



Hawaii State Department of Education
SCHOOL-BASED MEDICAID CLAIMING AUTHORIZATION FORM
(PARENTAL CONSENT FORM – Updated July 2018)

Dear Parent/Guardian:

The purpose of this Parental Consent form is to seek your authorization for the Hawaii State Department of Education (Department) to bill the state Medicaid program known as Med-QUEST. By obtaining your consent the Department can receive partial federal reimbursement for the medically necessary and educationally necessary, health-related services provided through your child's Individualized Education Program (IEP).

CHECK THE APPROPRIATE BOX and return to your school's Student Services Coordinator/Designee.

I give my consent to the Department to claim federal reimbursement for medically necessary and educationally necessary, health-related services provided to my child through the Individualized Education Program by accessing Med-QUEST. I have read the notice and understand that:

- The Department may disclose to Med-QUEST personally identifiable information included in my child's IEP (e.g. student name, address, date of birth, student identification number, disability, service dates, and type of service provided).
- All information provided to Med-QUEST concerning my child is strictly confidential. Upon request, I may receive copies of disclosed records.
- The Department accessing Med-QUEST for the purpose of obtaining federal reimbursement shall not affect my child's Med-QUEST benefits. Neither my child nor I shall experience financial loss or reduction in available benefits as a result of enrollment in Med-QUEST.
- The Department cannot require me to sign up for Med-QUEST for my child to receive the special education services to which my child is entitled.
- I may withdraw my consent, in writing, at any time, and such withdrawal will apply prospectively only.
- Withdrawal of my consent does not relieve the Department of its responsibility to ensure that all required special education services are provided at no cost to the parent, in accordance with state and federal education requirements.
- The Department shall provide an annual written notice of parental rights regarding consent.

I do not give my consent to the Department to claim federal reimbursement for medically necessary and educationally necessary, health-related services provided to my child through the Individualized Education Program.

PLEASE PRINT CLEARLY OR TYPE:

Date: _____

Student's Name: _____ School: _____

Print Parent/Guardian name: _____

Parent/Guardian signature: _____

Parent/Guardian Home Address: _____

Parent/Guardian Telephone Number: _____ Email address: _____

QUESTIONS OR INFORMATION:

Contact the Health Care Contracts & Reimbursement Office at (808) 305-9787.