COMPLETE ONLY IF STUDENT HAS MEDICAID NUMBER

2009 - 2010 School Year

Dear Parent/Guardian:

Avon C.U.S.D. #176 is a "Health Care Service Provider" with the Illinois Department of Public Aid/Medicaid. Medicaid reimbursement is a source of federal funds approved by Congress to help school districts maintain and improve special education services.

Therapy and diagnostic services provided to your child (you) are partially reimbursable. Unless you object in writing, Avon C.U.S.D. #176 / West Central Illinois Special Education Coop. Will claim Medicaid/Kid Care reimbursement for services provided. These claims will have no impact on your ability to receive Medicaid funding either now or anytime in the future.

If you object to this release of information related to Medicaid claims for your child, you must do so in writing. We do ask that you complete the lower portion of this form.

Thank you for your attention to this notice.

PLEASE COMPLETE THE FOLLOWING STEPS (Please Print):

STEP 1

Child's Name: _____ _____ _____
Last First Middle

Child's Date of Birth: _____ _____ _____
Month Day Year

Parent/Guardian Name: _____

Parent/Guardian Address: _____

_____

Parent/Guardian Phone: (____) _____

Child's Social Security #: ____ - ____ - _____ (optional)

STEP 2

If your child has "Medicaid coverage", please complete the following:

___ ___ ___ ___ ___ ___ ___ ___ ___
Child's NINE DIGIT Recipient Number

STEP 3 **Return this form to Avon C.U.S.D. #176**