



## **SPECIAL SERVICES INFORMATION PACKET**

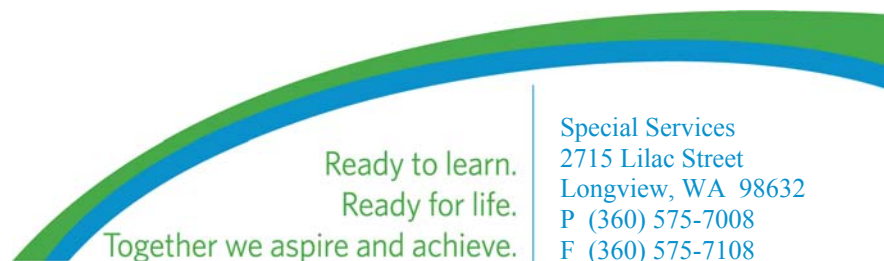
Welcome to the Longview School District. You and your child are encouraged to be active participants in the education process. You know your child best, and we welcome and value the information and ideas you bring.

Your school will review information from the previous district to confirm eligibility. Your child's placement in the Special Education Program may be temporary. Within thirty (30) days of admission, you will be notified of your student(s) suggested service model.

The Family Educational Rights Privacy Act (FERPA) allows a school district to re-disclose educational records to schools in which the student enrolls or intends to enroll. This includes approved nonpublic agencies and other private schools.

The parent or eligible student has a right to:

1. Inspect and review the student's education records;
2. Request amendment of the student's education records to ensure that they are not inaccurate, misleading, or otherwise in violation of the student's privacy or other rights;
3. Consent to disclosures of personally identifiable information explained in the student's education records, except to the extent that the Act and the regulations in this part authorize disclosure without consent;
4. File with the U.S. Department of Education a complaint under Section 99.64 concerning alleged failures by the agency to comply with the requirements of the Act and this part;
5. Obtain a copy of the policy adopted under Section 99.6. A copy of this policy is available by request at the Longview School District Superintendent's Office located at 2715 Lilac Street, Longview, WA 98632



## Authorization for Exchange of Educational Records

Student name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_

Serving school \_\_\_\_\_ Home school \_\_\_\_\_ Date \_\_\_\_\_

### I hereby authorize the exchange of records between:

**Longview School District** \_\_\_\_\_

*Name of agency/person*

\_\_\_\_\_

*Name of agency/person*

**2715 Lilac Street** \_\_\_\_\_

*Address*

\_\_\_\_\_

*Address*

**Longview, WA 98632** \_\_\_\_\_

*City/State/Zip*

\_\_\_\_\_

*City/State/Zip*

**(360) 575-7008** \_\_\_\_\_

*Telephone*

\_\_\_\_\_

*Telephone*

**(360)575-7108** \_\_\_\_\_

*Fax*

\_\_\_\_\_

*Fax*

**SpecialEducation@longview.k12.wa.us** \_\_\_\_\_

*Email*

### Check all record types to be released:

Health records

Psychological & Counseling records

Special Education records

Threat Assessments

Evaluations, IEP's, reports  
& testing

Other: \_\_\_\_\_

### The reason for exchanging the record(s) information is:

Eligibility verification

Evaluation/Reevaluation eligibility determination

Educational placement

New Transfer Student

The Family Educational Rights Privacy Act (FERPA) allows a school district to redisclose educational records to schools in which the student enrolls or intends to enroll. This includes approved nonpublic agencies and other private schools. This information may no longer be protected under federal law.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive services.

I understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

This consent and authorization is valid for 90 days from the date of parent/adult student signature.

Consent may be withdrawn at any time in writing, except where information has already been released based upon my authorization.

\_\_\_\_\_  
Parent/Guardian/Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

## Social/Developmental History Update

Date: \_\_\_\_\_

Dear Parent/Guardian:

As part of the assessment process, we would appreciate your completion of this form. Please note any changes you have observed in your child over the past three years that should be considered with regard to design of his/her current educational program.

