**Holland Public Schools** 

*Student Services Office* **www.hollandpublicschools.org**

**Parent Permission**

**For Medicaid School Based Services**

**Dear Parent/Guardian:**

**Student Name:** **Request Date:**

Since 1993 the Ottawa Area Intermediate School District and its local districts have participated in the Medicaid School Based Services program. This program allows school districts to bill the Medicaid program for reimbursement for health services provided in the schools to special education students who are eligible for Medicaid.

The **Medicaid School Based Services Program** in Michigan:

* Provides partial reimbursement for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work Services, Orientation and Mobility Services, Transportation, or Nursing Services.
* Does **NOT** affect a family’s Medicaid insurance benefits and there is **NO** cost to the family, now or in the future.
* Helps school districts because it offsets some of the costs of health care that we provide to children and students.
* Requires information about your child’s school based services (which could include date of birth, disability, gender, school, date of therapy, type of therapy, and progress reports) by the Michigan Medicaid and billing agencies to obtain this reimbursement.

If your child receives any of the above services and qualifies for Medicaid benefits at any time during the school year, we request your permission to bill Medicaid to receive reimbursement. **Please complete the area in the box below and return this form to your child’s teacher as soon as possible.** You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid. If you do not provide consent, the district will still provide the services but the district will not receive any Medicaid reimbursement for these services. ***Please note: consent will be assumed "granted" unless we receive a response to the contrary within 10 school days from the request date.***

**I give permission for the Ottawa Area Intermediate School District and my local school district to bill Medicaid for reimbursement of School Based Services provided during the school year as described in my child’s IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan).**

**Parent/Guardian Signature: Date:**