CHURCHVILLE-CHILI CENTRAL SCHOOL DISTRICT

REGISTRATION PACKET FOR PRE-SCHOOL SERVICES

139 Fairbanks Road, Door #26
Churchville, NY 14428

Office hours:
Monday – Friday
8 a.m. – 4 p.m.

District Registrar
(585) 293-1800, ext. 2041
Fax: (585) 293-1013

Where learning leads to a lifetime opportunities…

CHURCHVILLE-CHILI CENTRAL SCHOOL DISTRICT
139 Fairbanks Road, Door #26
Churchville, NY 14428

Dear *Preschool* Parent(s)/Guardian(s):

Welcome to the Churchville-Chili Central School District. If you are new to the district and your child was receiving services in another district - or if you are requesting services for the first time, you must complete these documents. Please take the time to read the forms carefully and fill them out completely.

We only accept registrations in person, the Registration Packet must be brought in to the Registrar's office; we do not accept registrations by mail, fax or email.

*Note – completing this paperwork does not automatically register your child into the Churchville-Chili Central School District for kindergarten. When your child becomes of age to attend kindergarten, you will be receiving a full registration packet to complete. If you have any questions regarding this process, please call the registration office at 293.1800 x2041. Office hours are 8:00a.m. – 4:00p.m.

Sincerely,
June Mead
District Registrar

For Office Use Only

Preschool Registration Packet Forms – Please be sure to fill out all forms completely	**Date Rec'd**	**Initials**
Student Registration Form		
Custody Disclosure Form		
A letter stating what you are requesting (ie. Continuation of services, evaluation for ??, etc.)		

Bring these documents with you to registration also		**Date Rec'd**	**Initials**
Proof of Residency *When registering your children, you must provide proof that you reside in the Churchville-Chili Central School District*	**One of the Following:** Mortgage Statement; School or Property Tax Receipt; Closing Documents; Homeowner's/Renter's Insurance Policy; Lease Agreement ***OR***		
	3 of the following: Current utility bills, phone bill, pay stub, bank statement, insurance statement, major credit card statement, Income tax form, voter registration document, a legal document with printed name and address		
Proof of Age	ORIGINAL Birth Certificate; If not available, a Baptismal certificate or a Passport can be used		
Immunization Record signed by Doctor's Office			
Parent/Guardian ID			

FOR OFFICE USE ONLY

Student# _____ Date Paperwork was Received _____

Date Sent to PPS: _____

CHURCHVILLE-CHILI CENTRAL SCHOOL DISTRICT

REGISTRATION FORM FOR PRE-SCHOOL SERVICES

STUDENT INFORMATION

Please PRINT all information and complete BOTH sides of this form

_____ Male Female

Child Last Name First Middle

_____ Date of Birth _____

Residence Address City St Zip

PARENT/GUARDIAN

Mr. Mrs. Ms. Miss Dr. Other

Name:_____

Last *First*

Address:_____

Street

_____

City *State* *ZIP*

Home Phone#:_____ **Pager#** _____

Cell#: _____ **Work#:** _____

Email Address: _____

Employer: _____

Occupation: _____

Marital Status: **Single** **Married** **Separated**

Divorced **Widowed**

Relationship to Student: **Mother** **Father**

Step Mother **Step Father** **Foster Parent**

Other (Specify) _____

PARENT/GUARDIAN

Mr. Mrs. Ms. Miss Dr. Other

Name:_____

Last *First*

Address:_____

Street

_____

City *State* *ZIP*

Home Phone#:_____ **Pager#** _____

Cell#: _____ **Work#:** _____

Email Address: _____

Employer: _____

Occupation: _____

Marital Status: **Single** **Married** **Separated**

Divorced **Widowed**

Relationship to Student: **Mother** **Father**

Step Mother **Step Father** **Foster Parent**

Other (Specify) _____

PLEASE COMPLETE BOTH SIDES

Brothers and Sisters (Birth to age 21)	Birth Date	M/F	Grade	Where Attending School	Living at Home?

