Division for Teaching and Learning

LORAIN CITY SCHOOLS
Charleston Administration Center
2350 Pole Avenue, Lorain, OH 44052
440.233.2314 fax 440.233.2341

Parent Consent to Share Information and Access Public Benefits
Lorain City Schools

Ohio School Districts have the opportunity to receive Federal Medicaid dollars through a program called the Ohio Medicaid School Program (OMSP). *Through this important program, all Ohio school districts can receive critically necessary Medicaid dollars to help support the special education type services provided to its students, such as Speech/language, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling and Social Work.*

In the process of billing Medicaid for these services, a limited amount of billing information must be shared with the Ohio Department of Medicaid. To do so, we must obtain a one-time/life signed Parental Consent to share the following **NON-MEDICAL** information:

- Your child's name, Medicaid recipient number, and birth date
- Service code (numerical code that identifies the service(s) provided)
- Service time spent with your child (number of minutes)

Your consent is voluntary. You have the right under Federal Medicaid Regulations (34 CFR Part 99 and Part 300) to withdraw your consent at any time. *You are not ever required to enroll in Medicaid for your child to receive special education services in this or any other Ohio Public School District.* No matter whether you grant, refuse or revoke consent, ***your child will be provided with an evaluation and/or the services listed in their IEP, AT NO COST to your family.*** The School District's Medicaid billing process **will not require** you to incur any out-of-pocket expenses such as deductible or co-pay, decrease lifetime coverage, increase premiums or lead to the discontinuation of benefits, or result in you paying for services that would otherwise be covered by Medicaid.

Student Name: _____

Date of Birth: _____

☐ I understand and agree to give permission to share my child's IEP records in order to access Medicaid.

☐ I do not give my permission to share my child's IEP records in order for the School District to receive Medicaid funding.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____