Oakfield-Alabama Central School District
7001 Lewiston Road, Oakfield, NY 14125
Phone: (585) 948-5211
Fax: (585) 948-8913

Grades 1-12 Registration Requirements

WELCOME TO THE OAKFIELD-ALABAMA CENTRAL SCHOOL DISTRICT

In order to register your child(ren) you must complete all of the information in the enclosed registration packet and turn it into Mrs. Fisher in the Elementary Office. Each child must have a registration packet completed.

Proof of Residency (2 forms are required)
To register your child, you must be a resident of the Oakfield-Alabama Central School District. Examples of proof of residency include a lease agreement, a signed purchase offer, a utility bill (gas, electric, phone, cable), a current bank statement, a current computer printed pay stub, NYS Drivers' License, NYS Certificate of Title, and/or NYS Registration Document with your name and address.

Birth Certificate
Birth certificates for all students born in the United States are required.

Citizenship
If your child is not a citizen of the United States, please bring your child's I-94 form or alien registration card (green card).

Are both natural parents living at the same address as the student?
If there has been a divorce or separation, a copy of a signed document stating the custody and the primary residence of the child(ren) is required. The District must comply with all legal arrangements set forth by the Court and/or agreements made by both the natural parents.

Records of Immunization
We must have each child's complete up to date shot history from your physician or previous school at the time of registration. These must be signed by a doctor and will need to be reviewed by our School Nurse.

Physical
We must have each child's complete up to date physical from your physician or previous school at the time of registration. These must be signed by a doctor and will need to be reviewed by our School Nurse.

Dental Appraisal
We must have each child's complete, up to date dental appraisal from your family dentist or previous school at the time of registration. These must be signed by a dentist and will need to be reviewed by our School Nurse.

Health History Form
This form is enclosed and is requested for the student's health file. This information will be helpful to the nurse in determining illness should your child go to the Health Office for assistance.

Signed Release of Records
This form is enclosed and required to obtain records from previously attended school.

Student Information or Registration Form
This form is enclosed and required for parental contact, emergency contact, and emergency transportation information.

Home Language Questionnaire
This form is enclosed and needs to be completed to determine how well your child understands, speaks, reads and writes English.

Temporary Placement Consent/Request for Consent to Evaluate
This form is enclosed and needs to be completed if your child is currently receiving services through the Committee on Special Education or Committee on Preschool Special Education.

Consent for Accessing Medicaid Insurance (to pay for certain special education services on a child's IEP)
This form is enclosed and needs to be completed if your child is currently receiving services according to their Individual Education Program.

Free/Reduced Meal Application (only 1 per family needed)
This form is available on our website under Lunch Payment and needs to be completed if you wish to know if your child qualifies for free/reduce meals.

Report Card/Transcript
These will be requested from the former school if applicable.

Transportation Information Form
This form is available on our website under Transportation and is required to be completed and signed by a parent.

OAKFIELD-ALABAMA CENTRAL SCHOOL DISTRICT

7001 Lewiston Road Oakfield, New York 14125 – Phone (585)948-5211 Fax (585)948-8913

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: ______________________ Date of Birth: ______________________

School: ______________________ Gender: ☐ M ☐ F Grade: ______________________

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: ________
PPD: ☐ Positive ☐ Negative ☐ Not done Date: ________
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: ________
Dental Referral ☐ Yes ☐ No ☐ Not done Date: ________

Significant Medical/Surgical History: ☐ See attached ______________________

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: ______________________

Allergies: ☐ LIFE THREATENING ☐ Food: ________ ☐ Insect: ________ ☐ Other: ________
☐ Seasonal ☐ Medication: ________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Date of Exam: ________

Body Mass Index: ___ ___ . ___	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ________

Eyes___ Ears___ Nose___ Throat/Tonsils___ Teeth/Gums___ Lymph Glands___ Thyroid___ Lungs___ Breast___

Heart___ Genito-Urinary___ Hernia___ Orthopedic___ Nervous System___ Epilepsy___ Skin___ Nutrition___

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: ______________________ Dosage/Time: ______________________