Current address: \_\_\_\_\_

Phone: \_\_\_\_\_

### HEALTH HISTORY

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Brothers/Sisters (age & gender): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your child on medications? If yes, what: \_\_\_\_\_

Health problems and/or restrictions: \_\_\_\_\_

Past Illnesses:

Accidents

Operations

Ear Infections

Serious Head Injury

High Fever

Serious Illness

Seizures

Other: \_\_\_\_\_

Explain any checkmarks: \_\_\_\_\_

Vision and Hearing: Date last checked: \_\_\_\_\_ By whom: \_\_\_\_\_

Have there been consistent problems with:  Vision  Hearing  Speech  Motor Development

Please explain: \_\_\_\_\_

Recent stressors: \_\_\_\_\_

Family changes that might be significant to the educational process: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_/Relationship \_\_\_\_\_ Date: \_\_\_\_\_

**Child's History:**

Complications during pregnancy (explain): \_\_\_\_\_ High temps. \_\_\_\_\_

Complications at birth (explain): \_\_\_\_\_ Birth weight: \_\_\_\_\_

Smoked      Alcohol      Medications: \_\_\_\_\_

Age at which your child (use "N" if normal): Spoke: \_\_\_\_\_ words \_\_\_\_\_ Sentences \_\_\_\_\_

Sat up \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_ Toilet trained \_\_\_\_\_

**Consistent problems with (mark all that apply):**

**CONDUCT**

- High activity level
- Distractible
- Frequent inter-personal problems
- Aggressiveness
- Impulsivity-unable to delay gratification
- Lying
- Stealing
- Difficulty with authority rules, limits, laws

**ANXIETY/DEPRESSION**

- Unhappiness/depressed mood
- Apprehension/worrying
- Somatic complaints/illnesses
- General nervousness
- Food issues
- Nightmares
- Sleep problems/increased or decreased
- Thumb sucking, nail-biting or other nervous habits
- Bedwetting
- Concern about physical appearance
- Unreasonable fears
- Difficulty with attention/concentration
- Suicidal ideations

**THOUGHT PROCESSES**

- Bizarre ideas
- Disconnected, loose fragmented language
- Inability to deal with abstraction, environmental changes
- Inability to express ideas
- Unusual social mannerisms/ behaviors

Please explain as needed: \_\_\_\_\_

**Behavioral:**

Does your child have trouble getting along with (check if yes):

- Children at school       Other children
- Brothers and sisters       Parents
- Teachers       School

Comments: \_\_\_\_\_

Special Interests: \_\_\_\_\_

Does your child have difficulty accepting responsibilities at home?      Yes      No

Most effective method of discipline: \_\_\_\_\_

**Educational:**

Past school experiences (include grades repeated, dates, and location) \_\_\_\_\_

Please provide any additional comments, concerns or background information that might assist us in working with your child: \_\_\_\_\_

**Longview Public Schools**

2715 Lilac  
Longview, WA 98632  
360-575-7008

Student ID:  
WA SSID:  
Date of Birth:

**Medicaid Consent**

Date: \_\_\_\_\_

**PURPOSE:** This form asks for your consent to share the necessary information to verify Medicaid eligibility and bill for school-based Medicaid reimbursement with the Department of Social and Health Services, Health and Recovery Services Administration. The district is required to obtain parent consent each time they bill for a new procedure. Billing DSHS does not affect individual benefits under Medicaid or require a co-pay or deductible. If you have questions regarding this request, call the school district's Director of Special Education or designee for an explanation as to why the request is being made.

Student's Name: \_\_\_\_\_

Student's Number: \_\_\_\_\_

Current School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, occupational therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, Longview Public Schools will submit your student's name and birth date to the Department of Social and Health Services (DSHS) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

With your permission, we will share necessary identifying information from your child's education record to access federal Medicaid reimbursement from the Department of Social and Health Services (DSHS). If any additional Medicaid reimbursement services are added to the IEP, the school district will request additional consent. This consent is good for 365 days. If my child no longer is served by this school district, this consent does not transfer to a new district.

This authorization will begin on \_\_\_\_\_ and expire on \_\_\_\_\_.

By giving consent, you are acknowledging that (1) you have been fully informed of all information relevant to the activity for which consent is sought; (2) you understand that the granting of consent is voluntary on your part and may be revoked at any time; and (3) if you revoke consent, the revocation is not retroactive; which means that it does not negate any activity that has already taken place.

- I give my consent to verify Medicaid eligibility with DSHS and to submit claims for allowable services.
- I do not give my consent to verify Medicaid eligibility with DSHS and to submit claims for allowable services. I understand that my refusal does not affect my child's access to services under the Individualized Education Program.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date