Peekskill City School District

Our Mission is to educate and empower all students to strive for excellence as life-long learners who embrace diversity and are contributing members of a global society.

1031 Elm Street, Peekskill NY 10566-3499
Phone: (914) 737-3300 ext.1526 Fax: (914) 788-7584
Email: pdundon@peekskillschools.org

Dear Parents/Guardians:

We have received a referral for your child for the Committee for Pre-School Special Education (CPSE).

IN ORDER TO START EVALUATIONS ALL FORMS MUST BE FILLED OUT COMPLETELY

The following forms MUST be returned with your registration packet:

1. **Consent for Initial Evaluation**
2. **Medicaid Consent form – please attach a copy of the Medicaid card**
3. **Referral to the Committee on Preschool Special Education**
4. **Consent for Exchange of Confidential Information**

Once registration is complete, we will be able to complete the necessary evaluations.

If you have any questions, you may call the CPSE office at (914) 737-3300, Ext. 1526

**If your child receives Early Intervention services, please provide us with current evaluations and/or progress reports.

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Estimado Padres/Guardianes:

Hemos recibido la remisión de su hijo/a al Comité de Educación Especial Pre-Escolar (CPSE).

PARA INICIAR LAS EVALUACIONES TODOS LOS FORMULARIOS TIENEN QUE SER LLENADO COMPLETAMENTE

Los siguientes formularios DEBEN ser devueltos con su paquete de registro:

1. **Consentimiento para Evaluación Inicial**
2. **Consentimiento para Medicad – por favor adjuntar una copia de la tarjeta**
3. **Remisión al Comité de Educación Especial Preescolar**
4. **Consentimiento para el intercambio de Información Confidencial**

Una vez finalizado el registro, podremos completar las evaluaciones necesarias.

Si usted tiene alguna inquietud, puede llamar a la oficina de CPSE al (914) 737-3300, Ext. 1526

** Si su hijo recibe servicios de Intervención Temprana, por favor proporciónenos evaluaciones actuales y/o reportes de progreso.

Peekskill City School District
1031 Elm Street
Peekskill, NY 10566

Prior Written Notice
Proposed Referral and Request for Consent for Evaluation

Dear Parent/Legal Guardian,

The purpose of this notice is to inform you, in writing, of the school district's recommendation(s) regarding the identification, evaluation, educational placement and/or provision of special education services to your child.

SUBJECT OF THIS NOTICE:
Your child has been referred to the Committee on Preschool Special Education by
__ The County of Westchester Health Department, Early Intervention
__ You, the parent/legal guardian
__ The child's health provider
__ The Department of Social Services and/or Family Court
__ Other

DESCRIPTION OF ACTION PROPOSED OR REFUSED:
The Committee on Special Education is requesting consent to conduct an evaluation to determine initial eligibility for special education services.

EXPLANATION OF WHY THE ACTION IS PROPOSED OR REFUSED:
This referral was initiated in response to concerns about your child's progress.

DESCRIPTION OF EACH EVALUATION PROCEDURE, ASSESSMENT, RECORD, OR REPORT USED IN THE DECISION TO PROPOSE OR REFUSE THE ACTION:
Teacher reports and classroom tests.

DESCRIPTION OF THE PROPOSED INITIAL OR REEVALUATION AND THE USES TO BE MADE OF THE INFORMATION:
This evaluation will consist of a variety of tests and assessments provided to you at no cost which, if your child is found eligible for special education services, will be used to develop an appropriate Individualized Education Program (IEP). The proposed evaluation will consist of the following types of assessments or a review of current evaluative information, if appropriate:

- A social history, which is a report of information about the child, the child's family and environment that may be influencing performance in school.
- A psychological evaluation, which assesses such areas as development, organization, memory, learning and other personality and behavioral characteristics.
- A functional behavior assessment will be included if a student displays interfering behaviors in school which detract from the learning process.
- An educational assessment of the child's early learning skills
- A physical examination to assess any physical or medical factors that may be influencing performance in school or you may submit an exam from your family physician.
- An observation of the 'child in the child's classroom or home.
- If needed, a speech and language evaluation to assess the child's ability to understand and use language.
- If needed, an assessment of motor abilities that may be influencing development.

DESCRIPTION OF ANY OTHER OPTIONS CONSIDERED AND THE REASONS WHY THOSE OPTIONS WERE REJECTED:
There were no other options considered at this time.

DESCRIPTION OF OTHER FACTORS THAT ARE RELEVANT TO THE PROPOSED OR REFUSED ACTION:

There were no other factors relevant at this time.

YOU HAVE PROTECTION UNDER THE PROCEDURAL SAFEGUARDS OF THE REGULATIONS OF THE COMMISSIONER OF EDUCATION.
A copy of the Procedural Safeguards Notice that explains your rights regarding the special education process is available on our District Website www.peekskillcsd.org. If you wish to receive a written copy of the Procedural Safeguards Notice, please call 914-737-3300, ext 1526

SOURCES YOU MAY CONTACT TO OBTAIN ASSISTANCE IN UNDERSTANDING THE SPECIAL EDUCATION PROCESS:
SCHOOL DISTRICT CONTACT INFORMATION:
Ellen Gerace, Director of Special Education Services
Kelly LaFevre, CSE, K-12 Chairperson

NYSED SPECIAL EDUCATION PARENT CENTER CONTACT INFORMATION:
Naomi Brickel, Project Coordinator, (914)493-7665

ADDITIONAL INFORMATION RELATED TO THE SUBJECT OF THE NOTICE:
Your written consent to the proposed initial evaluation is requested and a consent form is enclosed. You have the right to consent or to withhold consent to the initial evaluation of your child. If you consent, please sign and return the enclosed form as soon as possible so that we can address your child's learning needs in a timely manner.

