MANSFIELD PUBLIC SCHOOLS
255 EAST STREET ~ 2ND FLOOR
MANSFIELD, MASSACHUSETTS 02048

JAMES T. LEONARD
Director of Special Education

Phone (508) 261-7507
Fax (508) 261-7518

Dear Parent/Guardian,

Mansfield Public Schools, as well as other local districts, participate in the Mass Health/Medicaid School Based Services Program. This program is an integral part of the Mansfield Public School's ability to provide a high level of quality care to our Special Education Students who receive Physical Therapy, Occupational Therapy, Speech & Language Therapy, Nursing, Autism Services, and/or Counseling Services. The Massachusetts Department of Elementary and Secondary Education has made a change to streamline the parental/guardian authorization process.

Attached please find a Parental/Guardian Authorization form explaining the process. Please read the form, sign it, and return it in the enclosed envelop. If you choose to refuse to consent, please write **REFUSE** in the parent/guardian signature and return the form in the enclosed envelop and we will remove you from our list.

It is necessary for MPS to have your written consent to bill for these services. We greatly appreciate your partnership in making this program a success. Please understand, allowing us to bill for these services in no way jeopardizes your Mass Health benefits.

If you have any questions, do not hesitate to contact my office.

Sincerely,

James T. Leonard
Director of Special Education

Massachusetts Parental Notice for One Time Consent to Allow the School District To Access MassHealth (Medicaid) Benefits

School District Name and Code: MANSFIELD PUBLIC SCHOOLS 01670000

School/District Contact: James Leonard (508) 261-7507

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share information about your child with MassHealth. Local communities in Massachusetts have been approved to receive partial reimbursement from MassHealth for the costs of certain health-related services provided by the district to your child (or children). In order for your community to get back some of the money spent on services, the school district needs to share with MassHealth the following types of information about your child: name; date of birth; gender; type of services provided, when, and by whom; and MassHealth ID.

With your permission, the school district will be able to seek partial reimbursement for services provided by MassHealth, including, among others, a hearing test or eye exam; a school physical; occupational or speech or physical therapy; some school nurse visits; and counseling services with the school social worker or psychologist. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share with MassHealth information about your child without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for MassHealth in order for your child to receive the health-related and/or special education services to which your child is entitled.

2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge MassHealth for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.

3. If you give the school district permission to share information with and request reimbursement from MassHealth:
   a. This will not affect your child's available lifetime coverage or other MassHealth benefit; nor will it in any way limit your own family's use of MassHealth benefits outside of school.
   b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
   c. Your permission will not lead to any changes in your child's MassHealth rights; and
   d. Your permission will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

4. If you give permission, you have the right to change your mind and withdraw your permission at any time.

5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with MassHealth for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission to the school district to share with MassHealth records and information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our community seek partial reimbursement of MassHealth covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**
Child's Name:	**Date of Birth:**	**SASID # (for district to add):**

Add more children