KIDSS

PARENT CONSENT FOR MEDICAID

Information to be completed by Parents/Guardians for the Kansas Local Education Agency Medicaid Billing Program

STUDENT'S NAME: ______________________________

STUDENT'S SOCIAL SECURITY NUMBER: ______

STUDENT'S MEDICAID ID NUMBER: [ ]

STUDENT'S BIRTHDATE: _______ STUDENT'S SEX: _

STUDENT'S ADDRESS: ______________________ ___________ _ _______

STUDENT'S PHONE NUMBER: _______________

NAME OF SCHOOL STUDENT ATTENDS: _____________________________________ USD# __

PARENT/GUARDIAN NAME: ______________ ______________

NAME OF STUDENT'S DOCTOR: [ ]

DOCTOR'S ADDRESS: [ ]

DOCTOR'S PHONE NUMBER: [ ]

Please allow the school to copy or send a copy of your child's Medicaid Card with this form.

RELEASE OF INFORMATION AUTHORIZATION

My signature below authorizes the school district indicated above and the Kansas State Department of Education to share with the Kansas Medicaid Agency my child's identification and IEP information. This information is to be used to allow the school district to claim Medicaid funds for health related services delivered to my child.

I am aware that the Local Education Agency is responsible for providing special education and related services as listed on my child's IEP at no cost to me. My signature on this form will assist my school district in receiving funds to help pay for special education services. I have signed and understand this information.

Parent/Guardian Signature: ____________________________ Date: ___________