Medical Assistance Parent Permission

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF
EARLY INTERVENTION AND SPECIAL EDUCATION SERVICES (Form approved by MSDE for use July 1, 2019)

Student Name: _____ Agency: MD School for the Blind IEP Team Meeting Date:

MEDICAL ASSISTANCE (MA)

Parental consent must be obtained before the provider agency discloses, for billing purposes, their child's personally identifiable information to the Maryland Department of Health and Mental Hygiene (DHMH), the State agency responsible for the administration of the Medical Assistance Program, consistent with the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Education Act (IDEA). By providing consent, you understand and agree in writing that the public agency may access your child's Medicaid to pay for services provided to your child.

In order to provide a free appropriate public education (FAPE) to your child, the provider agency may not:

- Require you to sign up for or enroll in State's Medical Assistance in order for your child to receive FAPE under IDEA,
- Require you to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services,
- Use your child's benefits under Medical Assistance if that use would:
  - Decrease available lifetime coverage or any other insured benefit;
  - Result in your family paying for services that would otherwise be covered by Medical Assistance and that are required for your child outside of the time your child is in school;
  - Increase premiums or lead to the discontinuation of benefits or insurance; or
  - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

You have the right to withdraw your consent to disclosure of personally identifiable information to State's Medical Assistance Program at any time.
If you withdraw consent for the provider agency to disclose your child's personally identifiable information it does not relieve the provider agency of its responsibility to ensure that all required services are provided to your child at no cost to you.

Is the student eligible for MA? (please circle one) ☐ **Yes** ☐ **No** MA Number _____

I agree to Service Coordination for Children with Disabilities and that the Service Coordinator(s) identified on this IEP may be appointed as MA Service Coordinator(s). (COMAR 10.09.52)
I understand that I am free to choose an MA Service Coordinator for my child. At this time, I accept the following Service Coordinator(s).

MA Service Coordinator Name: _____ MSB Teacher_____

MA Service Coordinator Name: _____

I understand that if I wish to change the MA Service Coordinator in the future, I can call the school to make a change.
I understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services.
I give my consent for the provider agency to disclose my child's personally identifiable information to the State's Medical Assistance Program in order to access Medical Assistance Benefits.
I give permission to the provider agency to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's IEP goals. I understand that if I refuse to allow the provider agency access to MA funds, it does not relieve the public agency of its responsibility to ensure that all required services are provided to my child at no cost to parent.
I understand that this service does not restrict or otherwise affect my child's eligibility for other Medical Assistance benefits. I also understand that my child may not receive a similar type of case management service under Medical Assistance if he/she qualifies for more than one type.

Parent Signature: _____ Date:_____