DOCUMENTS FOR THE DISCLOSURE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

_____ SCHOOL DISTRICT (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in a Michigan Department of Community Health program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to Michigan Department of Community Health. This may include personally identifiable information (ex. Name, Date of Birth) as well as records or information about the services that may be provided to your child.

The School District requests your consent to disclose information from your child's education records to Michigan Department of Community Health as necessary for the School District to seek Medicaid funds to help cover the costs of the school-based health services the School District provided to your child. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide necessary health services to your child at no cost to you, the parent/guardian.

NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information to Michigan Department of Community Health,
- may not require you to sign up for or enroll in any public benefits or insurance programs,
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the School District provides to your child, and
- may not use your child's Medicaid or other public benefits if that use would.
    - decrease available lifetime coverage or any other insured benefit,
    - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school,
    - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance, or
    - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

Giving your consent will cost you, the parent guardian, nothing, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

Please use the attached form to select your consent option.

PARENT/GUARDIAN CONSENT TO DISCLOSE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

STUDENT'S NAME_____
(First) (Middle Initial) (Last)

STUDENT'S DATE OF BIRTH ___ ___/___ ___ / ___ ___

Please review the statements below and select your option by checking the appropriate box.

☐ Yes. As the parent/guardian of the student named above, I give my consent to the School District to disclose information from my child's education records to Michigan Department of Community Health as necessary to allow the School District to seek Medicaid funds to help cover the costs of the school-based health services School District provided to my child.

I understand that my consent will remain in effect until I withdraw it, and that I may withdraw my consent at any time by notifying the School District. If I withdraw my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

☐ No. As the parent/guardian of the student name above, I *do not* give my consent to the School District to disclose information from my child's education records to Michigan Department of Community Health

I understand that if I do not give my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

Name: _____
(Name of parent/guardian)

Signature: _____ Date: _____
(Signature of parent /guardian) (Month-day-year)