MEDICAID RBHS CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND USE OF INSURANCE FOR MEDICAID REIMBURSEMENT

The Williamsburg County School District and the South Carolina Department of Education (SCDE) have my permission to provide Rehabilitative Behavioral Health Services (RBHS) to my child and to release and exchange medical, psychological, and other personally identifiable and confidential information, as necessary, to the Department of Health and Human Services and to any third party insurance carrier/billing agent. I understand that the purpose of this consent is to bill Medicaid, and any applicable third party insurance carrier/billing agent, for services under Part B of the Individuals with Disabilities Education Act (IDEA). I understand that if my child is not eligible for services under the IDEA, this does not prevent my child from qualifying for RBHS services. I understand that Medicaid reimbursement for health-related services provided by the District and the SCDE will not affect any other Medicaid services for which my child is eligible. I also, understand that the District and the SCDE's use of my child's Medicaid or third party insurance must not decrease my child's benefits or result in any costs to me or my child.

I understand that the granting of consent is provided at the beginning of RBHS treatment and that it is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

I understand that the District and the SCDE will operate under the guidelines of Part B of the IDEA, if applicable, and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and the provision of health-related services.

*I understand, if applicable, that as the parent/guardian/caregiver I will participate as a full member of the RBHS team.

- Participate in the development of the Individual Plan of Care.
- Support counseling services as well as community agencies involved with my child. Support the linkage of home, school, and community through home visits by the RBHS staff and family services as appropriate.
- Attend the service plan meeting, conferences, parent programs, and school activities.

* Participation as a full member of the RBHS team is not required if only the assessment services will be rendered.

Signature of Student _____ Date _____

Birthdate _____ Student Medicaid # _____

Signature of Parent/Guardian/Primary or Caregiver/Legal Representative _____ Date _____
(This signature is required in cases of a minor)

Check if applicable: _____ Beneficiary is unable to sign and requires emergency treatment.

Signature of Physician / LPHA _____ Date _____ Title _____

Signature of Staff Member _____ Date _____ Title _____

Important: This form must be completed at the beginning of RBHS treatment.