Parent Consent for an Area Education Agency to Share Data and Seek Payment for Individualized Education Program (IEP) Health Related Services

Student:_____ Birthdate:_____ Gender:____ Grade:____

Attending District:_____ Area Education Agency:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Your Area Education Agency may bill Iowa Medicaid for the health-related services your child receives. The type, amount, and frequency of services are described in your child's Individualized Education Program(IEP). We need your signature to share data with the Iowa Department of Human Services (DHS) and to bill for these services. The data include your child's name, date of birth, member number, dates of services, and types of service codes.

In audits by DHS, or the U.S. Department of Health and Human Services (DHHS), the data shared may also include your child's IEP, evaluation reports, documentation of service and attendance, and medical orders.

I understand and agree that the AEA named above may bill DHS and use my public benefits and/or my child's public benefits to pay for special education and related services that the school district and/or AEA are required to provide under the Individuals with Disabilities Education Act.

I understand and agree that the AEA named above may share data with DHS and DHHS.

I understand that:

- My consent starts on the date of my signature, may include billing for services already provided through my child's current IEP, and for services that were in the IEP in place at the time of the services provided on or after _____ (which may be up to 365 days prior to today), and is good as long as my child is eligible for special education.
- My consent can be changed or stopped by me at any time in writing.
- The type, amount, and frequency of services are described in my child's IEP.
- If I ask, I can get copies of all data shared with DHS or DHHS.
- I can get a copy of this release.
- Laws that protect private data sometimes allow the data to be re-disclosed.
- If I do not sign this consent, my child's IEP services will not change or stop.

My signature allows the AEA to 1) share data with DHS for billing purposes, 2) share data with DHS or DHHS for audit purposes, and 3) bill Iowa Medicaid or Medical Assistance for special education and related services.

_____ _____

Signature of Parent/Guardian (Both parents may sign, but only one signature is required) Date

Parent Refusal of Consent or Withdrawal of Consent for an AEA to Share Data and Seek Payment for Individualized Education Program (IEP) Health Related Services

Student:_____ Birthdate:_____ Gender:____ Grade:____

Attending District:_____ Area Education Agency:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Your Area Education Agency (AEA) may bill Iowa Medicaid for the health-related services your child receives ***if*** you give your consent to share data with the Iowa Department of Human Services (DHS) and to bill DHS for these services.

☐ I choose to **not allow** the AEA named above to share data with the Iowa Department of Human Services and to bill for covered IEP health related services.

☐ I choose to **withdraw my consent** for the AEA named above to share data with the Iowa Department of Human Services and to bill for covered IEP health related services.

I understand:

- By signing below, my child's IEP services will not change or stop; and
- I can get a copy of this denial or withdrawal of consent.

_____ _____

Signature of Parent/Guardian (Both parents may sign, but only one signature is required) Date

Parent Consent for a School District to Share Data and Seek Payment for Individualized Education Program (IEP) Health Related Services

Student:_____ Birthdate:_____ Gender:____ Grade:____

Attending District:_____ Area Education Agency:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Your school district may bill Iowa Medicaid for the health-related services your child receives. The type, amount, and frequency of services are described in your child's Individualized Education Program(IEP). We need your signature to share data with the Iowa Department of Human Services (DHS) and to bill for these services. The data include your child's name, date of birth, member number, dates of services, and types of service codes.

In audits by DHS, or the U.S. Department of Health and Human Services (DHHS), the data shared may also include your child's IEP, evaluation reports, documentation of service and attendance, and medical orders.

I understand and agree that the school district named above may bill DHS and use my public benefits and/or my child's public benefits to pay for special education and related services that the school district and/or AEA are required to provide under the Individuals with Disabilities Education Act.

I understand and agree that the school district named above may share data with DHS and DHHS.

I understand that:

- My consent starts on the date of my signature, may include billing for services already provided through my child's current IEP, and for services that were in the IEP in place at the time of the services provided on or after _____ (which may be up to 365 days prior to today), and is good as long as my child is eligible for special education.
- My consent can be changed or stopped by me at any time in writing.
- The type, amount, and frequency of services are described in my child's IEP.
- If I ask, I can get copies of all data shared with DHS or DHHS.
- I can get a copy of this release.
- Laws that protect private data sometimes allow the data to be re-disclosed.
- If I do not sign this consent, my child's IEP services will not change or stop.

My signature allows the school district to 1) share data with DHS for billing purposes, 2) share data with DHS or DHHS for audit purposes, and 3) bill Iowa Medicaid or Medical Assistance for special education and related services.

_____ _____

Signature of Parent/Guardian (Both parents may sign, but only one signature is required) Date

Parent Refusal of Consent or Withdrawal of Consent for a School District to Share Data and Seek Payment for Individualized Education Program (IEP) Health Related Services

Student:_____ Birthdate:_____ Gender:____ Grade:____

Attending District:_____ Area Education Agency:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Name:_____ Relationship:_____

Address:_____ Email:_____

_____ Home:_____ Cell:_____

City, ST Zip:_____ Work:_____

Your school district may bill Iowa Medicaid for the health-related services your child receives ***if*** you give your consent to share data with the Iowa Department of Human Services (DHS) and to bill DHS for these services.

☐ I choose to **not allow** the school district named above to share data with the Iowa Department of Human Services and to bill for covered IEP health related services.

☐ I choose to **withdraw my consent** for the school district named above to share data with the Iowa Department of Human Services and to bill for covered IEP health related services.

I understand:

- By signing below, my child's IEP services will not change or stop; and
- I can get a copy of this denial or withdrawal of consent.

_____ _____

Signature of Parent/Guardian (Both parents may sign, but only one signature is required) Date