LOUISIANA DEPARTMENT OF EDUCATION
SPECIAL SCHOOL PROGRAMS

PARENTAL CONSENT TO SEEK MEDICAID REIMBURSEMENT

I, _____(Parent/Guardian Name)_____, hereby authorize to seek reimbursement for the IEP/Medicaid-covered health services that are provided to _____Student's Name)_____during the _____ school year. I understand that this access may not result in any decrease in available lifetime coverage, may not result in any cost to me or my family, may not increase any premiums or lead to the discontinuation of my child's benefits or insurance, and may not create any risk of loss of my child's eligibility for home and community-based waivers based on total health-related expenditures. I understand that this consent must be renewed annually. I also understand that my refusal to allow access to the Medicaid benefits does not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to me.

_____ _____

Parent(s)/Guardian(s) Signature Relationship to Student

_____

Date

Return To:

Name: _____

Site: _____

Address: _____

(For assistance in this area, please contact: Contact Name_____at (Phone number and/or email)

Louisiana Believes.

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