AURORA PUBLIC SCHOOLS
OFFICE OF MEDICAID SERVICES

REQUEST FOR MEDICAID FUNDS FOR UNINSURED STUDENT MENTAL HEALTH NEEDS

(Fund for children who are uninsured and have a financial need)

DATE _____

STUDENT NAME_____ DOB_____

STUDENT ID# _____ SCHOOL _____

PARENT NAME _____ADDRESS_____

PHONE (HOME) _____ (WORK) _____

INFORMATION REGARDIING REQUEST
(Include a description of the student's mental health and ***financial needs***)

Signature of person making referral_____ Date_____

Telephone number and best time to be reached_____

RELEASE OF INFORMATION

I desire that the Aurora Public Schools refer my child to a mental health professional, and give my permission for the school district to release the information included on this form to the assigned agency or therapist. I understand that there is a limit of ten therapy visits and that I am responsible for providing transportation to the site of service.

I understand that the Aurora Public Schools District has conducted no investigation to determine the competence of individual therapists and assumes no responsibility for his/her professional conduct.

Signature of parent/guardian: _____ Date: _____

Fax request to the Office of Medicaid Services - 303-326-1813