Informed Consent

Dear Parent/Guardian:

You are receiving this because your child has been referred to the Mental Health Services Team to assess if additional support is needed. We are very excited about the opportunity to collaborate with you and provide tools and strategies that will help your child succeed both in and out of school. Please fill out and return this form.

These services are intended to gather important data that will help support your child behaviorally, academically, socially, and emotionally. These services may include:

- Observing the Student in the School Setting
- Using Screening Tools
- Attending Team Meetings
- Individual and/or Group Therapy
- Community Resources
- Telehealth

Should schools go to remote learning, or you decide to have your child participate in remote learning, mental health services will continue to be available through telemental health.

Information and data gathered is intended to be kept confidential. However, information that will enhance the child's success in school may be shared with his/her teacher(s) and/or administrator(s) on a need-to-know basis. If there is specific information you do not want shared, please notify us. The therapeutic process is one that requires trust between the client and therapist; therefore, the student's confidentiality will be maintained. Limits to confidentiality required by law, include if a child discloses that he/she or another child is being hurt or is in danger and if a child threatens to harm him/herself or another person. Measures will be made to protect confidentiality, however, telehealth communications may be at greater risk of information being accessed by non-authorized persons, as computers and cell phones could be hacked, lost, or stolen.

Medicaid: If your child receives medical or social/emotional services listed above, has a Plan of Care, or needs crisis support services and is eligible or becomes eligible for Medicaid benefits at any time during the school year, we will share your child's information with the state Medicaid agency and its affiliates to obtain reimbursement. This may include name, address, date of birth, student ID, Medicaid ID, disability, dates, and services your child received.

The Medicaid School-Based Services Program:

- Provides partial reimbursement to school districts for school-based mental health services.
- Does NOT affect a family's Medicaid insurance benefits and there is NO cost to the family, now or in the future.
- Helps the school districts to offset some of the costs of health care provided to children.

This consent remains in effect one year from signature date. You have the right to withdraw this consent at any time by notifying your school district in writing.

AGREEMENT FOR TREATMENT/SERVICES

_____ YES - I AGREE for my child to receive school-based services as described above
_____ NO - I DO NOT AGREE for my child to receive school-based services as described above

CHILD NAME: _____

PARENT/LEGAL GUARDIAN NAME: _____

DATE: _____

By signing this form, I acknowledge that I have read and understand the above information.

SIGNATURE: _____

We believe working as a team is one of the most beneficial ways to support student progress, and we look forward to the possibility of being part of your child's team. Please provide your contact information.

EMAIL: _____

PHONE: _____