♦ PLEASE PRINT ALL FIELDS ♦

Troup County School System
SPECIAL EDUCATION DEPARTMENT
PARENTAL/GUARDIAN
MEDICAID AND OR PEACHCARE CONSENT FORM

STUDENT: ____DOB: ______________________

SSN: _______________________________________ IEP DATE: ____________________________

STREET ADDRESS: ____

CITY: ___________________________________STATE: _____________ZIP CODE: __________

DR. NAME (student's physician):____

DR. PHONE NUMBER:____

DR. ADDRESS:____CITY:___________________

Reimbursement for services does require that a form be completed by your child's physician. Once you provide the contact information requested on this consent form, a document will be sent to the physician for completion. Your selection and signature gives or denies your permission for the School System to provide pertinent information pertaining to services provided in the student's IEP to their physician as required by Medicaid.

The School System is providing the health-related services to your child in accordance with his/her Individual Education Program or Individual Family Service Plan. Medicaid and/or PeachCare is required to cover some of the cost of certain services.

The School System cannot bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health-related services that your child is receiving in accordance with his/her Individual Education Program or Individual Family Service Plan, check the "Yes" box and sign below

Your selection and signature (parent/guardian) gives or denies permission to the school to bill Medicaid/PeachCare for the frequencies of services as defined in your child's IEP or IFSP beginning with the current school year.

☐ **YES** I authorize the School System to bill Medicaid and/or PeachCare for the health related services listed in my child's IEP or IFSP

☐ **NO** I do not want Medicaid and/or PeachCare billed for health related services my child is receiving

☐ My child does not currently receive Medicaid, however, if they were in the future, I give The Troup County School System permission to bill for services.

Parent/Guardian Name (**PLEASE PRINT**): ____

Parent/Guardian Signature:____

Date:______________________________

It is my responsibility as a parent to notify the school system's Special Education Department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid/PeachCare.

NOTE: As of April 1, 2003, the Children Intervention Services Program (CIS) and the Children Intervention Schools Service Program (CISS) have been separated. Students can receive medical services in both programs without impacting service limitations.

If you have any questions, please call: Lakshmi Sankar – 706-812-7939