CPSE PARENT REGISTRATION CHECKLIST:

- ☐ Parental Referral to CPSE Letter
- ☐ Registration Form
- ☐ School Admittance/Statement of Legal Residence (Must be notarized)
- ☐ Proof of Age (Birth Certificate, Passport)
- ☐ Health History Update Form
- ☐ Health Appraisal Form or Physician's Examination Form
- ☐ Home Language Questionnaire (HLQ)

Proof of Residency: 3 required

- ☐ (1) Deed, School Tax Bill, Property Tax Bill, Lease or Landlord Affidavit
- ☐ (Choose 2) cable bill, gas bill, home telephone bill, water bill (Must be a recent bill and reflect your name and current address)

Please note that you must bring with you ALL of the required documents referenced above or we will not be able to complete the registration.

We only need to view the original documentation. We will make a copy to maintain in our files and you will take the originals back home with you.

Parental Referral to CPSE

Name: _____

Address: _____

_____

Phone: _____

Susan O'Connell
CPSE Chairperson
Putnam Valley Central School District
171 Oscawana Lake Road
Putnam Valley, NY 10579

Dear Ms. O'Connell,

I am writing to refer my child to the Committee on Preschool Special Education. My child's name is _____ and he/she was born on _____.
I am concerned with:

( ) – Overall cognitive development
( ) – Speech and Language skills
( ) – Articulation skills
( ) – Social and emotional development
( ) – Fine motor skills
( ) – Gross motor skills
( ) – Other: _____

Please accept this letter as my formal referral to the Committee on Preschool Special Education.

Sincerely,

_____ _____

Signature Date

FORM A

Putnam Valley Central School District
Registration Form
I. STUDENT INFORMATION

Please complete this entire section about the student. Be prepared to provide birth verification and proof of residency (see below*) at the time of enrollment.

*Property owners must provide an original Property School Tax bill PLUS any two of the following recent original bills: Gas/Electric bill, Oil bill, Telephone bill, Mortgage bill

*Renters must provide an original Lease or Notarized Landlord Affidavit (Form R-1, from school) PLUS any two of the following recent original bills: Gas/Electric bill, Oil bill, Telephone bill, Cable/Satellite bill.

Last Name _____ First: _____ Middle _____ Sex: _____

Home Address: _____

_____

Home Phone: _____ Date of Birth: _____ Place: _____

Previous School: _____ Grade: _____ School Address: _____

_____

For certain Federal and State programs, the district must report student ethnicity. Please check the appropriate designation for your child

____African American (not Hispanic origin) ____Asian/Pacific Islander ____Hispanic

____American Indian/Alaska Native ____Caucasian (not Hispanic origin)

II. CONTACT INFORMATION

Please complete this entire section. You must provide information for three contacts. For additional contacts use a blank page

	PARENT/GUARDIAN	OTHER PARENT/GUARDIAN	EMERGENCY CONTACT (OTHER THAN PARENT)
Contact full name			
Relationship to student			
Lives with student? (Circle one)	Yes / No If no, provide address here	Yes / No If no, provide address here	Please provide address here.
Home phone	( )	( )	( )
Work phone	( )	( )	( )
Cell phone	( )	( )	( )
Email address			This information not needed
Employer			This information not needed
Primary language if other than English			

III. SIBLING INFORMATION

Complete this section only if applicable.

SIBLING FULL NAME	DATE OF BIRTH	PRESENT SCHOOL	GRADE

The information provided above is true to the best of my knowledge

_____ _____

Parent/Guardian Signature *Date*

OFFICE USE ONLY: Start Date: _____ Grade/Homeroom: _____ Bus: _____

DISTRIBUTION OF COPIES: Student file, Nurse, Guidance, Transportation

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

171 Oscawana Lake Road
Putnam Valley, NY 10579

School Admittance/Statement of Legal Residence

Affidavit of Parent/Guardian:

(NOTE: Affidavit must be renewed each time there is a change of address.)

