Annual Notice Regarding Medicaid Reimbursements

DATE

Student's Name

You have authorized __________________________ to share personally identifiable information about your child with Louisiana Medicaid and to seek reimbursement for the IEP/IHP/Medicaid covered health services that are provided at school.

This disclosure of personally identifiable information to Louisiana Medicaid and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime coverage, shall not result in any cost to you or your family, shall not increase any premiums or lead to the discontinuation of your child's benefits or insurance, and shall not create any risk of loss of your child's eligibility for home and community-based waivers based on total health-related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP/IHP services are provided at no cost to your child.

For assistance in this area, please contact: __________ at _______________________.

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