COLORADO
Department of Education

Colorado Department of Education
Medicaid School Health Services Program
Consent to Access Benefits

The Colorado Department of Education and the district have my permission to provide health related services to my child and to release and exchange medical and other confidential information, as necessary, to the Department of Health Care Policy and Financing (Medicaid) for health services provided to my child after the date of this consent. Information released may include personally identifiable information, records or information about the services which may be provided to my child. The purpose of the disclosure is to access the child's public benefits to receive Medicaid reimbursement for said services.

By signing this form, I give the District and the Department of Health Care Policy and Financing my permission to send claims to Medicaid and receive payment from Medicaid for health related services as set forth in my child's individualized education plan (IEP).

I understand that Medicaid reimbursement for health related services provided by the District and the Colorado Department of Education will not affect any other Medicaid services for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public benefits. I also understand that my refusal to allow access to the Department of Health Care Policy and Financing does not relieve the District of its responsibility to ensure that all required services are provided to my child at no cost to me.

I understand that the granting of consent 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retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).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 also understand that the District and the State Department of Education will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentially regarding my child's treatment and provision of health related services.

Legal Name of Student:

DOB:

LASID:

SASID:

Medicaid #:

Date:

Consent Granted **Yes**___ **No**___ **Parent Signature**_____

For Internal Use Only

Date received: