KANKAKEE SCHOOL DISTRICT 111

SUPERINTENDENT OF SCHOOLS
240 WARREN AVENUE
KANKAKEE, ILLINOIS 60901-4319
(815) 933-0700 FAX (815) 936-8944

UPDATED
MEDICAID
CONSENT FORM

Please complete this form if your child receives Speech, Social Work, Psychological, Occupational Therapy, Physical Therapy, Audiological, or Nursing services.

PARENT/GUARDIAN CONSENT FOR REIMBURSEMENT OF HEALTH RELATED SERVICES FROM THE STATE

Your child's IEP includes one or more health related services, such as Social Work, Psychological, Nursing, Speech, Occupational Therapy, or Physical Therapy Services. To comply with federal law, Kankakee School District #111 or its agent must obtain consent from parents of students requiring health related services to bill the Illinois Department of Healthcare & Family Services (IDHFS) for reimbursement of these services.

I understand that records or information about services provided to my child may be disclosed to IDHFS for reimbursement of these services. I understand my consent is voluntary. I understand if I give consent, Kankakee School District #111 or its agent will bill IDHFS for reimbursement of health related services indicated on his/her IEP. I understand my consent will apply for any additional services which may be required in an updated IEP for my child. I also understand that the health related services as assigned in the IEP, will be **provided at no cost to me**, the parent/guardian.

I understand if I do not consent, Kankakee School District #111 or its agent will continue to provide the health related services to my child in accordance with the IEP at no cost to me, the parent/guardian.

I also understand I may revoke my consent at any time, and if I revoke consent, Kankakee School District #111 or its agent will continue to provide the necessary IEP health related service to my child at no cost to me, parent/guardian.

Please check the appropriate statement.

____ I give consent for Kankakee School District #111 or its agent to bill IDHFS for reimbursement of evaluation and health related services provided to my child.

____ I do not give consent for Kankakee School District #111 or its agent to bill IDHFS for reimbursement of evaluation and health related services provided to my child.

Print Student Name _____ Birth Date_____

Print Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____Print Student's School_____