1. I (**circle one**) temporarily/permanently reside at _____ _____, which is my legal residence and which is located in the Putnam Valley Central School District.

2. I am the (**circle one**) parent/guardian of (child's full name-**Please Print**)_____ _____ who (**circle one**) temporarily/permanently resides at the address mentioned in paragraph one above.

3. I will immediately notify the Putnam Valley Central School District if I should change residence.

4. I understand that a student admitted under falsified information is illegally enrolled and will be dismissed from the Putnam Valley Central School District. Moreover, the District reserves the right to seek reimbursement for the costs of educating students accepted into the District's schools based upon falsified information.

5. I understand that Putnam Valley Central School District Policy defines a resident student only as a student who resides with his/her parent or guardian within the Putnam Valley Central School District.

Certification of Residence Owner/Lessor:

I certify that I am the (**circle one**) Owner/Lessor of the premises identified in paragraph one above of the Affidavit of Parent/Guardian and that the above-named parent/guardian and child (**circle one**) temporarily/ permanently reside at that address. I understand that I am under obligation to inform the Putnam Valley Central School District of any change of residence of the child or parent. (If a lease is available, attach copy)

Date: _____ Address: _____

Apartment Number:_____ City: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Name (Please Print): _____ Signature: _____

UNDER PENALTY OF LAW I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT.

PLEASE NOTARIZE Sworn to and subscribed before me this _____ day of _____, 20_____. Notary Public: _____	Parent/Guardian Name (Please Print):_____ Parent/Guardian Signature:_____ Principal/Designee Signature:_____

Note: The above information is subject to verification through investigation.

If you rent your home, your landlord needs to complete this form.
Disregard if you **own** your home.

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

171 Oscawana Lake Road
Putnam Valley, NY 10579

Affidavit of Property Owner/Landlord

STATE OF NEW YORK)
COUNTY OF PUTNAM)

_____, being duly sworn deposes and says I am the owner and
(Name of Property Owner/Landlord)

landlord of the premises known and designated as _____,
(Address)

New York. These premises constitute a (multiple dwelling, single dwelling) residence.

_____, is a tenant occupying these premises; occupying same
(Name of parent/guardian)

under (oral) (written) rental agreement commencing on the _____ Day of _____ 20___.

_____ occupies said residence with _____who is a
(Name of Student)

minor and plans to attend School in Putnam Valley. **Utilities Included in Lease?____(y/n)**

This affidavit is made in order to induce the Putnam Valley Central School District to accept

_____ in the District based upon the residency as stated herein.
(Name of Student)

I CERTIFY that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Putnam Valley Central School District will rely upon them in determining whether the above-named child(ren) will be admitted to its school system. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the District may commence legal proceedings against me personally to collect the costs of educating such child(ren) and/or seek criminal action against me for falsifying business records and/or filing a false instrument.[1]

_____
Signature of Property Owner/Landlord

Sworn to before me this _____ day
of _____, 20_____

_____
Notary Public

NOTE: THE DISTRICT RESERVES THE RIGHT TO CONTACT THE APPROPRIATE MUNICIPALITY TO VERIFY THAT THE USE OF THE PREMISES IS IN COMPLIANCE WITH LOCAL LAWS AND CODES. [1]Penal Law §175.05 (Falsifying Business Records in the Second Degree)- Class A Misdemeanor. Penal Law §175.20 (Tampering with Public Records in the Second Degree)- Class A Misdemeanor. Penal Law §175.25 (Tampering with Public Records in the First Degree)- Class D Felony. Penal Law §175.30 (Offering a False Instrument for Filing in the Second Degree)- Class A Misdemeanor. Penal Law §175.35 (Offering a False Instrument for Filing in the First Degree)- Class E Felony.

Putnam Valley Central School District

HEALTH HISTORY UPDATE

STUDENT NAME_____ **GRADE**____ **DATE OF BIRTH**_____

To be completed by parent or guardian: Please provide the following information and approximate dates. Use additional sheets if necessary.

