**Aurora Public Schools**

**—SCHOOL BASED MEDICAID REIMBURSEMENT CONSENT—**

| **Student Name:** | **Student ID:** |
|---|---|
| **Date of Birth:** | **School Name:** |

The school district can be partially reimbursed by Medicaid for health related services prescribed in your student's Individualized Education Program. The funds received help to pay the cost of providing those services and to provide additional health services to all students.

Under the Family Education Rights and Privacy Act (FERPA), your written parental consent is needed in order for the School District to bill Medicaid for these services. Billing information includes your student's name, date of birth, address, educational disability and type and amount of services that have been provided. Your consent allows the school district to submit this information to Medicaid for reimbursement for said services.

**Rights:**

- The District will not require you to enroll in Medicaid in order for your child to receive special education services.
- Your child will continue to receive the services listed in his or her IEP, without interruption and at no cost to you, whether or not you sign this form.
- Your consent will not impact your child's Medicaid coverage.
- Your consent is voluntary and may be withdrawn at any time.
- If you withdraw your consent, the district will not bill Medicaid for any services provided from that date forward.
- You are entitled to notice of your rights annually. A copy of the annual Notice of Rights is attached.

☐ **Yes** I give permission, if and when my child is Medicaid eligible, for the District to bill Medicaid for health related services in accordance with my student's IEP. I have read and understand the information in this form.

☐ **No** I do not give permission for the District to bill Medicaid for health related services in accordance with my student's IEP.

**Date:** _____

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**Parent/Guardian Signature**

**Aurora Public Schools Medicaid Department: 303-365-7813**