

[SCHOOL DISTRICT NAME]
Consent for Medicaid School Based Services

New Mexico School districts may bill Medicaid for health/health related services documented in the child's/student's Individualized Education Program (IEP). **In order to bill Medicaid, parent(s)/guardian(s) must be fully informed of these IEP services, as well as their frequency and duration. The district must provide written notification to the child's parent/guardian before accessing a child's or parent's public benefits or insurance (e.g., Medicaid) for the first time. Written notification must be provided annually thereafter. Districts need only obtain parental consent one time. These guidelines are set forth herein and in 34 CFR 300.154(d)(2)(iv) & (v).** Questions/Comments: contact School and Family Support Bureau, Medicaid in the Schools Program: 505.827.1804.

Child's Name (Last, First, Middle): _____

Date of Birth: _____ **Medicaid Number:** _____

Child's Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian(s) Name(s): _____

Phone Number - Home: _____ **Work:** _____

Cell: _____ **Other:** _____

Parental one-time consent for services for which Medicaid will be billed:

I _____, parent/guardian of child, _____, have been fully informed of all services listed in my child's IEP and agree to have Medicaid billed for these services. In order to bill Medicaid, I consent for my child's name, date of birth, Medicaid number, IEP services provided to my child, dates covered and the code for the type of service to be given to the Medicaid agency (New Mexico Human Services Department) for payment.

I understand that:

- my consent is voluntary and may be revoked at any time;
- revocation of consent is not retroactive; and
- refusal to allow access to Medicaid benefits does not relieve my child's school of its responsibility to ensure that all required services included in my child's IEP are provided at no cost to me.

My signature below also allows the district to release my child's information as described in the first paragraph above to my child's primary care provider or clinic.

Parent/Guardian's Signature: _____ **Date:** _____

Primary Care Provider/Clinic Name: _____