You must select an approved evaluation site to conduct an initial evaluation of your child. Enclosed is a list of approved evaluation sites and the procedures you must follow to select a program that is available to conduct the evaluation of your child within the time period required by State regulations.

You may also submit evaluation information which will be considered by the Committee as part of the initial evaluation.

When the evaluation is completed, you will have the opportunity to discuss the test results and meet with the Committee on Preschool Special Education. You will receive a written notice of the date, time and location of the Committee meeting, and we encourage your attendance.

You have the right to address the Committee, either in person or in writing, on the appropriateness of the Committee's recommendations. If you have any questions or would like to request a meeting to further discuss information contained in this notice, please contact (914) 737-3300, ext 1526

Sincerely,

Patricia Dennis

CPSE/OOD Chairperson

Encl.: 1.Procedural Safeguards Notice (please see note above)
2. Consent for Initial Evaluation
3. List of Approved Evaluators

CPSE-01A

Peekskill City School District

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Patricia Dundon
CPSE/OOD Chairperson

1031 Elm Street, Peekskill NY 10566-3499
Phone: (914) 737-3300 ext.1526 Fax: (914) 788-7584
Email: pdundon@peekskillschools.org

Committee on Preschool Special Education Consent for Initial Evaluation

I have received and understand the notice that my child has been referred to the Committee on Preschool Special Education for evaluation to determine if my child has a disability that may require special education services. 1 understand that I must give written consent to the district in order for my child to be evaluated.

I have also received a copy of the Procedural Safeguards Notice or have been informed as to how to obtain a copy (available at www.peekskillcsd.org).
Please check one box:

□ I hereby grant consent for evaluation by the Committee on Preschool Special Education as indicated below:

- o Psychological Evaluation
- o Educational Evaluation
- o Social History
- o Speech/Language Evaluation
- o Occupational Therapy Evaluation
- o Physical Therapy Evaluation

□ I do not consent for evaluation by the Committee on Preschool Special Education.

Parent/Guardian (Print Name)	Signature	Date

Peekskill City School District

CONSENT FOR INITIAL EVALUATION

Please complete, sign and return this form to the address below

Date: _____

RE: _____

DOB: _____

Peekskill City School District
Committee on Preschool Special Education
1031 Elm Street
Peekskill, NY 10566

I have received and understand the notice that my child has been referred to the Committee on Preschool Special Education for evaluation to determine if my child has a disability that may require special education services. I understand that I must give written consent to the district in order for my child to be evaluated.

I have also received a copy of the Procedural Safeguards Notice or have been informed as to how to obtain a copy (available at www.peekskillcsd.org).

Please check one box:

☐ I hereby grant consent for evaluation by the Committee on Preschool Special Education as indicated below:

☐ I do not consent for evaluation by the Committee on Preschool Special Education.

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

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Referral to the Committee on Preschool Special Education

DATE: _____

STUDENT NAME: _____ D.O.B._____

REFERRING PARTY: _____

RELATIONSHIP TO STUDENT: _____

MOTHER: _____ FATHER: _____

ADDRESS: _____, PEEKSKILL, NY 10566

TELEPHONE:

HOME: _____ MOBILE: _____ WORK:. _____

REASON FOR REFERRAL (ONE OR MORE):

MANAGEMENT (BEHAVIORAL CONTROL DIFFICULTY): _____

_____

LEARNING (SKILLS, CONCEPTS, ATTENTION, FOLLOWING DIRECTIONS): _____

_____

PHYSICAL (HEARING, VISION, GROSS MOTOR, FINE MOTOR): _____

_____

SOCIAL (INTERACTIONS, CONFLICTS WITH PEERS/ADULTS, ANTI-SOCIAL): _____

_____

LANGUAGE (UNDERSTANDING, EXPRESSING, ARTICULATION): _____

OTHER: _____

Peekskill City School District

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CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

I HEREBY AUTHORIZE THE PEEKSKILL CITY SCHOOL DISTRICT CSE/CPSE TO CONTACT AND/OR EXCHANGE ALL PERTINENT AND CONFIDENTIAL INFORMATION REGARDING:

STUDENT NAME: _____ D.O.B. _____

WITH THE FOLLOWING:

___ AGENCIES ____DOCTOR'S OFFICE ____FACILITIES ___OTHER

NAME: _____

ADDRESS: _____

TELEPHONE _____

FAX _____

EMAIL: _____

THIS CONSENT HAS BEEN AUTHORIZED BY:

RELATIONSHIP TO STUDENT: ____PARENT ___ LEGAL GUARDIAN ___ OTHER

PRINTNAME: _____

SIGNATURE: _____ DATE: _____

TELEPHONE: _____

Peekskill City School District
Committee on Preschool Special Education
1031 Elm Street
Peekskill, NY 10566

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/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: 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/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: 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:
    - 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;
    - 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;
    - Increase your premium or lead to the cancellation of your public benefits or insurance; or
    - 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.**

Peekskill City School District
Committee on Special Education
1031 Elm Street
Peekskill, NY 10566 ((914) 737-3300)

Medicaid Consent

Dear Parent/Legal 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)	
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

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: _____

Client Identification Number (CIN): _____