PARENT CONSENT FOR MEDICAID

Information to be completed by Parents/Guardians for the Kansas Local Education Agency Medicaid Billing Program

STUDENT'S NAME: _____

STUDENT'S SOCIAL SECURITY NUMBER: _____

STUDENT'S MEDICAID ID NUMBER: _____

STUDENT'S BIRTHDATE: _____ STUDENT'S SEX: M F

STUDENT'S ADDRESS: _____
Street City/State zip

STUDENT'S PHONE NUMBER: _____

NAME OF SCHOOL STUDENT ATTENDS: _____ USD# _____

PARENT/GUARDIAN NAME: _____

NAME OF STUDENT'S DOCTOR: _____

DOCTOR'S ADDRESS: _____

DOCTOR'S PHONE NUMBER: _____

Please allow the school to copy or send a copy of your child's Medicaid Card with this form.

RELEASE OF INFORMATION AUTHORIZATION

My signature below authorizes the school district indicated above and the Kansas State Department of Education to share with the Kansas Medicaid Agency my child's identification and IEP information. This information is to be used to allow the school district to claim Medicaid funds for health related services delivered to my child.

I am aware that the Local Education Agency is responsible for providing special education and related services as listed on my child's IEP at no cost to me. My signature on this form will assist my school district in receiving funds to help pay for special education services. I have signed and understand this information.

Parent/Guardian Signature _____ Date _____