EATON
INTERMEDIATE SCHOOL DISTRICT
1790 E. Packard Hwy. ~ Charlotte, Michigan 48813
517-543-5500 * Fax: 517-543-5166

# Parent Permission to Bill Medicaid for School Based Services

Student Name: _____ Birth Date: _____

Attending District: _____

Since 1993 the Eaton Intermediate School District and its local districts have participated in the Medicaid School Based Services program. This program allows the districts to bill the Medicaid program for reimbursement for health services provided in the schools to special education students who are eligible for Medicaid.

The **Medicaid School Based Services Program** in Michigan:

- Provides partial reimbursement for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work Services, Orientation and Mobility Services, Transportation, Nursing Services, Case Management and Assistive Technology Services.
- Does **NOT** affect a family's Medicaid insurance benefits and there is **NO** cost to the family, now or in the future.
- Helps school districts because it offsets some of the costs of health care that we provide to children and students.
- Is voluntary and requires parent or guardian to provide written consent to release information about their child in order to bill Medicaid. This consent may be revoked at any time by the parent or guardian.
- Requires information about your child's school based services (which could include date of birth, disability, gender, school, date of therapy, type of therapy and progress reports) by the Michigan Medicaid and billing agencies to obtain this reimbursement.

If your child receives any of the above services and qualifies for Medicaid benefits at any time during the school year, we request your permission for the Eaton Intermediate School District and its local school districts to bill your child's Medicaid insurance to receive reimbursement. You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid. If you do not provide consent, the district will still provide the services but the district will not receive any Medicaid reimbursement for these services.

I give permission for the Eaton Intermediate School District and its local school districts to bill my child's Medicaid insurance for reimbursement of School Based Services provided during the school year as described in my child's IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan).

**Date:** _____

**Parent/Guardian Signature:** _____