Name: ______________________ Dosage/Time: ______________________

If AM dose is missed at home: ______________________

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** ______________________ ☐ None

☐ **Known or suspected disability:** ______________________ ☐ Please monitor

☐ **Restrictions:** ______________________ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: ________

(Stamp below)

Provider's Signature: ______________________ Phone: ________

Provider's Name/Address: ______________________ Fax: ________

Parent Signature: ______________________ Date: ________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*

Oakfield-Alabama Central School

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year | Sex: ☐ Male ☐ Female | Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name | Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature______________________________ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of ________________________ on ______________ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) | Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Oakfield Alabama CSD

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	

Continues on back page

Oakfield Alabama CSD

During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:____

Please list any additional concerns: (use back of sheet if necessary)______________________________

____

Parent/Guardian Signature:______________________________ Date:__________________

Oakfield-Alabama Central School District
Registrar Office
7001 Lewiston Road
Oakfield, New York 14125
Phone: (585) 948-5211 x 3211
Fax: (585) 948-8913

Date: ________________________________

School Transferring From: ________________________________
____
____

The following student has enrolled at Oakfield-Alabama Central School District:

____
Name Date of Birth Grade

____
Signature of Parent

Please mail to the address above or fax the following records regarding the above-named student to:

- ✓ Academic Records
- ✓ Health/Medical Records
- ✓ Social/Emotional Records
- ✓ Psychological/Psychiatric Reports
- ✓ Birth Certificate (copy)
- ✓ Social Security Card (copy)
- ✓ Standardized Achievement and Aptitude Test Scores
- ✓ Personality and Interest Scores
- ✓ Teacher Ratings
- ✓ Record of Extra-Curricular Activities
- ✓ Individualized Education Program
- ✓ Social History
- ✓ Original Consent to Evaluate
- ✓ Original Consent for Placement
- ✓ Student Observation Reports
- ✓ Reevaluation Reports
- ✓ Most Recent Related Services Evaluations/Reports
- ✓ Any Other Pertinent Records

☐ OA Elementary	☐ OA Middle/High School	☐ OA CSE Office
Attn: Kim Fisher	Attn: Heather Gayton	Attn: Sally Pask
FAX: 585-948-8913	FAX: 585-948-9362	FAX: 585-948-8964

The FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) allows schools to disclose records, without consent, to the following parties or under the following conditions (34 CFR_99.31): School officials with legitimate educational interest; Other schools to which a student is transferring; Specified officials for audit or evaluation purposes; Appropriate parties in connection with financial aid to a student,; Organizations conducting certain studies for or on behalf of the school; Accrediting organizations; To comply with a judicial order or lawfully issued subpoena; Appropriate officials in cases of health and safety emergencies; and State and local authorities, within a juvenile justice system pursuant to specific State law.

Oakfield-Alabama Central School
7001 Lewiston Road
Oakfield, NY 14125
(585) 948-5211

Student Information Form

Please list the student and all children, to age 21, living in the home.

	Name	Social Security Number	DOB (mm/dd/yyyy) Location	Gender (circle)	Ethnicity (circle-see below)	Grade (PreK-12)	Services (circle)
STUDENT		- -	/ /	Male Female	A B H I P W		CSE 504
Siblings/Other children		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504
		- -	/ /	Male Female	A B H I P W		CSE 504

A=Asian, B=African-American, H=Hispanic, I=American Indian/Alaskan Native, P=Native Hawaiian or other Pacific Islander, W=White

Student Information:

Address: ____________________

Mailing Address (if different from above): ____________________

Student Resides With: ________ (circle one if different): Guardian #1 Guardian #2 Both Joint Custody Other: ________

If parents are divorced or separated, who has legal custody? ____________ ***Court documentation must be provided.***

Guardian #1 Information:

Guardian #1's Full Name: ____________

Relationship to Child: ____________

Guardian #1's Address (if different from above): ____________

City: ________ State: ______ Zip Code: ______

Guardian #1's Land Line Phone: ____________

Guardian #1's Cell Phone: ____________

Guardian #1's Employer: ____________

Guardian #1's Work Phone: ____________

Guardian #1's Email: ____________

Guardian #2's Information:

Guardian #2's Full Name: ____________

Relationship to Child: ____________

Guardian #2's Address (if different from above): ____________

City: ________ State: ______ Zip Code: ______

Guardian #2's Land Line Phone: ____________

Guardian #2's Cell Phone: ____________

Guardian #2's Employer: ____________

Guardian #2's Work Phone: ____________

Guardian #2's Email: ____________

In the event of an emergency, parents will be contacted first. If parents are not available, list additional emergency contacts in the order they should be contacted.

Emergency Contact #1

Last Name, First Name ____ Relationship to Child ____ Phone ____ Phone Type: ____

Emergency Contact #2

Last Name, First Name ____ Relationship to Child ____ Phone ____ Phone Type: ____

Emergency Contact #3

Last Name, First Name ____ Relationship to Child ____ Phone ____ Phone Type: ____

The above will be authorized to pick up your child in case of early dismissal due to illness, injury, inclement weather or any other emergency situation. The above will only be used if parents cannot be reached.

If school is dismissed early or evacuated for any reason and ALL students will be bused, please indicate below where your child should be sent. ***(Must be in the Oakfield-Alabama School District).***

Location (circle one): Home Other Location

Name: ____

Address: ____

Phone: ____

The questions below are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

Is your current address a temporary living arrangement? Yes No Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here.

Where is the student presently living? (circle) Motel Shelter With more than one family in a house/apartment Moving from place to place Car/Park/Campsite

Street ____ City ____ State ____ Zip ____ ( ) Home Phone ____ Email Address ____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition or others costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian ____ Date ____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

McKinney-Vento Liaison Signature ____ Date ____

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT *Please print or type clearly*

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** ______ *specify*
2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ **English** ❑ **Other** ______ *specify*
3. What language(s) does the student understand? ❑ **English** ❑ **Other** ______ *specify*
4. What language(s) does the student speak? ❑ **English** ❑ **Other** ______ *specify*
5. What language(s) does the student read? ❑ **English** ❑ **Other** ______ *specify* ❑ **Does Not Read**
6. What language(s) does the student write? ❑ **English** ❑ **Other** ______ *specify* ❑ **Does Not Write**
7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

Signature of Parent/Guardian/Other ______

Date Month: Day: Year:

HLQ (2/00) 99-337 PM

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

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 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 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 can ask you to provide your consent to access your or your child's public 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. If you choose not to provide your consent, or later decide to withdraw your 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)

Beginning on July 3, 2013, before your school district 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. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing [sharing] personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the district will (1) identify the records [or information] about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to bill your public insurance program (for example, Medicaid): Your consent must include a statement specifying that you understand and agree that your school district may use your or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

If your school district has on file your consent that you provided before July 3, 2013 to release your child's records and to use your or your child's public benefits or insurance to pay for special education and related services, your school district is required to request a new consent from you only when there is a change in any of the following: the type of services to be provided to your child (for example, physical therapy or speech

therapy), the amount of services to be provided to your child (for example, hours per week lasting for the school year), or the cost of services (that is, the amount charged to the public benefits or insurance program).

If any of these changes occur, your school district must obtain from you a new one-time consent. Before you provide your school district the new, one-time consent, your school district must provide you with this notification. Once you provide this one-time consent, you will not be required to provide your school district with any additional consent in order for it to access your or your child's public benefits or insurance even if your child's services change in the future. However, your school district must continue to provide you with this notification annually.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS
34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)
The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for, or enroll in, a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:

a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;

b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;

c. increase your premium or lead to the cancellation of your public benefits or insurance; or

d. cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see:
http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html.

QUESTIONS AND ANSWERS REGARDING PARENTAL CONSENT AND NOTIFICATION REQUIREMENTS FOR ACCESS TO PUBLIC BENEFITS AND INSURANCE

The following guidance is based on information published in the Federal Register, Volume 78, Issue 3, dated February 14, 2013.

