to you before accessing your child's or your public insurance for the first time, prior to obtaining the one-time parental consent, and annually thereafter.

You have the right to withdraw your consent to disclosure of your child's personally identifiable information to the agency responsible for the administration of the state's public benefits or insurance program at any time. Withdrawal of your consent or refusal to provide consent to disclose personally identifiable information does not relieve the school district of its responsibility to ensure that all required services are provided at no cost.

The District School Board of Pasco County:

1. May not require you to sign up for or enroll in public benefits or insurance programs in order for your child to receive a free appropriate public education under IDEA Part B;
2. May not require you to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but the school district may pay the cost that you otherwise would be required to pay;
3. May not use your child's benefits under a public benefits or insurance program if that use would:
    a. Decrease available lifetime coverage or any other insured benefit;
    b. Result in your family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for your child outside of the time your child is in school;
    c. Increase premiums or lead to the discontinuation of benefits or insurance; or
    d. Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

If you have questions about this notification, please contact Medicaid Program Coordinator at (813) 794-2601.

The District School Board of Pasco County
Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

The Individuals with Disabilities Education Act 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school [34 CFR Section 300.154(d)(2)(iv)(A)-(B)]. Our school district wishes to seek reimbursement for certain services provided to your child by accessing Medicaid. IDEA requires that we obtain your written informed consent for the purpose of releasing certain information related to seeking Medicaid reimbursement. Medicaid reimbursement helps the school district fund costs of providing special education and related services.

Consent given or denied: (please read, initial, sign and date at the bottom)

___ I understand and give my consent to the district to share information about my child with the state Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the district's Medicaid billing agent or billing facilitator for the district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary to receive an appropriate education at no charge to my child in accordance with 34 CFR section 300.154(d)(2)(v)(D). If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

The information shared may include my child's name, date of birth, address, primary special education disability, Social Security number, Florida Medicaid identification number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, physical therapy services, speech therapy services, hearing and language therapy services, occupational therapy services, behavioral services, transportation services, nursing services.
The records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records.

___ I do not give my consent to the district to share information about my child in order for the district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. Please also call (813) 794-2601 and give notice that you are opting out.

Please note that public insurance benefit use as described herein will not effect your public insurance benefits in any way.

Parent/Guardian Signature		Date signed:	
Parent/Guardian Name (Print)			
Student/Child's Full Name (Print)			
Student/Child's DOB			