NIAGARA COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS DIVISION

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Early Intervention and Therapeutic Services
Children with Special Needs
Preschool Special Education

PARENT CONSENT FORM FOR ACCESSING A PARENT OR STUDENT'S MEDICAID INSURANCE TO PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM (IEP) AND TO CHECK WHETHER A CHILD HAS A CLIENT IDENTIFICATION NUMBER/MEDICAID COVERAGE

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) 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 county to bill Medicaid for covered health-related services and to release information to the county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of: _____
(PRINT Parent Name)

DOB: _____ **Medicaid CIN # _____**

I have received a written notification from the 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 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 county must give me annual written notification of my rights regarding this consent.

I also give my consent for the 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 (such as records or information about services your child receives)	
IEP, Written Order/Referral/Scripts	Special Transportation Log and Program Attendance
Evaluation Reports/Session Notes	Other Personally Identifiable Information
"Under the Direction Of" Logs and Certifications	Any other specific records pertaining to the child's services or program
Medication Administration Report	

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 Name and Signature:

SIGN

_____ _____ _____
Name (Please Print) Parent/Guardian Signature Date