Student Name: _____
School: _____
Student Local ID: _____ **Date of Birth:** _____ **Grade Level:** _____

Annual Notice of Parental Rights Regarding Use of Public Benefits or Insurance

Dear Parent(s) or Guardian(s):

The Broward County Public Schools may request the use of Medicaid or other public benefits or insurance programs in which your child participates to provide or pay for services required under the Individuals with Disabilities Education Act (IDEA), as permitted under the public benefits or insurance program.

Services may include assistive communication services, physical therapy services, occupational therapy services, speech therapy services, language therapy services, hearing services, behavioral services, specialized transportation services, nursing services.

IDEA requires that the school district provide written notification of your rights and protections under Part B of the IDEA before we seek to use your or your child's public benefits or insurance for the first time and prior to obtaining your one-time written consent to use those benefits for the first time, then **annually** thereafter. This notification advises you of the following:

The Broward County Public Schools

1. May not require you to sign up for or enroll in public benefits or insurance programs in order for your child to receive a free appropriate public education under IDEA Part B;
2. May not require you to incur out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services pursuant to this part, but the school district may pay the cost that you otherwise would be required to pay;
3. May not use your child's benefits under a public benefits or insurance program if that use would:
    a. Decrease available lifetime coverage or any other insured benefit;
    b. Result in your family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for your child outside of the time your child is in school;
    c. Increase premiums or lead to the discontinuation of benefits or insurance; or
    d. Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

The one-time parental consent must specifiy:

1. That you understand and agree that the school district may access your child's or your public benefits or insurance to pay for services under Part B of the IDEA;
2. The personally identifiable information that may be disclosed;
3. The purpose of the disclosure;
4. The agency to which the disclosure may be made.

Copies of records disclosed as a result of this consent are available to you upon request.

Your consent to disclose personally identifiable information for Medicaid purposes is a **one-time requirement** and will remain in effect for the period of time your child is enrolled in Exceptional Student Education programs.

You have the right to withdraw your consent to disclosure of your child's personally identifiable information to the agency responsible for the administration of the state's public benefits or insurance program at any time by providing **written notice to the school district.** Withdrawal of your consent or refusal to provide consent to disclose personally identifiable information does not relieve the school district of its responsibility to ensure that all required services are provided **at no cost to you**.

If you have any questions about this information, please contact the person(s) or department below.

ESE School Medicaid Office (754) 321-3471

IDEA Notice: Review with parent at annual IEP meeting.
FERPA Consent: One-time requirement.

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