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**ROCHESTER SCHOOL MEDICAID PROGRAM
 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 the child's name.

His/her name is: _____

His/her school is: _____ DOB: _____

His/her MEDICAID # is: _____ - _____

His/her Physician is:

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 MEDICAID funds. This number will be held confidential and only used for reimbursement of MEDICAID funds to the Rochester School District.

SIGNED: _____

DATE: _____

Please return this form to the school that 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, 603-332-3678 x220 with questions or concerns. Thank you.