

SCHOOL-BASED HEALTH SERVICES PARENTAL CONSENT FORM

_____ School District

Our school district is committed to partnering with families to support students while responsibly managing the cost of services. We are seeking permission to access Medicaid to obtain reimbursement for certain health-related services provided to your child. This this end, we are requesting written formal consent to share limited information necessary for billing. Such reimbursement helps to cover the costs of eligible services provided under Medicaid.

Federal policy authorizes school districts to seek Medicaid reimbursement for covered health services provided to Medicaid-enrolled students, including both special education and general education programs. In addition, New Jersey law ([P.L.2023, c.108](#)) requires districts to pursue Medicaid reimbursement for certain covered health services provided to eligible students.

Your consent allows the district to obtain Medicaid reimbursement for eligible services. This will not result in any out-of-pocket expense to your family or impact your child's Medicaid coverage or benefits.

Consent Given or Denied

(Please read, check or initial, sign, and date at the bottom)

___ I understand and **give my consent** for the school district to share limited information about my child with the New Jersey Medicaid program, including the New Jersey Department of Human Services, its agents, and the district's Medicaid billing service, for the purposes of verifying Medicaid eligibility, seeking Medicaid reimbursement, and responding to audit or review requests related to services provided to my child.

I understand that I may withdraw this consent at any time, and if I refuse to give consent or later withdraw it, the school district will continue to provide all required services necessary for my child to receive a thorough and efficient public education at no cost to me. If I withdraw consent, it will take effect on the date of withdrawal, and no information will be shared after that date.

The information shared may include my child's name, date of birth, address, primary disability (if applicable), Medicaid identification number, and information about the type, amount, and dates of health-related services provided. Records that may be shared include Individualized Education Programs (IEPs) if applicable, evaluations and eligibility records, therapy service logs, transportation logs, progress notes, and nursing records.

___ I **do not give my consent** for the school district to share information about my child for the purpose of verifying Medicaid eligibility, seeking Medicaid reimbursement, or responding to audit and review requests related to services provided.

Child's Name: _____

Child's Date of Birth: ____/____/____

Parent/Guardian: _____

Date: ____/____/____