	NO	YES	DATES	DESCRIPTION
ALLERGIES				
ALLERGIES: FOOD				
ALLERGIES: MEDICATION				
ALLERGIES: INSECT STINGS				
ALLERGIES: ENVIRONMENT (HAY FEVER)				
ALLERGIES: OTHER				
ASTHMA				
EPI-PEN OR INHALER PRESCRIBED?				
INTERNAL				
BLADDER/KIDNEY INJURY OR PROBLEM				
SPLEEN INJURY				
STOMACH ULCER				
TESTICULAR PROBLEMS				
FAINTING				
FAINTING SPELLS				
FAINTING DURING EXERCISE				
LOSS OF CONSCIOUSNESS FROM BLOW TO HEAD				
LOSS OF MEMORY FROM BLOW TO HEAD				
CONVULSIONS/SEIZURES				
CARDIO				
HEART MURMUR				
CHEST PAIN				
ELEVATED BLOOD PRESSURE				
OTHER HEART PROBLEM				
MUSCULOSKELETAL				
BACK/NECK/SPINE PAIN OR INJURY				
FRACTURES/DISLOCATIONS				
JOINT SPRAIN/LIGAMENT TEAR				
KNEE INJURY/PAIN				
WEAR BRACE/SPLINT FOR GYM OR SPORTS				
MUSCLE PULLS				
VISION				
EYE PROBLEMS/VISION LOSS				
UNCORRECTABLE LOSS OF VISION IN ONE EYE				
WEAR CORRECTIVE GLASSES/CONTACT LENSES				
OTHER EYE/VISION PROBLEMS				

	NO	YES	DATES	DESCRIPTION
HEARING				
EAR PROBLEMS/HEARING LOSS				
HEARING LOSS IN ONE OR BOTH EARS				
USE HEARING ASSISTANCE DEVICE				
ORAL				
HAVE ORTHODONTIC APPLIANCES				
HAVE CAPPED TEETH				
DISEASES				
MONONUCLEOSIS				
DIABETES				
VARICELLA (CHICKEN POX)				
RHEUMATIC FEVER				
OTHER DISEASES				
OTHER				
HEADACHES/MIGRAINS				
NOSE BLEEDS (FREQUENT OR SEVERE)				
HAD A SURGICAL PROCEDURE SINCE LAST YEAR				
BEEN ILL FOR 5 OR MORE CONSECUTIVE DAYS				
SUDDEN DEATH OF FAMILY MEMBER UNDER 50				
ONGOING				
TAKE MEDICATION (PLEASE SPECIFY)				
ANY SIGNIFICANT INJURY SINCE LAST YEAR				
UNDER MEDICAL CARE NOW				

DOES YOUR CHILD HAVE A REGULAR PHYSICIAN? PHYSICIAN PHONE:			PHYSICIAN ADDRESS:
COVERED UNDER HEALTH INSURANCE			CARRIER
I agree to emergency medical treatment as deemed necessary by the physician/nurse designated by school authorities.	YES	NO	
I give permission for my child's condition to be shared with staff when necessary in case of a medical emergency.	YES	NO	LIMITATIONS (IF ANY)

LIMITATIONS (IF ANY)

EMERGENCY CONTACT: Please contact in emergency if parent or guadian is unavailable:

CONTACT #1 _____ PHONE # _____

CONTACT #2 _____ PHONE # _____

PARENT/GUARDIAN SIGNATURE _____ PHONE # _____

PRINT NAME _____ ALTERNATE PHONE NUMBER _____

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: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
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: _____

