PURPOSE: This form asks for your consent to obtain information from the Department of Social at Health Services, Medical Assistance Administration for the purpose of Medicaid eligibility verification. If you have questions regarding this request, you may call the school district director of special education for an explanation as to why the request is being made.

MEDICAID ELIGIBILITY VERIFICATION

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, occupational therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, we will submit your student's name and birth date to the Department of Social and Health Services (DSHS) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

By giving consent, you are acknowledging that (1) you have been fully informed of all information relevant to the activity for which consent is sought; (2) you understand that the granting of consent is voluntary on your part and may be revoked at any time; and (3) if you revoke consent, the revocation is not retroactive; which means that it does not negate any activity that has already taken place.

☐ I do give consent to verify Medicaid eligibility with DSHS.
☐ I do not give consent to verify Medicaid eligibility with DSHS.

Parent/guardian signature	Date
Student Name	Date of birth