

MISSISSIPPI DEPARTMENT OF EDUCATION  
OFFICE OF SPECIAL EDUCATION  
EDUCABLE CHILD PROGRAM  
P.O. BOX 771, SUITE 301  
JACKSON, MS 39205

INSTRUCTIONS FOR COMPLETING THE PARENT MEDICAID APPLICATION FORM: (SDE-BSS-F11)

**General Directions:**

- Please print or type.
- Complete all blanks or provide an explanation as to why it was left blank.

**Section 1: INFORMATION PERTAINING TO STUDENT:**

- Use child's legal name – DO NOT USE NICKNAME.
- Provide Date of Birth, Age, Sex and Race.
- Complete Public School District of parent/guardian's residence.
- Provide parent/guardian name, relation to student, current address, phone number and email address.(if available)
- Provide the student's MSIS ID or Social Security Number. (Social Security number is optional)
- Provide the current date of eligibility located on the Determination of Eligibility.
- Circle Type of Disability: This should be the same information as contained on the Determination of Eligibility.

**Section 2: CERTIFICATION OF SCHOOL/FACILITY DIRECTOR OR DULY-**

**AUTHORIZED OFFICIAL: Intermediate Care Facility For the Intellectual Disability (ICF-ID)**

- Complete Name of school and address.
- Complete the Name of student being accepted to school/facility.
- Complete Date services began and Date this school/facility session ends.
- Have the School Official sign and date the application

**Section 3: CERTIFICATION OF SCHOOL/FACILITY DIRECTOR OR DULY-**

**AUTHORIZED OFFICIAL: Psychiatric Residential Treatment Facility (PRTF)**

- Complete Name of school and address.
- Complete the Name of student being accepted to school/facility.
- Complete Date services began and Date this school/facility session ends.
- Have the School Official sign and date the application

NOTE: An incomplete application or missing documents will result in the application being returned and will delay approval. Make sure all documents submitted are legible. Faxed copies are not acceptable.

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PARENT MEDICAID APPLICATION for financial assistance when a child who is certified as requiring inpatient care in a private Intermediate Care Facility for the Intellectual Disability (ICF-ID) or in a Psychiatric Residential Treatment Facility (PRTF) with Medicaid Reimbursement. **(BLUE FORM)**

SESSION 20 \_\_\_\_\_ - 20 \_\_\_\_\_  
APPLICATION MUST BE COMPLETE (Please Type or Print)

1. INFORMATION PERTAINING TO STUDENT

Name \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_  
(Month) (Day) (Year)

Public school of parent/guardian's residence: District Name: \_

Parent/Guardian Name \_\_\_\_\_ Relation to Student \_\_\_\_\_

Address \_\_\_\_\_  
(Street, Route and/or Box No.) (City) (State) (Zip)  
Phone \_\_\_\_\_  
(Email address of Parent/Guardian)

NOTE: If there is any change in legal parent, guardian or person standing IN LOCO PARENTIS, address, or school attending, notify the MS Department of Education, Office of Special Education, immediately by submitting the change in writing.

MSIS ID \_\_\_\_\_ OR SSN Number \_\_\_\_\_

DATE OF CURRENT ELIGIBILITY: \_\_\_\_\_

TYPE OF DISABILITY (Circle the Child's Primary Disability)

- |                                 |                             |
|---------------------------------|-----------------------------|
| 1. Intellectual Disability      | 8. Other Health Impairment  |
| 2. Specific Learning Disability | 9. Multiple Disabilities    |
| 3. Language/Speech Impaired     | 10. Autism                  |
| 4. Hearing Impaired             | 11. Developmentally Delayed |
| 5. Visually Impaired            | 12. Traumatic Brain Injury  |
| 6. Deaf-Blind                   | 13. Orthopedic Impairment   |
| 7. Emotional Disability         |                             |

**COMPLETE ONLY ONE: SECTION 2 OR SECTION 3**

**2. SECTION 2 IS FOR INTERMEDIATE CARE FACILITY FOR THE INTELLECTUAL DISABILITY (ICF-ID)**

**(a) CERTIFICATION OF SCHOOL/FACILITY DIRECTOR OR DULY-AUTHORIZED OFFICIAL (ICF-ID)**

Name of School \_\_\_\_\_

Address \_\_\_\_\_ (Street) \_\_\_\_\_ Route \_\_\_\_\_  
and/or Box No.) (City/Town) (State) (Zip)

I, being the director or duly-authorized official of the above-named private or residential facility, certify that \_\_\_\_\_, has been accepted by the Division of Medicaid as requiring inpatient care  
(Name of Student) (Certification # \_\_\_\_\_) Attach copy of Certification.

I also certify that this child has been accepted in our school, has a current eligibility determination in accordance with State regulations, as well as an Educable Child Form for Parentally Placed Students, has written parental permission to place, and is being provided appropriate special education and related services in accordance with regulation. Actual attendance in the special education program for this school session will be from

\_\_\_\_\_ to \_\_\_\_\_  
(Date services began) (Date this school session ends) (Total number of session days)

I hereby certify that the above-named ICF-ID facility has met all requirements of the Mississippi Department of Education to provide educational services for children with disabilities. If there is any change in the placement of this child, including the child's certification status with the Division of Medicaid and/or receipt of educational services, the MS Department of Education, Office of Special Education will be notified immediately in writing. Written notification will also be provided immediately if any change occurs in the facility's physical location, including facility's address and/or changes in State-issued licensure status of the facility by the Department of Health.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Signature and Title of School Official

**INFORMATION PERTAINING TO WHOM WARRANT SHOULD BE MAILED:**

Name \_\_\_\_\_

Address \_\_\_\_\_

3. **SECTION 3 IS FOR PSYCHIATRIC RESIDENTIAL TREATMENT (PRTF)**

(a) **CERTIFICATION OF SCHOOL/FACILITY DIRECTOR OR DULY-AUTHORIZED OFFICIAL (PRTF)**

Name of School \_\_\_\_\_

Address \_\_\_\_\_  
(Street, Route and/or Box No.) (City/Town) (State) (Zip)

I, being the director or duly-authorized official of the above-named private or residential facility, certify that \_\_\_\_\_, has been accepted by the Division of Medicaid as requiring inpatient care  
(Name of Student) (Certification # \_\_\_\_\_) Attach copy of Certification.

I also certify that this child has been accepted in our school, has a current eligibility determination in accordance with State regulations, as well as an Educable Child Form for Parentally Placed Students, has written parental permission to place, and is being provided appropriate special education and related services in accordance with regulation. Actual attendance in the special education program for this school session will be from:

\_\_\_\_\_ to \_\_\_\_\_  
(Date services began) (Date this school session ends) (Total number of session days)

I hereby certify that the above-named PRTF facility has met all requirements of the Mississippi Department of Education to provide educational services for children with disabilities. If there is any change in the placement of this child, including the child's certification status with the Division of Medicaid and/or receipt of educational services, the MS Department of Education, Office of Special Education will be notified immediately in writing. Written notification will also be provided immediately if any change occurs in the facility's physical location, including facility's address and/or changes in State issued licensure status of the facility by the Department of Health.

\_\_\_\_\_ (Date) \_\_\_\_\_ (Signature and Title of School Official)

**INFORMATION PERTAINING TO WHOM WARRANT SHOULD BE MAILED:**

Name \_\_\_\_\_

Address \_\_\_\_\_