Federal Way Public Schools
33330 8th Avenue South, Federal Way, WA 98003
Phone: 253-945-2000 Fax: 253-945-2177

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL EDUCATIONAL INFORMATION

RE: ______________________________ Birthdate: ______________
(Student's Name) (Month, Day, Year)

I hereby authorize the exchange of confidential information regarding the above named student for the purpose of establishing special education eligibility, placement, and program planning between:

Federal Way Public Schools
and

____
Name of School District, Agency, etc.

____
Street Address

____
City State Zip

______________ ______________
Phone FAX number

Information Requested: **(check all that apply)**

- ☒ Special Education Records
- ☒ Educational Evaluations/Test Scores
- ☒ Psychological and Counseling Records
- ☒ Social/Emotional
- ☒ Manifestation Determination Review(s)
- ☐ Health Records
- ☐ Other (specify): ______________

I acknowledge notification of this transfer of records as required by the Family Educational Right and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect. This authorization is valid until revoked in writing.

PLEASE RETURN TO:

Federal Way Public Schools
Student Support Services
33330 8th Avenue South
Federal Way, WA 98003

Attn: ______________

FW Home School: ______________

______________________________ ______________
Signature of parent, guardian, or adult student Date

____
Relationship to student

____
Street Address

______________ ______ ______
City State Zip

WAC 392-172-422
WAC 392-172-102 & 104
RCW 70.02.005-904

Revised July 2006

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SPECIAL EDUCATION REGISTRATION FOR TRANSFER STUDENT

Student: ______________________________ Gender: M ☐ F ☐ Birthdate: ______________
(First Name) (MI) (Last Name)

Federal Way **Neighborhood** School: ______________________ Grade: ________ Age: ______

Parent / Guardian: ______________________________

Email Address ______________________________

Phone: Work # ____________ Home # ____________ Cell # ____________

Address: ______________________ ______________ ________
(Street) (City) (Zip)

Apt. #: ________ Name of Apartment Complex: ______________________

First Language Spoken: ____________ Language Used at Home: ____________ Country of Birth: ____________

Language interpreter needed? ☐ Yes ☐ No Sign language needed? ☐ Yes ☐ No

Please list names, ages, and relationships of the people living in this student's home:

Name	Relationship to Student	Age (Child)	Name	Relationship to Student	Age (Child)

Has this student previously received Special Education Services in **Federal Way Public Schools**? ☐ Yes ☐ No
If yes, what year and/or grade? ______________

Has this student repeated a grade? ☐ Yes ☐ No If yes, what grade? ______________

Date student left the last school he or she attended (month, day, year): ______________

Previous schools this student has attended in the last five years (list the most recent school first):

Name of **School District**	Name of **School** and City and State	From: (Dates or Grades)	To:

Reason(s) for Special Education Services:

☐ Behavior ☐ Learning ☐ Writing ☐ Speech / Language ☐ Hearing ☐ Personal / Social
☐ Health ☐ Reading ☐ Math ☐ Motor Skills ☐ Vision ☐ Other: ____________

Please explain/describe:

______________________ ______________________ ______________
(Signature of Person Completing This Form) (Position: Parent, Relative, Teacher, etc.) (Date)

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PARENT QUESTIONNAIRE
for TRANSFER STUDENT or INITIAL EVALUATION

STUDENT ______________________ BIRTHDATE ____________ AGE ________

MOTHER ______________________ PHONE ____________ BEST TIME TO CALL ________

FATHER ______________________ PHONE ____________ BEST TIME TO CALL ________

IS THERE ANYONE BESIDES THE PERSON SUPPLYING THIS INFORMATION THAT SHOULD BE NOTIFIED OF MEETINGS? (LIST BELOW)

NAME ______________ ADDRESS ______________ PHONE ________

DEVELOPMENTAL HISTORY

AT WHAT AGE DID YOUR STUDENT FIRST SPEAK WORDS? ________ SPEAK IN SENTENCES? ________ WALK? ________

DID YOUR STUDENT ATTEND PRESCHOOL? ☐ YES ☐ NO IF YES, HOW LONG? ________

DOES YOUR STUDENT HAVE DIFFICULTY WITH? READING ☐ WRITING ☐ MATH ☐

PLEASE DESCRIBE: ______________________

MEDICAL HISTORY

WERE THERE ANY BIRTH COMPLICATIONS? ☐ YES ☐ NO IF YES, WHAT KIND? ________

ALLERGIES? ☐ YES ☐ NO IF YES, WHAT KIND? ________

ARE THERE CONTINUING MEDICAL PROBLEMS? ☐ YES ☐ NO IF YES, WHAT KIND? ________

HAS THIS STUDENT EVER HAD: (check any that apply)

