



**CONSENT FOR TREATMENT, RELEASE OF INFORMATION, & REIMBURSEMENT FOR NON-IEP NURSING SERVICES**

**Please Note: THIS CONSENT IS FOR SCHOOL BASED SERVICES PROVIDED FOR YOUR CHILD.**  
**SIGNING THIS CONSENT DOES NOT AFFECT ANY BENEFITS THAT YOU RECEIVE.**

By my signature below, I consent for the **Horry County School District** (the District) to:

- Provide non-IEP nursing services to my child;
- Release and exchange the following information from my child’s record to the Department of Health and Human Services (Medicaid Agency) or my child’s health insurance carrier for the purpose of billing for the non-IEP nursing services provided to my child – information about the service provided, my child’s name, date of birth, Medicaid or health insurance number, gender, and my contact information;
- Bill the Medicaid Agency and other insurance carriers for the health-related services; and
- Receive payment from the Medicaid Agency and other insurance carriers for the non-IEP nursing services that the District provides to my child.

I understand that:

- Medicaid reimbursement for non-IEP nursing services provided by the District will not affect any other Medicaid services for which my child is eligible.
- The District will continue to provide required non-IEP nursing services for my child at no cost to me even if I refuse to allow billing for services.
- Granting consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).
- The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child’s treatment and provision of non-IEP nursing services.

\_\_\_\_\_  
**Student’s Name**

\_\_\_\_\_  
**Student’s Date of Birth**

\_\_\_\_\_  
**Medicaid #**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**\*\*\*Please return this completed form to the School Nurse.\*\*\***



## PARENT COPY OF NOTIFICATION

### **NOTIFICATION OF USE OF PUBLIC BENEFITS (Medicaid) OR INSURANCE TO PAY FOR SERVICES UNDER THE INDIVIDUAL'S WITH DISABILITIES ACT (IDEA)**

This notification is to inform you of the intent of the **Horry County School District and the South Carolina Department of Education (SCDE)** to bill Medicaid and/or third party insurance and receive payment from Medicaid and/or any third party insurer for health-related services, as permitted under Part B of the Individuals with Disabilities Education Act (IDEA), and as set forth in your child's individualized education program (IEP). The district or agency and the SCDE may also bill Medicaid for psychological evaluation services, nursing services, and other health-related treatment services billable to Medicaid without the requirement of an IEP. The district or agency must provide this notice to you prior to requesting your consent to bill Medicaid and/or any third party insurance and once a year thereafter for services that the district or agency will provide in the future.

This document also serves as notice that the district or agency and the SCDE will release and exchange medical, psychological, and other personal identifiable confidential information, as necessary, to the Department of Health and Human Services and any applicable third party insurance carrier regarding health-related services provided to your child.

Medicaid reimbursement for school based health-related will not affect any other Medicaid services for which your child is eligible. The district or agency cannot bill Medicaid or your child's insurance program if it will decrease available lifetime coverage or any other insurance benefit, result in the family paying for services that would otherwise be covered, increase your insurance premiums, or risk loss of eligibility for waived programs. Your child will receive the services listed in the IEP regardless of whether you enroll your child in public or private benefits or insurance programs and whether or not you provide consent for the district or agency to bill Medicaid for services. Your refusal to allow access to Medicaid or any third party insurance carrier does not relieve the District of its responsibility to ensure that all required services are provided at no cost to you.

Any previous, current, or future consent to bill Medicaid or insurance was voluntary and you may revoke your consent at any time. If you choose to revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

The District and the SCDE will continue to operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding your child's treatment and provision of health-related services.

## PARENT COPY OF NOTIFICATION