OKEECHOBEE COUNTY SCHOOL BOARD
Exceptional Student Education
700 S.W. 2nd Avenue, Okeechobee, Florida 34974
Medicaid Reimbursement Programs

MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PARENTAL CONSENT

Print or Type

Student Name: _____ _____ _____
Last First Middle

Medicaid Number _____ Student Number: _____

Date of Birth: _____

I/We give consent to the School Board of Okeechobee county to release and exchange my child's personally identifiable information including my child's date of birth and Medicaid number with Medicaid's fiscal agent, the school district's billing agent and any representative of the Agency for Health Care Administration (AHCA) for the purpose of determining Medicaid eligibility status, billing for direct therapy services provided to my child while at school, and participation in AHCA monitoring activities of the school district's Certified School Match Program.

_____
Parent/Guardian Signature Date

_____
Name of Parent/Guardian (Print or Type)

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

One Copy: Cumulative folder One Copy: Medicaid Office/ESE Office