☐ SERIOUS ACCIDENT(S) ☐ SERIOUS PHYSICAL ILLNESS ☐ SEIZURES

☐ OPERATION(S) ☐ MENTAL ILLNESS ☐ HEAD INJURY

IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE: ______________________

CURRENT MEDICATIONS AND WHY TAKEN ______________________

NAME OF PHYSICIAN MOST FAMILIAR WITH STUDENT: ______________________

HAS THIS STUDENT EVER BEEN IN THERAPY OR COUNSELING? ☐ YES ☐ NO WHEN? ________

IF CURRENTLY, WITH WHOM? ______________________

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF ANY: (check any that apply)

☐ DISABILITIES ☐ LEARNING PROBLEMS ☐ PHYSICAL OR MENTAL DIAGNOSIS

IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE: ______________________

SOCIAL

HOW DOES YOUR CHILD GET ALONG WITH OTHER FAMILY MEMBERS? ______________________

HOW DOES YOUR CHILD GET ALONG WITH OTHER CHILDREN? ______________________

WHAT ACTIVITIES DOES YOUR CHILD ENJOY DOING? ______________________

HABITS

DO YOU HAVE ANY CONCERNS REGARDING THE FOLLOWING: (check any that apply)

☐ APPETITE ☐ DRUG USAGE ☐ SERIOUS BEHAVIOR PROBLEMS

☐ SLEEP HABITS ☐ ALCOHOL USAGE ☐ RESPONSIBILIITIES/SCHEDULE

IF YES, PLEASE EXPLAIN: ______________________

WHAT DO YOU LIKE MOST ABOUT YOUR CHILD'S PERSONALITY OR BEHAVIOR? ______________________

IN WHAT WAY(S) WOULD YOU LIKE YOUR CHILD TO IMPROVE? ______________________

______________________ ______________________

SIGNATURE DATE

Ethnicity and Race Data Collection Form for _______________________________________ *(Child's Name)*

QUESTION 1. Is your child of Hispanic or Latino origin? (Check all that apply.)

- ☐ NOT HISPANIC/LATINO
- ☐ CUBAN
- ☐ DOMINICAN
- ☐ SPANIARD
- ☐ PUERTO RICAN
- ☐ MEXICAN / MEXICAN AMERICAN/ CHICANO
- ☐ CENTRAL AMERICAN
- ☐ SOUTH AMERICAN
- ☐ LATIN AMERICAN
- ☐ OTHER HISPANIC/LATINO

QUESTION 2. What race(s) do you consider your child? (Check all that apply.)

- ☐ AFRICAN AMERICAN
- ☐ BLACK

- ☐ WHITE

- ☐ ASIAN INDIAN
- ☐ CAMBODIAN
- ☐ CHINESE
- ☐ FILIPINO
- ☐ HMONG
- ☐ INDONESIAN
- ☐ JAPANESE
- ☐ KOREAN
- ☐ LAOTIAN
- ☐ MALAYSIAN
- ☐ PAKISTANI
- ☐ SINGAPOREAN
- ☐ TAIWANESE
- ☐ THAI
- ☐ VIETNAMESE
- ☐ OTHER ASIAN

- ☐ NATIVE HAWAIIAN
- ☐ FIJIAN
- ☐ GUAMANIAN or CHAMORRO
- ☐ MARIANA ISLANDER
- ☐ MELANESIAN
- ☐ MICRONESIAN
- ☐ SAMOAN
- ☐ TONGAN
- ☐ OTHER PACIFIC ISLANDER

- ☐ ALASKA NATIVE
- ☐ CHEHALIS
- ☐ COLVILLE
- ☐ COWLITZ
- ☐ HOH
- ☐ JAMESTOWN
- ☐ KALISPEL
- ☐ LOWER ELWHA
- ☐ LUMMI
- ☐ MAKAH
- ☐ MUCKLESHOOT
- ☐ NISQUALLY
- ☐ NOOKSACK
- ☐ PORT GAMBLE KLALLAM
- ☐ PUYALLUP
- ☐ QUILEUTE
- ☐ QUINAULT
- ☐ SAMISH
- ☐ SAUK-SUIATTLE
- ☐ SHOALWATER
- ☐ SKOKOMISH
- ☐ SNOQUALMIE
- ☐ SPOKANE
- ☐ SQUAXIN ISLAND
- ☐ STILLAGUAMISH
- ☐ SUQUAMISH
- ☐ SWINOMISH
- ☐ TULALIP
- ☐ YAKAMA
- ☐ OTHER WASHINGTON INDIAN
- ☐ OTHER AMERICAN INDIAN/ALASKA NATIVE

____ ________________

Parent/Guardian Signature   Date

NOTIFICATION FOR THE DISCLOSURE OF STUDENT INFORMATION TO THE WASHINGTON STATE HEALTH CARE AUTHORITY AND PARENT RIGHTS AND PROTECTIONS

PURPOSE: This form provides parents with information about the school district's request to verify a student's Medicaid eligibility, seek reimbursement for eligible school-based health services by accessing the parent's or child's public benefits and provides parents with notice of their rights and protections under WAC 392-172A-07005. This notice is provided: 1) annually; 2) the first time a school district seeks to verify Medicaid eligibility and submit school based Medicaid reimbursable claims; and, 3) any time a school district determines that it needs to obtain an updated consent. This notice is provided to parents or guardians, and adult students.

