Exceptional Student Education

Medicaid Certified School Match Program

Student Name:_____ Today's Date:_____

Student #:_____ School:_____ Grade:_____

Date of Birth:_____ Sex:_____ Race:_____ Primary Language at Home:_____

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Home Phone:_____ Work Phone:_____

Dear Parent:

This letter is to inform you that *if your child is eligible for Medicaid* the Alachua County School District will be billing Medicaid for certain *health-related services* that your child may be receiving. The money earned from Medicaid will be used by the School District to support existing programs. Services currently provided to your child will not change.

I authorize the School District of Alachua County, Florida to release and exchange my child's confidential information to agencies of the State of Florida which would allow Alachua County Public Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individual educational plan (IEP) and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school.

Parent/Legal Guardian Signature:_____ Date:_____

Return form to: Your student's school

To be completed when student is initially staffed into an ESE program.