

**Parental Consent for Medi-Cal Billing in Schools**  
**Nevada Joint Union High School District**  
2013-14

Nevada Joint Union High School District participates in the LEA Medi-Cal Billing Option Program offered through the California Department of Health Care Services and the Centers for Medicaid Services. The program allows for the school district to receive federal reimbursement funds for some health services provided to Medi-Cal eligible students while they are at school. The funds are reinvested back into the school programs to benefit students and their families.

Nevada Joint Union High School District can bill Medi-Cal for assessments and services for IEP students, as well as for students who, upon assessment, do not qualify for Special Education services. The areas of service include speech, psychology, occupational therapy, physical therapy and nursing services.

**Consistent with the following Codes of Federal Regulations:**

**34 CFR 300.154(d)(2)(iv), 34 CFR 300.154(d)(2)(v), 34 CFR 99.30 and 34 CFR 300.622:**

- Parental consent must be obtained before NJUHSD can submit Medi-Cal claims for the student's billable health services. This is a one-time consent that can be revoked by the parent at any time.
- The services that NJUHSD provides to the student will not be affected in any way by the parent's consent or refusal.
- The parent/student will never pay a fee for health services provided to the student by NJUHSD.
- The parent/student's Medi-Cal benefits will never be affected in any way.
- The student's medical/educational records may be disclosed to Medi-Cal for the purpose of authenticating claims.
- NJUHSD will provide annual written notice to parents before accessing their child's public insurance benefits (Medi-Cal).

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I understand that:

- \* By giving consent, I am not disclosing whether or not my child is currently eligible for Medi-Cal benefits.
- \* If I give consent now, I may withdraw my consent at any time in the future.
- \* Whether I consent or refuse, the services my child receives under his/her IEP will never be affected.
- \* Whether I consent or refuse, I will never be required to pay for the health services my child receives under his/her IEP.
- \* Whether I consent or refuse, the Medi-Cal benefits of my child and/or family will never be affected.
- \* Upon request, I may receive copies of my child's medical/educational records that are disclosed to Medi-Cal as a result of this authorization.

- Yes, I give consent for NJUHSD to bill Medi-Cal for my child's IEP health services
- No, I do not give consent for NJUHSD to bill Medi-Cal for my child's IEP health services

Name of Student \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

***Please return this form to the Special Education Department at NJUHSD.***

*Thank you.*