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.

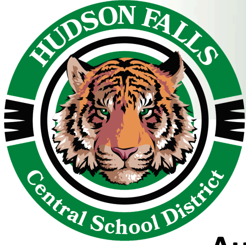
PARENTAL CONSENT
34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

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.

---

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



Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, ____ authorize my child's healthcare provider(s) listed below:

Name____Phone______________________FAX________________________

Name____Phone______________________FAX________________________

Name____Phone______________________FAX________________________

to release the medical records of my child, ____, DOB _______________________
Medicaid CIN #_______________________ to the district's:
❒ Medical Director ❒ School Nurse ❒ Athletic Trainer (AT) ❒ Counselor ❒ Occupational Therapist (OT) ❒ Physical Therapist (PT)
❒ Psychologist ❒ Social Worker ❒ Speech Therapist (ST) ❒CSE Office ❒Other____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
❒ Immunizations ❒ Medical Records ❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ❒ Mental Health ❒ Substance Abuse Treatment ❒CSE Records ❒ Other_____________________________

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)
❒ To develop care or therapy plans for routine and emergent school management
❒ To design appropriate educational, school, or athletic programs
❒ To assess the impact of the medical condition(s) on school programming and/or attendance
❒ To share school observations/concerns surrounding behavior
❒ To assess a medical basis for modification of transportation and/or home tutoring
❒ Medication delivery or therapy prescriptions
❒ At patient's request with no specified purpose
❒ Other_________________________________

PARENT: Please select one.
❒ This authorization is valid for the entire academic school year 20____-_20__________
❒ This authorization is valid for the duration of attendance within the school district
❒ This authorization shall expire on ____/_______/______ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

____

Signature of Parent/Guardian or student if over 18 Relationship Date

Hudson Falls Central School District
Committee on Special Education
P.O. Box 710
Hudson Falls, NY 12839 (518-747-2121; x 4117)

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.

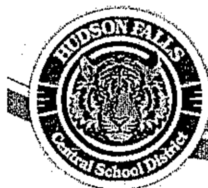
Records to be shared (e.g. records or information about services your child receives, student demographic information):	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific 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
Phone: (518) 681-4263 • Fax: (518) 681-4149

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