PA MEDICAL ASSISTANCE BILLING PARENTAL NOTICE

Child's Name _____ Date of Birth_____

**********Early Intervention

Child's Name:

Date Sent:

Name and Address of Parent/Guardian/Surrogate:

Dear ,

This notice is being given to you so that you are fully informed of your rights including your consent before a public agency can access your child's public benefits or insurance to pay for services under the Individuals with Disabilities Education Act (IDEA).

Local Educational Agencies (LEAs) are eligible to receive federal reimbursement through the School-Based Access Program for certain medically necessary services provided to students with disabilities ages 3-21 in accordance with the students' Individualized Education Program (IEP). Examples of services covered include speech therapy, occupational therapy and physical therapy, and others. The LEAs use of this reimbursement program does NOT in any way affect or impact other medically necessary, covered services that are provided to your child out of school. Medical Assistance will continue to pay for these services. Any reimbursement that the LEAs receive from the School-Based Access Program is used to help cover the cost of special education services. *In this instance, the Local Education Agency (LEA) refers to the preschool early intervention program which serves children from age 3 to school-age. Special education services refer to any services covered by an Individualized Education Program (IEP).*

Before the LEAs can apply for reimbursement for services, a one-time written parental consent is required by The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) under Part B (Assistance to the States for the Education of Children with Disabilities) and the Family Educational Rights and Privacy Act (FERPA). By signing the parental consent document, you are authorizing the LEA to share your child's information such as records or information about the services that may be provided to your child with the PA Department of Education, the PA Department of Human Services, and a physician or nurse practitioner in order to bill Medical Assistance for services your child receives as part of his/her IEP. The only purpose of this disclosure is to bill for services provided.

You have the right to withdraw your consent at any time. Withdrawing your consent or not giving consent, will not affect the services that your child is receiving. It is still the responsibility of the LEA to provide all of your child's required services at no cost to you.

Giving consent for reimbursement will also be at no cost to you.

We recommend that you keep a copy of this form for your records.

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**********Early Intervention

If you have any questions about Medical Assistance Billing, please contact me.

Name: _____ Phone: _____

Position: _____ Email: _____

DIRECTIONS FOR PARENT/GUARDIAN/SURROGATE: Please check one of the options, sign this form, and return it.

I understand the following:

- I can either give permission or refuse to give permission for the LEA to release information about my child in order to receive reimbursement for services.
- Consent is given only one time but I may withdraw it for future services at any time.
- My refusal to give consent will not change the services my child receives under his/her IEP.
- Whether I consent or refuse, I will not have to pay for these services.
- Upon request, I may receive copies of my child's records that are disclosed as a result of this authorization.

1. ☐ I have read this notice and I understand the LEA's obligations and my parental rights

2. ☐ I have read this notice and I **DO NOT** understand the LEA's obligations and my parental rights

3. ☐ I would like to schedule an informal meeting to discuss this request with preschool early intervention personnel

SIGN HERE:

_____ _____ _____

Parent/Guardian/Surrogate Signature Date Daytime Phone

PLEASE RETURN THIS ENTIRE FORM TO:

Name:

Address: