NIAGARA COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS

5467 Upper Mtn. Road
Suite 100
Lockport NY 14094
439-7460
FAX: 438-3006

Trott Access Center
1001 – 11th Street
Niagara Falls NY 14301
278-8180
FAX: 278-8288

LISA M. CHESTER, B.A.,M.P.A.
Director/EIO

STACY L. LAMPMAN, M.A., CCC/A
Clinical Director

Early Intervention and Therapeutic Services
Children With Special Needs
Preschool Special Education
Physically Handicapped Children's Program

Dear Parent/ Guardian of _____:

This is to ask your permission (consent) for Niagara 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 Niagara County to bill Medicaid for covered health-related services and to release information to Niagara County's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____
(Print Parent's Name) (Print Child's Name)
have received a written notification from Niagara 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 Niagara 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 county must give me annual written notification of my rights regarding this consent.

I also give my consent for Niagara 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:

Records to be shared (e.g. records or information about services your child receives, student demographic information):
Name, Date of Birth, Gender, Client Identification Number (CIN),Evaluation Results, IEP Services, Transportation Logs, Session Notes, Written Orders including diagnosis codes

Student's CIN, if known:_____

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.

_____
Print Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date