Gretchen Roussin
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Medicaid to Schools Program / Rochester School District
Medicaid Questionnaire/Consent for Release of Information

Please check the line below and answer the appropriate questions, and sign your name at the bottom. Thank You.

_____ My child **is** covered by MEDICAID Health Insurance or Healthy Kids Gold.

_____ My child **is not** covered by MEDICAID Health Insurance or Healthy Kids Gold.

If your child is covered by New Hampshire MEDICAID Health Insurance, or is a recipient of the "Healthy Kids" program, please complete the following. If your child is not covered by MEDICAID, please only fill in your child's name.

Student's Name_____

Student's School_____D.O.B_____

Student's MEDICAID # ____ ___ ___ ___ ____ ____ ____ _____ ____ -____ ____

Student's Physician_____
Name Address City State/Zip

I understand that the office of the Superintendent of Schools will administer the MEDICAID Program for my child, if applicable. I further understand that my child's MEDICAID number will not be shared with any party who is not directly involved with the reimbursement of MEIDCAID funds. This number will be held confidential and only used for reimbursement of MEIDCAID funds to the Rochester School District.

Signed:_____

Date:_____

Please return this form to the school your child attends. They will forward the form to the Office of the Superintendent. Feel free to contact Gretchen Roussin, Rochester School District Medicaid Coordinator at 603-332-3678 with questions or concerns. Thank You.