Medicaid Annual Parent Notification Letter

Today's Date: _____

Student's Name: _____ Current School: _____

Dear _____*(parent's name)*_____,

The _____*(district name)*_____ School District is pleased to provide your child with special education and related services as stated in his or her Individualized Education Program (IEP) or your child who qualifies for basic medical necessity through Expanded Access. Your child is entitled to free services, which means at no cost to you.

State and federal laws allow school districts to be Medicaid service providers for children with disabilities who are eligible under the Individuals with Disabilities Education Act (IDEA) or students who require medical services and their districts participates in Expanded Access; both are enfolded in the Medicaid program. This means that our school district can bill the Department of Medicaid for related health services stated in your child's IEP or for children who qualify for essential medical services.

Our school district is approved by the Kentucky Department for Medicaid Services to participate in the Medicaid School-Based Health Services Program. School claims for Medicaid payment for these services will not affect your child's receipt of health services from your family physician or other health providers in any way.

Our school district cannot submit claims to Medicaid for your child's services if you do not want us to do so. Our district billing Medicaid for these services will not change your child's IEP services or your right to receive Medicaid services if your son or daughter continues to be eligible for Medicaid services.

If you wish to deny the district's access to reimbursement from Medicaid for health services in your child's IEP or necessary medical services, you should do so in writing. Our school district will continue to bill Medicaid for special services unless you notify us in writing that you wish us to stop. We will remind you once a year. If you wish to stop the district from submitting claims to Medicaid for your child, send a written statement to the district's Medicaid Liaison.

If you have any questions or concerns about your child's Medicaid coverage, please contact _____*(name)*_____ at __*(phone number)*_____.

If we do not hear from you, we will begin or continue to submit claims to Medicaid for your child's services. I want to thank you for your support of our efforts.

Sincerely,

(name)
Medicaid Liaison
(phone number)