Southwest Kansas Area Cooperative District 613

Parent Consent for Release of Information for Medicaid Reimbursement & Notification

Student Name: _____ **Birthdate:** _____

Permission is given for the Southwest Kansas Area Cooperative District 613 LEA to share appropriate information concerning the above listed student with the Kansas Health Policy Authority so the LEA, can, if applicable, seek reimbursement for any health-related services that are claimable under the Title XIX Medicaid Program.

In conjunction with the above, I understand that the LEA may also need to obtain a "Physician's Prescription" for some/all of the health-related services that is provided to the student. In this regard, I hereby give permission for the LEA, if applicable, to share portions of the student's Individual Education Plan (IEP) with a qualified health care professional in order to obtain such "Physician's Prescriptions".

I understand that the LEA is required to provide certain Health-related services to any student who has and IEP at no additional cost to the student's parent(s)/guardian(s). I also understand that my signature or failure to sign this form will not affect whether such services are provided to the student.

I understand all of the statements set forth above and I hereby grant all of the above referenced permissions.

_____ **Date:** _____

Parent(s)/Guardian(s) Signature(s)

Dear Health Care Provider:

As specified in the Student's Individual Education Plan (IEP), the student qualifies to receive one or more of the following services during the time period that is specified in the IEP.

___ RN/LPN services	___ Physical Therapy
___ Occupational Therapy	___ Speech/Language Therapy
_X__ School Psychologist Evaluation	___ Counseling Services

If/as appropriate, the LEA may seek reimbursement from the Kansas Health Policy Authority for some/all of the above listed services. In order to do that, however, the LEA must obtain the signature of a qualified health care provider.

Your signature certifies that the student qualifies to receive all of the above listed services that are specified in the student's IEP. In this regard, this document will serve as the required "Physician's Prescription" with respect to those services.

Physician Signature _____ **Date:** _____