Specify any abnormality (use reverse of form if needed): _____

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*

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. **What language(s) is(are) spoken in the student's home or residence?** ❑ English ❑ Other *specify*
2. **What was the first language your child learned?** ❑ English ❑ Other *specify*
3. **What is the Home Language of each parent/guardian?** ❑ Mother *specify* ❑ Father *specify* ❑ Guardian(s) *specify*
4. **What language(s) does your child understand?** ❑ English ❑ Other *specify*
5. **What language(s) does your child speak?** ❑ English ❑ Other *specify* ❑ Does not speak
6. **What language(s) does your child read?** ❑ English ❑ Other *specify* ❑ Does not read
7. **What language(s) does your child write?** ❑ English ❑ Other *specify* ❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ *If yes, please explain: _____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been ***referred*** for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever ***received*** any special education services in the past?
❑ No ❑ Yes – Type of services received: _____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ❑ Mother ❑ Father ❑ Other: _____

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

171 Oscawana Lake Road
Putnam Valley, NY 10579

Request for Release of Records

_____ _____
Student's Last Name, First Name DOB

_____
Name of Last School Attended

_____
Address of School

_____ _____
School's Phone School's Fax

In accordance with the provisions of the Family Educational and Privacy Act of 1974, I hereby request that the Board of Education transfer copies of all school records and reports including:

__Student's complete file including Kindergarten through date of transfer.
__Grades to date of withdrawal from your school and date of withdrawal.
__Standardized test scores
__Psychological test results of special placement
__Any assessment or evaluation reports, without restriction, which may be of value in the educational planning of this student (RTI, IEP, Section 504 Plan, ELL, etc.)
Please transfer any IEP or 504 on IEPDirect to Putnam Valley Central School District.

_____ _____
Parent/Guardian Signature Parent/Guardian Print

(Please indicate if this student is in need of any special educational __or psychological services __).

PLEASE FORWARD ALL RECORDS TO:

_____ _____ _____

Main Office
Putnam Valley Elementary School
171 Oscawana Road
Putnam Valley, NY 10579
Tel: 845-528-8092
Fax: 845-528-8171

Guidance Department
Putnam Valley Middle School
142 Peekskill Hollow Road
Putnam Valley, NY 105789
Tel: 845-528-8101
Fax: 845-528-8145

Special Education Department
171 Oscawana Lake Rd
Putnam Valley, NY 10579
Tel: 845-528-8130
Fax: 845-528-8110

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT
171 Oscawana Lake Road
Putnam Valley, NY 10579

This letter is to allow the child's preschool teacher to be invited to any meetings held throughout their time in CPSE.

I _____ allow my child's preschool teacher to be invited to any/all
Parent's Name
meetings necessary which involve the Committee on Preschool Special Education.

_____ _____

Signature Date

PUTNAM VALLEY CENTRAL SCHOOL DISTRICT

OFFICE OF PUPIL PERSONNEL
171 OSCAWANA LAKE ROAD
PUTNAM VALLEY, NY 10579
845-528-8130

Dear Parent/Guardian,

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. 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 school 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 check with the New York State Department of Health whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school

district or county, for preschool, may use you or your child 's public benefits or insurance (e.g., Medicaid) to pay for some of your child 's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all 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.S(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 for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-ot-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 or county, for the provision of preschool special education, 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-parentalconsent.htm I.

CONSENT FORM TO CHECK WHETHER A CHILD HAS MEDICAID COVERAGE AND FOR ACCESSING A PARENT'S OR STUDENT'S MEDICAID INSURANCE TO PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM

Dear Parent/Guardian:

This is to ask your permission (consent) for school district/county 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, _____ (Print Parent's /Guardian's Name) as the parent/guardian

of_____ (Print Child's Name)

I 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.

CHOOSE ONE OF THE FOLLOWING:

_____ I **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: IEP, Written Order/Referral, Evaluation Reports, Session Notes, Medication Administration Report, Special Transportation Log, Other Personally Identifiable Information, and any Other Specific Records Pertaining to the Student's Services or Programs. 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.

_____ I **do not 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.

Parent / Guardian Name & Signature: _____

Student's CIN #, if known: _____

District: **PUTNAM VALLEY CENTRAL SCHOOL DISTRICT**