The Federal Way School District participates in the Washington State Health Care Authority's (HCA) program that makes federal Medicaid funds available to school districts to help cover the costs of providing necessary, school-based health services. By participating in this program, the school district can seek federal Medicaid reimbursement for the costs of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are identified in their individualized education programs (IEP). In order to seek the federal Medicaid funds to assist in reimbursing the district for school-based services, the school district must disclose information from your child's education records to the HCA to verify Medicaid eligibility, and to seek reimbursement for those services the school district provides.

NOTIFICATION OF YOUR PARENT RIGHTS AND PROTECTIONS

To ensure that your child has access to a free appropriate public education, the school district:

- must obtain your written consent prior to disclosing your child's name, birthdate and information in your child's education record about reimbursable health-care services to the HCA;
- may not require you to sign up for or enroll in any public benefits or insurance programs;
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the school district provides to your child; and,
- may not use your child's Medicaid or other public benefits if that use would:
  - decrease available lifetime coverage or any other insured benefit;
  - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school;
  - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance; or,
  - cause you to risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

Giving your consent does not cost you anything. It will allow the school district to seek federal Medicaid reimbursement to provide necessary services for your child. If you have already given your consent, or you are giving the district a new consent for services, you may revoke your consent at any time. The school district will continue to provide the services in an IEP to your child at no cost to you, as the parent whether or not you give your consent.

If the district is requesting an updated consent from you, or has asked you to provide initial consent to verify Medicaid eligibility and seek reimbursement from Medicaid for necessary school based services, a consent form is attached to this notification.

If you need this document translated into another language, please contact this office at 253-945-2086.
Si necesita este documento traducido, por favor póngase en contacto con esta oficina al 253-945-2086.
Nếu bạn cần tài liệu này được dịch, xin vui lòng liên hệ với văn phòng này tại 253-945-2086.
Этот документ содержит важную информацию. Если Вам необходим перевод этого документа на русский язык, пожалуйста, позвоните по телефону 253-945-2086.
Даний документ містить важливу інформацію. Якщо ви потребуєте її перекладі, будь ласка, зв'яжіться з цієї посади на 253-945-2086.
이 서류는 중요한 정보가 포함되어 있습니다. 번역이 필요하시면, 이 사무실의 전화번호253-945-2086 으로 연락해 주십시오.

PURPOSE: This form asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with the Washington State Health Care Authority (HCA). When the district verifies Medicaid eligibility or bills HCA for school-based services based on you or your child's eligibility for public benefits, it does not affect either of your individual benefits under Medicaid.

CONSENT TO VERIFY ELIGIBILITY AND BILL FOR SCHOOL-BASED MEDICAID REIMBURSEMENT

Student's Name: ____
Current School: ____
Student's SSID (if known): ____________________
Date of Birth: ______________________

A school district is required to obtain your consent to verify eligibility for Medicaid and submit claims for reimbursable school-based services provided on behalf of your child. The types of services that can be reimbursed by Medicaid include physical therapy, occupation therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluations. These types of services which may be provided to your child through an individualized education program (IEP), may also be reimbursed by Medicaid if your child is eligible to receive Medicaid benefits. With your permission, Federal Way Public Schools will submit your student's name and birth date to the Washington State Health Care Authority (HCA) to verify Medicaid eligibility. The submission of this information will not change the services provided in your child's IEP. With your consent, Federal Way Public Schools will also share necessary information from your child's education record to obtain reimbursement from the HCA if the services provided to your child can be reimbursed because of your child's eligibility for Medicaid benefits.

I authorize _____________________________ to share any necessary identifying information from my child's educational record to verify Medicaid eligibility with the HCA, and to access my or my child's public benefits to obtain Medicaid reimbursement for school-based health services from the HCA. If my child is no longer served by this school district, I understand that this consent will not transfer to a new school district. This authorization will begin on the date that I sign and give consent below.

By giving consent, I acknowledge that: (1) I have been fully informed of all information relevant to accessing my or my child's Medicaid benefits and informed of the reasons I have been asked to provide consent to release relevant information from my child's education records to verify eligibility and to obtain reimbursement from HCA; (2) I also understand that the granting of consent is voluntary on my part and I may revoke consent at any time; and (3) if I revoke consent, the revocation is not retroactive; which means that it does not undo any verification or billing through HCA that has already taken place, but it will stop any future verification or billing.

☐ I give my consent to verify my child's Medicaid eligibility with HCA and to submit claims for allowable services.

☐ I do not give consent. I understand that my refusal to consent means that the district cannot verify eligibility or make a claim for reimbursement for services that might otherwise be covered by HCA. I also understand that my refusal does not affect my child's access to special education services under his or her IEP.

____   ____________________________
Parent/guardian signature   *Date*

If you have questions about this consent, please call your school district for an explanation as to why the request is being made at 253-945-2086.