Louisiana Parental Notice for One time Consent to Allow the School District To Access Louisiana Medicaid Benefits

School District Name: Avoyelles Parish School District
School District Contact Information: 221 Tunica Dr. West, Marksville, LA 71351

Dear Parent/Guardian:

The purpose of this letter is to ask you for your permission (also known as consent) to share information about your child with the Louisiana Department of Health Medicaid program. Schools in Louisiana have been approved to receive partial reimbursement from Louisiana Medicaid for the cost of certain health-related services provided by the district to your child. In order for your child's school to get back some of the money spent on services, the school district needs to share with Louisiana Medicaid the following types of information about your child: name; date of birth; gender; type of services provided, when and by whom; diagnosis (if any) and Louisiana Medicaid ID. If your child is eligible to receive services to meet his/her needs, the services may be provided by the school system and/or you may take your child to another provider that accepts Medicaid.

With your permission, the school district will be able to seek partial reimbursement for services provided by Louisiana Medicaid including, among others, a hearing test or eye exam; occupational or speech or physical therapy; some school nurse visits; and counseling services. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child with Louisiana Medicaid without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for Louisiana Medicaid in order for your child to receive the health related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.
3. If you give the school district permission to share information with and request reimbursement from Louisiana Medicaid:
    a. This will not affect your child's available lifetime coverage or other Louisiana Medicaid; nor will it in any way limit your own family's use of Louisiana Medicaid benefits outside of school.
    b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
    c. Your permission will not lead to any changes in your child's Louisiana Medicaid rights; and
    d. Your permission will not lead to any risk of losing eligibility for other Medicaid funded programs.
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with Louisiana Medicaid for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission for the school district to share with Louisiana Department of Health (LDH) records and information concerning my child and their health-related services, as necessary. I understand that this will help my child's school seek partial reimbursement for Louisiana Medicaid covered services.

________________________________	________________________________	
Child's Name	Parent/Guardian Name	
________________________________	________________________________	________
Child's Date of Birth	Parent/Guardian Signature	Date