IRVINGTON SCHOOL DISTRICT

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. Your child will continue to receive services at no cost to you under this new system. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

If you have any questions, please call your child's case manager.
Please fill in the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Child's Name:

____

(First) (Mid. Initial) (Last)

Child's Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____

(Month) (Date) (Year)

As parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature: ____________________________________ **Date:** ________________________

(Parent or person in parental relationship) (Month/Day/Year)

Please return this form to:

Special Services Office
1324 Springfield Avenue
Irvington, NJ 07111