25-26 Parent/Guardian Release of Information for Taylor County Mental Health Services

Dear Parent/Guardian,

Your child has been referred to the **Taylor County Mental Health Coordination Program**. With your permission, we will work with school staff to gather the necessary information to help coordinate appropriate mental health services for your child.

While the school offers **very limited mental health services on campus**, the **majority of services are provided through referrals to trusted community partners**. Our team will help connect families to local therapists and agencies that can best support your child's needs.

Whenever possible, we aim to coordinate services that may take place during school hours and at the school. However, **we cannot guarantee that your child will be seen at school or during the school day**. Referrals will be based on provider availability and your child's insurance coverage.

We encourage you to review the list of agencies we work with and also feel free to explore other providers on your own. Families are welcome to reach out directly to any agency for support.

Please note:

- Services can only be arranged with your written consent.
- Information will be shared only with licensed therapists (or those under clinical supervision) to ensure high-quality, ethical care.
- Mental health information is kept confidential, except in cases involving self-harm or harm to others.

If you would like your child to participate in the school mental health coordination program, please complete and return the attached consent form.

Thank you for your continued partnership in supporting your child's well-being.

Sincerely,
Taylor County Mental Health Coordination Team

Here is a list of agencies that we coordinate with. We will be glad to coordinate the services; however, here is the contact information if you would like to research to contact them on your own.

Apalachee Mental Health Services (850) 584-5613

Disc Village(substance abuse counseling) (850) 838-2525

Panhandle Therapy (850) 674-8888

A New Dawn, A New Beginning (850) 329-5776

Student Information

1. Please enter your information.

Student First Name: _____ Student Middle Initials: _____ Student Last Name: _____

Student Preferred (NickName) _____ Student Gender: ○ Female ○ Male Student Date of Birth: _____

Student Race
☐ Asian ☐ Black ☐ Hispanic
☐ White ☐ More than one race
☐ Other

Legal Guardian First Name: _____ Legal Guardian Last Name: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: _____ Student School _____ Students Grade _____

2. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Insured Name _____

Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male Insured Street Address _____

Insured City _____ Insured State _____ Zip Code _____ Client Relationship to Insured _____

3. Please attach insurance card:

4. Current Concerns for referral purposed. Please check all that apply
☐ Academic Concerns ☐ Aggression/Anger
☐ Bullying ☐ Emotional Concerns
☐ Family Concerns ☐ Fighting
☐ History of Mental Health Diagnosis
☐ Social Skills /Social Concerns ☐ Grief/Loss
☐ Self-Harming ☐ Lying ☐ Peer Relationships
☐ Personal Hygiene ☐ Self-image/Confidence
☐ Other

Was your child required/recommended to complete an Anger Management Class?
☐ Yes ☐ No

Please explain how therapy can help student:

_____

_____

If notified prior to group would you also be willing to allow you child to participate in group therapy? (Group examples are social skills, anger management ect.)

_____

5. **Preferred Agency: (Please list in order from 1-6 agency preferences and we will try to coordinate based on your choice. 1=First preference 5=Last preference**

	First Preference	2	3	4	Last Preference
A New Dawn, A New Beginning					
Apalachee					
Panhandle Therapy					
Florida Therapy					
Disc Village (substance abuse counseling)					
No preference					

Consent of treatment, communication, and coordination of care:

By signing, I understand that the above-listed child's counseling information is confidential. I understand that I am permitting the Taylor County School Mental Health Providers and Taylor County Schools to release any protected health information (PHI) to each other and the agencies listed regarding treatment, payment, and coordination of care. Understand that you have the right to rescind this release at any time by contacting the Taylor County School Mental Health Department.

I understand that my child's counseling information is confidential. I understand that I am permitting the Taylor County School Mental Health Providers and Taylor County Schools to release any protected health information (PHI) to each other regarding treatment, payment, and coordination of care. Understand that you have the right to rescind this release at any time by contacting the Taylor County School Mental Health Coordinators. By signing, I hereby affirm that I am the current custodial parent or legal guardian of the child and I authorize them to participate in group therapy and/or individual therapy.

Parental Consent to Release Information for Medicaid Reimbursement For Taylor County School District

6. Our school district wishes to seek reimbursement for certain services provided to your child by accessing Medicaid. We must obtain your written informed consent for the purpose of releasing certain information related to seeking Medicaid reimbursement. Medicaid reimbursement helps the school district fund costs or providing special education. related services and any other services allowable by Medicaid. PLEASE NOTE: Giving consent does not mean your child is currently signed up for Medicaid or will be signed up for Medicaid services. Individual Educational Plan (IEP) Services The Individuals with Disabilities Education Act Of 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school (Title 34, section 300.154(d)(2)(iv)(A)-(B). Code of Federal Regulations ICFRI). Non-IEP Services School districts are also allowed to seek reimbursement from Medicaid for services provided under the Florida Administrative Code Medicaid rule for school-based services (Rule 59G4.03S). By giving consent you understand th you may withdraw this consent to release information for Medicaid reimbursement at any time. You also understand that if you refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary to receive an appropriate education at no charge to my child in accordance with 34 CFR 300.154(d)(2)(v)(D) or other services provided outside of the IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date. The information shared may include my child's name, date of birth, address, primary special education disability (if applicable), Social Security number, Florida Medicaid identification number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, physical therapy services, occupational therapy services, speech therapy services, hearing and language therapy services, behavioral services, transportation services, and nursing services. The records to be released or exchanged may include IEP's, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records. This is not signing up for any insurance and will not affect your child's access to free mental health services at the school. This is to help us stay compliant with the Department of Education.

- ○ Yes, I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency For Health Care Administration) its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.
- ○ No, I DO NOT give my consent to the school district to share information about my child in order for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

If you have any questions or concerns, please contact the ESE department at 850-838-2536.

7. Student First Name _____ Student Last Name _____ Student Date of Birth _____

By signing, you are acknowledging that you are the current custodial parent or gurdian

_____ _____

Signature Date