

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:				
Name:	Relationship:	Relationship:		
Address:	Email:			
	Home:	Cell:		
City, ST Zip:	Work:			
Name:	Relationship:			
Address:				
		Cell:		
City, ST Zip:	Work:			
child's IEP, evaluation reports, documentation of service and understand and agree that the AEA named above made benefits to pay for special education and related services the Individuals with Disabilities Education Act. I understand and agree that the AEA named above made and understand that: • My consent starts on the date of my signature, may incurrent IEP, and for services that were in the IEP in procure (which may be up to 365 days prior to today), and is expected in the incurrent to the interview of services are designed. The type, amount, and frequency of services are designed.	ay bill DHS and use my pulse that the school district an ay share data with DHS an include billing for services a place at the time of the ser good as long as my child in y time in writing.	blic benefits and/or my od/or AEA are required to DHHS. already provided throug vices provided on or after the state of t	o provide under h my child's er	

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:			
City, ST Zip:	Work:	<u></u>		
Name:				
Address:	Email:			
	Home:	Cell:		
City, ST Zip:	Work:			
Your Area Education Agency (AEA) may bill lowa Medicaid your consent to share data with the Iowa Department of Hurston I choose to not allow the AEA named above to share defor covered IEP health related services. I choose to withdraw my consent for the AEA named a Services and to bill for covered IEP health related services. I understand: By signing below, my child's IEP services will not change of consent.	uman Services (DHS) and to ata with the lowa Departmen above to share data with the ces. ge or stop; and	bill DHS for these t of Human Service	services.	

Date

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



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:		ency:	
Name:	Relationship:		
Address:			
		Cell:	
City, ST Zip:	Work:		
Name:	Relationship:		
Address:			
	Home:	Cell:	
City, ST Zip:	Work:		
Your school district may bill lowa Medicaid for the health-requency of services are described in your child's Individuals hare data with the lowa Department of Human Services on name, date of birth, member number, dates of services, and audits by DHS, or the U.S. Department of Health and Highlid's IEP, evaluation reports, documentation of service at understand and agree that the school district named at	ualized Education Progra (DHS) and to bill for thes nd types of service code luman Services (DHHS), and attendance, and med	am(IEP). We need your see services. The data incomes. the data shared may also dical orders.	signature to llude your child's so include your
public benefits to pay for special education and related se under the Individuals with Disabilities Education Act.			
I understand and agree that the school district named at	bove may share data wit	h 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 w audit purposes, and 3) bill Iowa Medicaid or Medical Assistance for special education and related ser	
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

Birthdate:	Gender:	Grade:	
Area Education Agency:			
Relationship:			
Email:			
Home:	Cell:		
Work:			
Relationship:			
Home:	Cell:		
Work:			
s (DHS) and to bill DHS for the to share data with the lowa	nese services. Department of Huma	an Services	
	Area Education Agend Relationship: Email: Home: Work: Relationship: Email: Home: Work: Orelated services your child res (DHS) and to bill DHS for the to share data with the lowarict named above to share data services.	Relationship: Email: Home: Work: Relationship: Email: Home: Cell: Work: I-related services your child receives if you give you go (DHS) and to bill DHS for these services. The to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share data with the lowa Department of Human arict named above to share dat	

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