PA MEDICAL ASSISTANCE BILLING PARENTAL CONSENT

Child's Name _____

Date of Birth_____

Date Sent: _____

Name and Address of Parent/Guardian/Surrogate: _____

_____

I understand that:

1. 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). In this instance, the Local Education Agency (LEA) refers to the preschool early intervention program which serves children from age 3 to school-age.

2. 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 SDs or IUs receive from the School Based Access Program is used to help cover the cost of special education services. Special education services refer to any services covered by an Individualized Education Program (IEP).

3. Before the LEA 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).

4. By giving consent, I am authorizing the LEA to share my child's information such as records or information about the services that may be provided to my 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 my child receives as part of his/her IEP. The only purpose of this disclosure is to bill for services provided.

5. I have the right to withdraw my consent at any time. Withdrawing my consent or not giving consent, will not affect the services that my child is receiving in school. It is still the responsibility of the LEA to provide my child's required services as written in his/her IEP at no cost to me.

6. Upon request, I may receive copies of my child's records that are disclosed as a result of this authorization. We recommend that you keep a copy of this form for your records.

PA MEDICAL ASSISTANCE BILLING PARENTAL CONSENT

Child's Name _____

Date of Birth_____

If you have any questions, or if you need the services of an interpreter, please contact me.

Name: _____

Position: _____

Email: _____

Phone: _____

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

☐ I have read the Notice and I give consent for the LEA to share my child's education and health-related information and bill Medical Assistance

☐ I have read the Notice and I DO NOT GIVE consent for the LEA to share my child's education and health-related information and bill Medical Assistance

☐ 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: _____

PA 医疗援助开具账单的家长同意书

儿童姓名：

出生日期：

发送日期：

家长/监护人/代理人的姓名和地址：

本人知悉：

1. 地方教育机构 (LEA) 有资格通过学校的援助计划获得联邦政府的费用报销，用于根据学生的个体化教育计划 (IEP)，为 3-21 岁的残疾学生提供必需的特定医疗服务。这里的地方教育机构 (LEA) 是指学前早期干预计划，旨在为 3 岁至学龄儿童提供服务。

2. LEA 对本报销计划的使用，不会以任何方式干扰或影响您孩子在校外接受到的其他必要的医疗承保服务。医疗援助将继续支付这些服务的费用。SD 或 IU 从学校援助计划中获得的任何报销都用于帮助支付特殊教育服务的费用。特殊教育服务指的是个体化教育计划 (IEP) 涵盖的各类服务。

3. 申请服务费用报销之前，根据《2004 年残疾人教育改善法案》 (IDEA) B 部分（各州残疾儿童的教育援助）和《家庭教育权利和隐私法案》 (FERPA)，LEA 须获得一次性的家长书面同意书。

4. 通过签署同意书，本人授权 LEA 向 PA 教育署、PA 公共服务署以及医生或护士分享我孩子的信息，例如：可能为我孩子提供的相关服务的记录或信息，以便就孩子（作为 IEP 的一部分）接受到的服务向医疗援助开具账单。信息披露的唯一目的是为所提供的服务开具账单。

5. 本人有权随时撤回此同意书。撤回此同意书或不签署同意书，将不会影响我孩子在学校接受的服务。LEA 仍有责任为我的孩子提供其 IEP 中所述的必要服务，且本人无需承担任何费用。

6. 经要求，本人可收到因此次授权所披露的孩子记录的副本。我们建议您保留此表格的副本，留作记录。

PA 医疗援助开具账单的家长同意书

儿童姓名：

出生日期：

如果您有任何疑问，或需要翻译服务，请与我联系。

姓名：

职务：

电子邮箱：

电话：

家长/监护人/代理人的说明：请选择其中一个选项，签署此表格，并寄回至学校。

☐ 我已阅读该通知，并同意 LEA 分享我孩子的教育和健康相关信息并向医疗援助开具账单

☐ 我已阅读该通知，不同意 LEA 分享我孩子的教育和健康相关信息并向医疗援助开具账单

☐ 我想安排一次非正式会议，与学前早期干预人员就这项要求进行讨论

请在这里签字：

家长/监护人/代理人签字：

日期：

日间联系电话：

请将整份表格寄回至：

姓名：

地址：