

# Massachusetts Parental Notice with One-Time Consent to Allow the School District To Access MassHealth (Medicaid) Benefits

Arlington Public Schools

Dear Parent/Guardian:

The purpose of this letter is to ask your permission to bill MassHealth for the cost of special education services that the district provides your child under the IEP that we developed with you. If you agree, MassHealth will reimburse the cost of services that they cover, such as therapy services as well as the cost of time spent by providers of such services to participate in Team meetings. We cannot send records and information about your child and your child's IEP services to MassHealth to ask for reimbursement without your consent and without first notifying you of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the special education services to which your child is entitled;
2. The school district cannot require you to pay anything towards the cost of your child's special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can bill MassHealth. The school district can agree to pay the co-pay or deductible if any such cost is expected.
3. If the school district receives your consent:
  - a. Your consent will not decrease your child's available lifetime coverage or other MassHealth benefit; nor will it in any way limit your own family's use of MassHealth benefits outside of school.
  - b. Your consent does not affect your child's special education services or IEP rights in any way.
  - c. Your consent will not lead to any changes in your child's MassHealth rights; and
  - d. Your consent will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.
4. If you consent, you have the right to change your mind and withdraw your consent at any time.
5. If you withdraw your consent, or refuse to agree to allow the school district to share your child's records and information with MassHealth for the purpose of billing the cost of his/her IEP services, the school district will continue to be responsible for providing your child the special education services in his/her IEP at no cost to you.

**I have read the notice and understand it. I have had my questions, if any, answered. I agree to give my consent to the school district to share records and information concerning my child and his/her IEP services as necessary to bill MassHealth to obtain federal reimbursement for the cost of the IEP services that MassHealth covers.**

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Student Name:**

**DOB:**

**SASID:**