CT Medicaid School Based Child Health Program - 504 Plan Parental Consent Form

This consent form allows the _____(school district) to bill your or your child's public benefits or insurance for covered health-related services (such counseling or nursing service) in your child's 504 plan. The funds received from your or your child's public benefits or insurance (HUSKY) help pay for the cost of providing these services.

Student's Rights to Special Education*

- ✓ Your child's right to receive the services listed in his or her 504 plan will continue, without interruption and at no cost to you, whether or not you sign this form.
- ✓ Giving consent will not impact your or your child's public benefits or insurance coverage.
- ✓ You have the right to refuse consent or withdraw your consent at any time.
- ✓

Consent for the _____ (School District) to Access Parent(s)/Guardian(s) or Student's Public Benefits or insurance for Student's Health-Related Educational Services.

Student's Name_____ _____ _____
Last Name *Middle Name* *First Name*

Student's Date of Birth: _____Student's SASID #: _____

The school district is seeking permission to access your or your child's public benefits or insurance and to release the following personally identifiable information in order to do so (to be filled out by the school district)		
What records are being disclosed? (such as records or information about the services that may be provided for a particular child)	***What is the purpose of the disclosure of the records? (such as eligibility determination, billing for services and auditing)***	***To what agency are the records being disclosed? (such as Medicaid)***
Records and information relating to the student's 504 plan	Eligibility determination, billing for services, and auditing	State of CT Medicaid Agency (DSS)

___ I have reviewed my child's 504 plan dated: _____. I understand and agree to give my consent for _____ (School District) to bill my or my child's public benefits or insurance, in accordance with state and federal laws, for health-related educational services in my child's 504 plan. By signing this consent I authorize the _____(School District) to release my child's records (as indicated above) to my or my child's public benefits or insurance as necessary for the purposes indicated above. I understand that, upon request, I may receive copies of records disclosed pursuant to this authorization.

____ I do not give my consent or am withdrawing my consent to the accessing of my or my child's public benefits or insurance and I do not consent or am withdrawing consent to the disclosure of the previously described personal data. I understand that my refusal does not affect my child's access to any service(s) to which he/she is entitled under the Individuals with Disabilities Education Act*.

Parent/Guardian Name and Signature:

_____ _____ _____
Print Name *Signature* *Date*

This form must be maintained and made available for audit purposes.