CONSENT FORM TO CHECK WHETHER A CHILD HAS MEDICAID COVERAGE AND FOR ACCESSING A PARENT'S OR STUDENT'S MEDICAID INSURANCE TO PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM

Dear Parent/Guardian of :

This is to ask your permission (consent) for school district/county 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) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____
(Print Parent's /Guardian's Name) (Print Child's Name)
have received a written notification from the school district/county 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or 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 and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared: *IEP, Written Order/Referral, Evaluation Reports, Session Notes, Medication Administration Report, Special Transportation Log, Other Personally Identifiable Information, and any Other Specific Records Pertaining to the Student's Services or Programs.*

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 Name & Signature: Student's CIN #, if known: _____

_____	_____	_____
Print Name	Signature	Date

Revised 9/4/2019

CERTIFICATION OF
UNDER THE DIRECTION AND ACCESSIBILITY
FOR SPEECH THERAPY SERVICES

School Year: _____

Name (TSHH/TSSLD): _____ Certification Number: _____
(Please circle one)

_____ _____
Signature of Certified TSHH or TSSLD **Date**

I am providing accessibility to the Teachers of the Speech and Hearing Handicapped in the following manner:

_____

_____

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student,** etc.). I verify that I am providing "Under the Direction of" services to the above named TSHH/TSSLD.

Print Name of SLP: _____ **NYS License #:** _____ **NPI #:** _____

_____ _____
Signature of Licensed / ASHA Speech/Language Pathologist **Date**

Contact Information:

_____

_____

Child: _____ **Date of Birth:** _____

SPEECH "Under the Direction of" LOG

Child Name: _____ Agency: _____

School Year: _____ Speech Services Mandated: _____

Assigned TSHH/TSSLD: _____ Certification #: _____

Supervising SLP: _____ License #: _____ NPI #: _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and TSHH/TSSLD).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SLP SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising SLP **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH/TSSLD "under the direction of ". The SLP must have on file the manner in which he/she has provided supervision to the TSHH/TSSLD for each and every child being serviced.

CERTIFICATION OF
UNDER THE DIRECTION AND ACCESSIBILITY
FOR OCCUPATIONAL AND PHYSICAL THERAPY

School Year: _____

Name (OTA/PTA): _____ License #: _____ NPI #: _____
(Please circle one)

_____ _____
Signature of Certified OTA/PTA **Date**

I am providing under the direction of and accessibility in the following manner:

- Participate in the development of the child's IEP program, signing and dating the treatment plan
- Monitor the mandated delivery of OT services;
- Be readily available to the OTA/PTA for assistance and consultation, through phone, email or fax;
- Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA with each student in the provision of services;
- Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA through regular monthly meetings and make recommendations, as appropriate; and
- Review service sheets used for Medicaid billing.

I will keep the appropriate records documenting that supervision activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)

Print Name of OT/PT: _____ **NYS License #:**_____ **NPI #:**_____

_____ _____
Signature of Licensed Occupational/Physical Therapist **Date**

Contact Information:

_____

_____

Child: _____ **Date of Birth:** _____

OCCUPATIONAL / PHYSICAL THERAPY "Under the Direction of" LOG

CHILD NAME _____ SCHOOL YEAR _____

AGENCY_____ **OT / PT** SERVICES MANDATED _____

ASSIGNED **OTA / PTA** _____ LICENSE # _____ NPI # _____

SUPERVISING **OT / PT** _____ LICENSE # _____ NPI # _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA / PTA).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	OT / PT SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising OT / PT MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an OTA / PTA.

The PT must have on file the manner in which he/she has provided supervision to the PTA for each and every child being serviced. (One PT cannot supervise more than four (4) PTA, per Article 136, section 3738 a.)

The OT must have on file the manner in which he/she has provided supervision to the OTA for each and every child being serviced. The supervision must be direct supervision.