PINELLAS COUNTY SCHOOLS
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PARENT CONSENT AND NOTIFICATION

PRINT OR TYPE

Student Name ____
Last First Middle

Student Identification Number ____________________

____ **I authorize** ____ **I do not authorize**

The School District of Pinellas County, Florida, to release and exchange my child's confidential information to agencies of the State of Florida which would allow Pinellas County Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's plan (IEP, 504 Plan, FBA, PBIP, Health Plan, etc.) and receive Medicaid reimbursement for services it provides to my child while at school. **I understand that my child will continue to receive services referenced on his/her IEP, 504 Plan, FBA, PBIP, Health Plan, etc. at no cost whether or not I give consent, and that I may revoke consent at any time in writing.**

______________________________________ ____________________
SIGNATURE OF PARENT/GUARDIAN **DATE**

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NAME OF PARENT/GUARDIAN **(PRINT OR TYPE)**

Parents/Guardians: Medicaid reimbursement funds are utilized to support programs for students with disabilities. Your consent does not affect Medicaid services that your child is receiving outside of the school setting.