SHAKER HEIGHTS CITY SCHOOL DISTRICT

15600 PARKLAND DRIVE
SHAKER HEIGHTS, OHIO 44120
(216) 295-1400, FAX (216) 295-4340

Dear Parent/Legal Guardian,

We are pleased to inform you that the Medicaid Program now allows Ohio Districts, including Shaker Heights City School District, to receive Medicaid funding for eligible services provided to students with disabilities. The eligible services covered in school districts include: occupational and physical therapy, speech/language therapy, audiology, nursing, school psychology, and counselor and social work services. This program is known as the Ohio Medicaid School Program (OMSP) and the Shaker Heights City School District is a designated healthcare provider under this program.

If your child is covered by *Medicaid health insurance through Ohio Healthy Start, the Medicaid Assistance Program, Healthy Families, or the WIC Program*, this letter applies to your family. **If you have Medicaid insurance benefits, they are NOT reduced or affected by this program (per Ohio Administrative Code 5101:3-34-01.2)**.

Under Federal Education law, we must inform you of two things:

1. In order to be paid for the services we provide to your child, we must send the Ohio Medicaid Agency the following information:
    - Your child's name, Medicaid number, and Birth date
    - Service code (numerical code that identifies the service(s) provided)
    - Service time spent with your child (number of minutes)

2. We need your one-time permission to send this information to the Ohio Medicaid agency. When you signed your Medicaid application, you gave permission to any Medicaid Healthcare provider to send information to the Medicaid Agency regarding services your child received. Since this school district is now considered a Medicaid Healthcare provider, we want you to know that we plan to use your Medicaid application signature as your approval to send the necessary information. ***A one-time consent form is attached for your signature.***

Please be reassured that your child's **Medicaid benefits and limits are NOT reduced or affected in any way by the Ohio School Medicaid Program.** Your consent for the Shaker Heights School District to obtain payment for the Medicaid services provided to your child is voluntary and can be discontinued at any time. If you do withdraw consent, the district is still obligated to provide your child with the services authorized by his/her Individualized Education Program (IEP).

If you do not want the district to bill the Medicaid program for your child's services, or if you have any questions about the information in this letter, please contact your school district. We will be pleased to assist you in any way. We very much appreciate your support as we continue to provide your child with the services he/she needs.

Best Regards,

Elizabeth A. Kimmel
Director of Pupil Services

Bryan Christman
Treasurer

Parent Consent to Share Information and Access Public Benefits
Shaker Heights City School District

Ohio School Districts have the opportunity to receive Federal Medicaid dollars through a program called the Ohio Medicaid School Program (OMSP). *Through this important program, all Ohio school districts can receive critically necessary Medicaid dollars to help support the special education type services provided to its students, such as Speech/language, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling and Social Work.*

In the process of billing Medicaid for these services, a limited amount of billing information must be shared with the Ohio Department of Medicaid. To do so, we must obtain a one-time/life signed Parental Consent to share the following **NON-MEDICAL** information:

- Your child's name, Medicaid recipient number, and birth date
- Service code (numerical code that identifies the service(s) provided)
- Service time spent with your child (number of minutes)

Your consent is voluntary. You have the right under Federal Medicaid Regulations (34 CFR Part 99 and Part 300) to withdraw your consent at any time. *You are not ever required to enroll in Medicaid for your child to receive special education services in this or any other Ohio Public School District.* No matter whether you grant, refuse or revoke consent, ***your child will be provided with an evaluation and/or the services listed in their IEP, AT NO COST to your family.*** The School District's Medicaid billing process **will not require** you to incur any out-of-pocket expenses such as deductible or co-pay, decrease lifetime coverage (***meaning this does not impact your child's available total lifetime medicaid monies***), increase premiums or lead to the discontinuation of benefits, or result in you paying for services that would otherwise be covered by Medicaid. **Please complete and return this form, a return stamp envelope is included.**

Student Name:

Date of Birth:

☐ I understand and agree to give permission to share my child's IEP records in order to access Medicaid.

☐ I do not give my permission to share my child's IEP records in order for the School District to receive Medicaid Funding.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____