Hudson Falls Central School District
Committee on Special Education
P.O. Box 710
Hudson Falls, NY 12839

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

This form has been adapted from the U.S. Department of Education's model Notification Form[1].

INTRODUCTION

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/county to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district (or, for preschool students, the county) to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT

34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

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1 For the full Suggested Model for Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see:
http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/accmodelwrittennotification-6-11-13.pdf

HUDSON FALLS
SPECIAL EDUCATION
80 East LaBarge St., Hudson Falls, NY 12839

Justine Miles
Director of Special Education

Lori Johnson
Asst. Director of Special Education

Victoria Peterson
CSE Chairperson

Authorization for Release of Confidential Information

I hereby consent to and authorize Hudson Falls Central School District to obtain from and/or release to:

Student's Name:	**D.O.B.**
CIN #:	**Phone #:**
Physician/Agency Provider:	**Fax #:**
Physician/Agency Provider Address:	**Other:**

Information to be disclosed or shared includes:	**Information is needed for the following purposes:**
• Educational Evaluations/Results/Reports/IEP • Medical Evaluations/Reports • Psychiatric/Psychological Evaluations/Reports • Medical history and physical examinations • Diagnosis, brief descriptions/summaries of treatment progress and prognosis • Immunization Records • Written prescriptions, orders, and/or referrals for related services • Other _____	• Provide ongoing treatment/continuity of care • Coordinate treatment efforts with parent/ guardian • Coordinate education planning • Coordinate services with authorized school officials and/or community service providers • Release records/information to the state's Medicaid Agency for the purposes of billing for special education and related services that are in a student's IEP • Other _____

I understand that I have the right to revoke this authorization at any time by submitting a request in writing. The revocation will not apply to information that has already been released in response to the authorization. I understand that disclosure of this information is voluntary. I understand that I have a right to receive a copy of this authorization.

Parent Signature _____ Date of Permission _____

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Medicaid Consent

Client Identification Number (CIN):

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____
have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (e.g. records or information about services your child receives, student demographic information):	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

Student's CIN, if known: _____

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

HUDSON FALLS
SPECIAL EDUCATION

80 East LaBarge Street, Hudson Falls, NY 12839
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Justine Miles
Director of Special Education

PARENT AGREEMENT AND CONSENT TO RECEIVE SPECIAL EDUCATION COMMUNICATION AND INFORMATION VIA ELECTRONIC MAIL (E-MAIL)

I, Parent of _____ am hereby agreeing to accept all communication related to my child's special education programs and services via electronic mail for the district.

My consent to receive electronic communication from the district applies to all information and documentation related to the identification, evaluation, educational placement or the provision of a free appropriate public education to my child. This consent to receive information via electronic communication remains in effect unless and until I revoke my consent in writing to the district.

My email address is: _____.

_____ _____

Parent Signature Date

_____

Print Parent Name