Others in the Home	Relationship to Student

Is your child currently attending a Pre-School program in preparation for Kindergarten? YES NO

If YES:

Name of Pre-School: _____

Address: _____

For How Long: _____

If NO:

Is your child currently receiving Early Intervention Services? YES NO

If YES:

Service Provider: _____

Address: _____

Services Provided: _____

EMERGENCY CONTACT INFORMATION

(If we are unable to reach parent in an emergency)

Name of Emergency Contact: _____
Relationship to Child: _____
Contact Home Phone#: _____ Cell#: _____

IF THESE TELEPHONE NUMBERS OR ANY TELEPHONE NUMBERS ON THIS FORM CHANGE DURING THE YEAR, PLEASE NOTIFY THE REGISTRAR IMMEDIATELY.

This is to confirm that all of the information provided on this document is accurate and that I am a resident of the Churchville-Chili Central School District.

_____ _____

Parent Signature/Legal Guardian Date

Churchville-Chili
Central School District

Where learning leads to a lifetime of opportunities

Loretta Orologio
Superintendent of Schools

AUTHORIZATION FOR RELEASE OF INFORMATION

School Name _____
School Address _____
City, State, Zip _____
School Telephone _____
School Fax _____

Permission is hereby given to Churchville-Chili Central School District to receive and/or release information regarding:

Student Name: _____

Date of Birth: _____

Please send a copy of the following:

- ☐ Academic Folder
- ☐ Speech Evaluation
- ☐ Standardized test scores
- ☐ Health Records
- ☐ Treatments
- ☐ Admissions & Discharge Summaries
- ☐ Any Treatments while Enrolled
- ☐ Psychological reports (if applicable)
- ☐ Any other Pertinent Information

_____ _____
Parent Signature (Print out before signing) **Date**

Information to be forwarded to:

Churchville-Chili Central School District
Attn: *Student Services Department*
139 Fairbanks Road
Churchville, NY 14428
Fax: (585) 293-4501

Churchville-Chili Central School District

Health History Form

To Be Completed By Parent/Guardian

Student's Name: _____ ☐ Male ☐ Female DOB: ___/ ___/ ___
mm dd yy

Pediatrician's Name: _____ Office phone: _____

Preferred hospital if needed: ☐ URMC (Strong) ☐ RGH ☐ Unity (Park Ridge)

Parent/guardian's name filling out this form: _____ Phone:_____

Does your child have or have they ever had any of the below conditions? **Check all that apply.** Enter year of occurrence/diagnosis.

☐ Asthma _____
☐ Allergies, environmental _____
☐ Allergies, food _____
☐ Allergies, medication _____
☐ Bladder concerns _____
☐ Bowel concerns _____
☐ Chicken Pox _____
☐ Diabetes _____

☐ Ear infections (frequent) _____
☐ Gastric reflux_____

☐ Heart problems _____
☐ Pneumonia _____
☐ Scoliosis _____
☐ Seizure disorder _____
☐ Skin disorders _____
☐ Strep throat _____
☐ Tuberculosis _____
☐ Vision problems, including color deficiency __
_____
☐ Other _____
_____

Does your child take any medication on a regular basis? ☐ Yes ☐ No If Yes, please list:

1._____ 3. _____
2._____ 4. _____

If he/she will need to take medication at school, please contact the school nurse as soon as possible.

Please list any serious illness, operations, accidents or hospitalizations your child has had and their age when it occurred:

_____
_____

Please note if your student has any of the following special needs and what accommodations have been made:

☐ Speech

_____

☐ Hearing

_____

Tubes currently in? ☐ Yes ☐ No

Date inserted _____

Date removed _____

☐ Vision _____

Glasses _____ farsighted _____ nearsighted _____

Reading only _____wear at all times _____

Color deficiency _____

☐ Inherited family medical concerns _____

☐ Special problems or concerns _____

☐ Physical restrictions _____

☐ Dietary restrictions _____

Has your child ever seen any of the following specialists? What were their findings:

☐ Audiologist _____

☐ Dentist regular cleanings? ☐ Yes ☐ No Problems _____

☐ Ear/Nose/Throat _____

☐ Gastroenterologist _____

☐ Gynecologist _____

☐ Neurologist _____

☐ Ophthalmologist _____

☐ Psychologist/Psychiatrist _____

☐ Other _____

Are there any other concerns that you have or any medical history your child has that was not covered that you feel we should know for his/her welfare?