1. What is meant by "other public benefits or insurance programs"?

Other public benefits or insurance programs are those associated with the State agency that is responsible for the administration of a State's Medicaid program, which is the source of funding for medically necessary school-based services that are covered benefits under Medicaid. Another example of a public benefit or insurance program is the Children's Health Insurance Program(CHIP) (e.g., Child's Health Plus). These regulations apply to all public benefits or insurance regardless of whether they are Medicaid programs.

2. Can a public agency ask a parent for permission to bill public insurance or benefits and/or to disclose personally identifiable information to the State public benefits or insurance program if the parent previously declined to provide consent (or withdrew consent) for such activity?

Yes. A public agency may make reasonable requests to obtain the parental consent required under the new regulations from a parent who previously declined or withdrew consent. Prior to seeking this consent, a public agency must provide the parent(s) with written notification consistent with the new regulations. However, a parent's refusal to consent or withdrawal of consent does not relieve the agency of providing services at no cost to the parent(s).

3. Will a public agency need to obtain a new consent if they already have consent on file that was signed by the parent before July 3, 2013?

No. A public agency is not required to obtain a new parental consent provided the following requirements are met.

☐ There is no change in any of the following: type of service(s) (e.g., speech therapy) to be provided to the child; the amount of services (frequency and duration) to be provided to the child; or the cost of services charged to public benefits or insurance; and

☐ A public agency has on file a parental consent that meets the requirements of the previous section 300.154 (d)(2)(iv)(A), 34 CFR 99.30 and section 300.622.

However, for children for whom the public agency already has consent under the previous section 300.154(d)(2)(iv)(A), the first time after the effective date of changes to State regulations (July 3, 2013) that there is a change in the type or amount of services to be provided, or the amount charged by the public agency or cost of services billed to the public benefits or insurance, the public agency must provide the parents the written notification and also obtain consent consistent with the new requirements consistent with section 200.5 of the Regulations of the Commissioner of Education.

4. Will a public agency need to obtain a new parental consent to disclose personally identifiable information to access a child's or parent's public benefits or insurance when consent was obtained in one school district and the child relocates to another school district outside the state or to a location within the state?

Yes.

5. Will the written notification take the place of the written parental consent?

No. Written notification is a separate and distinct requirement and does not replace the parental consent requirement.

6. When and how must a district provide the written notification to the parent?

The written notification must be provided to the parent before the parent provides consent to access the parent or child's public benefits or insurance for the first time and it must be provided annually thereafter. The notification may be mailed to the parent(s); personally delivered; and/or provided through electronic mail (email) communication provided the school district makes this option available and the parent(s) agrees to electronic communication.
Once the public agency provides the child's parent(s) the written notification that meets the requirements of the regulations, prior to accessing the child's or parent's public benefits or insurance for the first time, public agencies will have the flexibility to determine the timing of subsequent annual written notifications. However, the notification must be provided annually. Nothing would preclude districts from providing this notification more frequently than annually.

7. Can districts provide the annual written notification at the Committee on Special Education (CSE) meeting?

In those instances where a child has been determined eligible for public benefits prior to the CSE meeting, the public agency could provide the child's parent(s) with the written notification at the CSE meeting or at some other meeting, provided the child's parent(s) receives the written notification **before** the public agency obtains the requisite parental consent to access the parent's or child's public benefits or insurance for the first time.

8. Will the district need to provide written notification each time the public agency amends a child's IEP in a manner that would result in a change to the type or amount of services billed to the public benefits or insurance program?

No. Providing parents the annual written notification that meets the requirements of the final regulations is sufficient protection in these situations. A public agency may provide written notification more frequently than annually, if they deem it appropriate.

CONSENT FORM FOR ACCESSNG A PARENT OR STUDENT'S MEDICAID INSURANCE TO PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM (IEP)

Dear Parent/ Guardian of____:
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).

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

I, ____ as the parent/guardian of

____**,** have received a written notification from the school district 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 may 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;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

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

Records to be shared (such as records or information about services your child receives): Any or all of Counseling, Occupational Therapy, Physical Therapy and Speech Therapy.

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's rights 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.

__________________________________ Date ________________________

Parent/Guardian Signature