

✓

**Initial Notice and Consent
Regarding Medicaid Reimbursement**

NOTICE

The Louisiana Department of Health (LDH) Medicaid program allows school districts to request reimbursement for costs associated with provision of certain IEP and IHP related services. These services include occupational and physical therapy, speech pathology, behavioral health services, nursing services, and special transportation. Schools are required to provide notice and to obtain consent from a parent before accessing a child's Medicaid benefits.

Jefferson Parish Schools seeks your consent to disclose personally identifiable information about your child to Louisiana Medicaid to access reimbursement for the IEP/Medicaid covered health services that are provided at school. In order to submit claims for IEP/IHP/Medicaid covered services, the following types of records may be required: child's full name, address, date of birth, Medicaid ID, disabilities, types of services and dates of services delivered. This disclosure of information to Louisiana Medicaid and its affiliates and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime Medicaid coverage, result in any cost to you or your family, increase any premiums or lead to the discontinuation of your child's benefits or insurance or create any risk of loss of your child's eligibility for home and community-based waivers based on total health-related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to your child.

CONSENT

I hereby authorize Jefferson Parish Schools to disclose necessary information to Louisiana Medicaid in order to seek reimbursement for the IEP/IHP/Medicaid-covered health services provided to my child.

Name of Student

Date

Parent(s)/Guardian(s) Signature

Relationship to Student

✓

MEDICAID REFUSAL REPORT

Health Services

(To be completed and signed by parent or guardian)

School _____

It is the responsibility of each school to report Medicaid refusal for families who refuse to sign a Letter of Consent for Medicaid billing.

Student's Name (Please print)	Date of Birth

Parent/Guardian Signature _____

Date Signed _____

Please complete a separate form for each student.

One copy of this refusal form should be placed in student's CUM folder.

A second copy should be sent to:

Medicaid Office
501 Manhattan Boulevard, Suite 2501
Attn: Stacey Chalin