

**Ansonia Public Schools Notifications/Forms Federal
IDEA Consent to Access Public Benefits/Insurance**

**Parent Consent to Access Public Benefits or Insurance
to Pay for Services under the Individuals with Disabilities Education Act**

Student Name: _____ D.O.B. _____
Student Address: _____
Parent Name(s): _____
Parent Address (if different): _____

In accordance with the Individuals with Disabilities Education Act ("IDEA") and its implementing regulations (34 C.F.R. 300.154) the Ansonia Public Schools may, with parent consent, use public benefits or insurance to provide or pay for certain special education services recommended by a child's planning and placement team ("PPT"). In order to access such benefits for the first time, the Ansonia Public Schools must provide parents with written notification of various legal protections. Such written notification is attached.

Consent to Access Public Benefits or Insurance

I, _____ (Print name of parent), understand and agree that the _____ Public Schools may access my / my child's (Please circle) public benefits or insurance to pay for special education and related services under Part B of the IDEA. I further understand and agree that this written parental consent shall be effective for the entire period during which public benefits or insurance are accessed for my child for the payment of services under the IDEA and that written parental consent is not required each time benefits or insurance are accessed, nor is additional consent required if my child's IDEA services change in type (e.g. physical therapy or speech therapy), amount (frequency or duration) or cost of such services charged to the public benefits or insurance program. I specifically understand that:

1. The following personally identifiable information may be released regarding the above-named student:

2. The purpose of the disclosure of my child's personally identifiable information is for the billing of special education and related services under Part B of the IDEA and 34 C.F.R. part 300.
3. The disclosure of personally identifiable information may be made to (Name of public benefits or insurance program): _____

Signature of Parent: _____ Date: _____