_____

_____

_____

_____

Thank you from the Nursing Staff at Churchville-Chili. Your child's health and safety are our number one concern. Please contact your building nurse with any questions you may have.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

SCHOOL HEALTH SERVICES HIPAA RELEASE
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I authorize my child's physician(s) and/or therapists listed above to exchange the following information with the school district staff listed below in order to provide a safe and appropriate environment or program for my child (NOTE: all parts must be completed):

- ☐ School nurse
- ☐ Medical officer
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Athletic Trainer
- ☐ Counseling Department
- ☐ Special Educator
- ☐ Psychologist
- ☐ Other _____

- ☐ Immunizations/Physical exams to comply with NYS regulations
- ☐ Care or therapy plans for routine and emergent school management
- ☐ Authorization for medications/treatment during school or on school trips
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs, evaluations, programming
- ☐ Physician referral for services (OT, PT, ST, other)
- ☐ Medical condition that may have an impact in the school setting, including transportation, home tutoring, classroom accommodations, attendance
- ☐ At patient's request with no specified purpose
- ☐ Other _____

Parent, please select one:

- ☐ This authorization is valid for as long as my child is enrolled in the district
- ☐ This authorization is valid for the entire academic school year 20___ - 20____
- ☐ This authorization shall expire on ____/_____/_____(MO/DD/YR)

I acknowledge that I have the right to refuse to sign and to revoke this authorization at any time by sending written request to my healthcare provider and to the District Administration at the above address. I understand that if I revoke this authorization, it may not be effective if the Protected Health Information was already disclosed before receipt of 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 may no longer be protected by federal or state law. I understand that my child's enrollment is not dependent on my agreement to release or withhold information, except immunizations required by law. 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 pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the School District by the healthcare providers listed. If student is under 18 years of age, parent or legal guardian must sign consent form. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act, then the parent/guardian must <u>also</u> sign consent form.

_____

Signature of Parent, or Guardian Relationship Date

_____

Signature of Student over 18 Date

Churchville Chili Central School District

Custody Disclosure Form

The Registration Office is responsible for registration, **not** in determining which parent or guardian may check a child in/out of school, etc. If custodial or guardianship issues exist when you register your child in the Churchville Chili Central School District, it is your responsibility to provide custodial documentation to the Registration Office and a copy will be forwarded to your child's school principal.

Please inform your child's school of changes in custodial arrangements. _____ (parent's initials)

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA)

An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that **specifically revokes these rights.**

(Authority: 20 U.S.C. 1232g)

Please check the current custody/guardianship arrangement:

- ☐ 1. Parents/guardians are together residing at the same residence
- ☐ 2. Single parent (father and mother **are** listed on the birth certificate
- ☐ 3. Single parent (father **is not** listed on the birth certificate)
- ☐ 4. Parents/guardians divorced/separated – joint custody
- ☐ 5. Parents/guardians divorced/separated – sole custody
- ☐ 6. Parents have never been married and have no legal custody papers
- ☐ 7. Custody/guardianship is transferred by courts
- ☐ 8. Restricted pickup ***(legal documentation must be provided)*** _____
- ☐ 9. Student is *emancipated* ***(legal documentation must be provided)***

Please check all that apply:

- ☐ I have disclosed my current custody/guardianship arrangement.
- ☐ I have attached a copy of those pages of the legal court documents that describe custody arrangements.
- ☐ No legal documents that describe custody arrangements exist.
- ☐ I understand that it is my responsibility to update my child's school principal of changes in custody.

Student Name (please print): _____

_____ _____

Signature of Parent/Guardian Date

CHURCHVILLE-CHILI CENTRAL SCHOOL DISTRICT

HOUSING QUESTIONNAIRE

Name of LEA: **Nicole Livingston-Neal**

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____ /_____ /_____ Grade: _____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____

Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation (STAC2) Form is completed.

CHURCHVILLE-CHILI CENTRAL SCHOOL DISTRICT

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: **Nicole Livingston-Neal**

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer *(opciónal)*

Fecha de Nacimiento: _____ / _____ / _____ *Mes Día Año*

Grado: _____ *(jardín de infantes – 12)*

ID#: _____

Dirección: _____

Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja.*)

- ❑ En un refugio
- ❑ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ❑ En un hotel/motel
- ❑ En un carro, parque, autobús, tren, o camping
- ❑ Otra vivienda temporal (Por favor describa):

  _____

- ❑ En un hogar permanente

_____ _____

Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

Fecha

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante **NO** vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.

