DEPARTMENT OF EDUCATION

Consent to Share Data with Minnesota Health Care Programs for Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) Health-Related Services

Child's Last Name: _____ First Name: _____ Middle Initial: ___

Birthdate: _____ (month/day/year)

School districts may seek reimbursement from Minnesota Health Care Programs (MHCP) for health related services provided to students with disabilities. Our school district is asking for your consent to share data with the MHCP to seek reimbursements for health related services provided.

_____ (School District Name) will bill MHCP for covered health-related services your child receives at school. We need your signature to share data with the Minnesota Department of Human Services (DHS) to bill for these services. The information includes your child's name, date of birth, member number, dates of service and type of service codes. If our school district is audited by DHS or the U.S. Department of Health and Human Services (DHHS), the data shared may also include your child's IFSP or IEP, evaluation reports, documentation of services, school attendance and medical orders.

Things you should know about school billing MHCP for health related services:

- Allowing our district to share medical information for purposes of billing MHCP is optional for you, and require you as your child's parent or guardian to provide informed consent for sharing that information;
- Our school district will provide you a notification and information about our intent to bill MHCP at least once a year;
- You can tell our school district in writing to not share medical information or bill MHCP any time that you want to, and our district will stop doing that;
- If you ask, you can get copies of any information our school district shared with DHS or DHHS about your child.
- It does not affect a family's MHCP benefits, there is no cost to the family and will not in any way limit your family's use of your MHCP benefits outside of school.
- For children with an IFSP: My child has an IFSP and I have received a copy of the state system of payments policy, which includes: (1) Consent to Share Data and Seek Payment for IFSP Health Related Services; and (2) Written Annual Notice Related to Third Party Billing for IFSP Health Related Services. This policy will be provided to me each time my consent is required

By signing this document I give my consent for the school district to share information from my child's education records to Minnesota DHS or DHHS. I understand that my consent will remain in effect unless withdrawn in writing.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____