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

Monroe County Special Children's 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 and County to use your or your child's public benefits or insurance to pay for special education and related services that your school district and county are 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 and 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 your consent to access your or your child's public benefits or insurance for the first time, they 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 and County will ask you to provide. If you choose not to provide your consent, or later decide to withdraw your consent, your school district and County have 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 and 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, they must obtain your signed and dated written consent. Your County is only required to obtain your consent one time. Your school district may as for it a second time if your child is to receive Special Education services during the school age years.

This consent requirement has two parts.

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

Monroe County Special Children's Services

1. Consent to share records about your child: Your school district and County are 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 and County 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 and County 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.

Once you provide this one-time consent, you will not be required to provide you're the County 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 will need to request your consent again if your child continues to receive Special Education Services in their school age program . The 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:

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

Monroe County Special Children's Services

1. Your school district or County 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 or county 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 or county is otherwise required to provide your child without charge.

3. Your school district or County 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 and County 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.

PRESCHOOL

Parental Consent for Release of Information for Medicaid Funding

Dear Parent/Guardian of _____,

The Preschool Special Education program is administered and paid for at the local level by Monroe County. The Lead Education Agency (LEA) is the school district. Your school district obtains parental consent on behalf of Monroe County so that the County can bill Medicaid. Counties in New York State routinely access Medicaid funding to help meet the costs of providing these preschool special education services.

I, _____, as the parent/guardian
(print parent/guardian's first & last name)
of _____ (Child's Date of Birth _____)
(print child's first & last name)
give permission for Monroe County Department of Health's Preschool Special Education Program to access Medicaid funds to pay for any Medicaid eligible services listed on my child's Individualized Education Plan (IEP).

I have received written notification that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand that:

- Providing consent **will not** impact my child's/my Medicaid coverage;
- I **will not** incur any out-of-pocket expense such as payment of a deductible or co-pay amount;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- 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 Monroe County to provide to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. Unless otherwise noted on the line below, the following records will be shared with the Monroe County: Individualized Education Plan (IEP); written order/referral; session notes; progress notes (quarterly reports) and attendance logs if applicable.
List *exceptions only* here: _____
_____

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 Printed Name: Parent/Guardian Signature: Date:

_____ _____ _____

Student ID # _____

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

Lissette Colon-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:			GENDER:
Month	*Day*	*Year*	❑ 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:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

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:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Student Racial and Ethnic Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition or immigration status.

Student Name _____ **Grade**_____

Please answer questions **1 and 2.** Read carefully before responding.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

   ☐ **YES,** Hispanic

   ☐ **NO,** not Hispanic

2. **Select one or more races from the following five racial groups** (for this question, check all boxes that apply)

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

   ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Samoa, or other Pacific Islands.

   ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the black racial groups of Africa.

   ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian _____ Date _____

Churchville-Chili Central School District

Proof of Permanent Housing Checklist
(to be completed by District Registrar)

Student Name: _____

In-District Address: _____

Date Registered: _____

Check the box that represents your permanent residency status and provide proof of residency as listed below.

☐ **Homeowner** – Currently living at above In-District Address, purchasing an Existing Home or building a New In-District Home

PROOF (1) of either: Mortgage Statement, School or Property Tax Receipt, Homeowner's Insurance Policy, Copy of Builders Sales Contract indicating purchaser name, address and tentative completion date; Income Tax Form

***OR* 3** of: Utility bill, current FS20 Auto Insurance Policy with new address, bank statement, legal document with printed name and address, pay stub with address, state or government issued identification, voter registration document. **Driver's license is not an acceptable proof of residency.**

☐ **Renter**

Apartment Complex – Complex Name: _____

Multi-Family Dwelling – Landlord Name: _____

Single-Family Dwelling – Landlord Name: _____

PROOF: Lease agreement or Notarized Landlord Statement

☐ **Shared Housing: Shared Single Family Home or Apartment with Another Family.** (When shared housing is not due to the loss of residence because of hardship).

PROOF: Completed Shared Housing Affidavit provided by the district AND proof of residency for both Homeowner **and** "Individual Residing at or Moving in" as listed on the affidavit.