CHEHALIS-CENTRALIA STUDENT SUPPORT COOPERATIVE
IN-COMING STUDENT INFORMATION

Student Name: _____ Date of Birth: _____ Sex: _____

School Entering: _____ Grade: _____

Parent/Guardian: _____ Home Language:

Address: _____ Interpreter Needed: No ____ Yes _____

City: _____ Zip: _____ Surrogate Needed: No _____ Yes _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

LAST SCHOOL DISTRICT ATTENDED: _____

ETHNICITY AND RACE

Please answer questions 1 and 2.

Question 1: Is your child of Hispanic or Latino origin? (If so, check all that apply.) Yes No

- ☐ Cuban
- ☐ Dominican
- ☐ Spaniard
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino
- ☐ Mexican/Mexican American/Chicano
- ☐ Central American
- ☐ South American
- ☐ Latin American

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
- ☐ Mariana Islander
- ☐ Melanesian
- ☐ Micronesian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander
- ☐ Alaska Native
- ☐ American Indian
- ☐ Chehalis
- ☐ Colville
- ☐ Cowlitz
- ☐ Hoh
- ☐ Jamestown
- ☐ Kalispell
- ☐ Lower Elwha
- ☐ Lummi
- ☐ Makah
- ☐ Muckleshoot
- ☐ Nisqually
- ☐ Guamanian
- ☐ Nooksack
- ☐ Port Gamble S'Klallam
- ☐ Puyallup
- ☐ Quileute
- ☐ Quinault
- ☐ Samish
- ☐ Sauk-Suiattle
- ☐ Shoalwater
- ☐ Skokomish
- ☐ Snoqualmie
- ☐ Spokane
- ☐ Squaxin Island
- ☐ Stillaguamish
- ☐ Suquamish
- ☐ Swinomish
- ☐ Tulalip
- ☐ Yakima
- ☐ Other Washington Indian
- ☐ Other American Indian

CHEHALIS-CENTRALIA STUDENT SUPPORT COOPERATIVE
AUTHORIZATION FOR MUTUAL EXCHANGE OF CONFIDENTIAL INFORMATION

Attention:

Student: _____ Current School: _____

Date: _____ Birthdate: _____

I hereby authorize the mutual exchange of information between Chehalis-Centralia Student Support Cooperative and:

- ☐ Previous School District: _____ ☐ Fax: _____
- ☐ Mental Health Care providers: _____ ☐ Fax: _____
- ☐ Health Care provider: _____ ☐ Fax: _____
- ☐ DSHS/DDD contracted providers: _____ ☐ Fax: _____
- ☐ College(s): _____ ☐ Fax: _____
- ☐ Department of Corrections: _____ ☐ Fax: _____
- ☐ Other: _____ ☐ Fax: _____

Records that are being requested:

- ☐ **Special Education records (to include a current IEP and current 3 year Evaluation)**
- ☐ Psychiatric ☐ Health/Medical ☐ No Special Education services.
- ☐ Psychological ☐ other:

Reason for Release:

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

☐ Parent(s)/Guardian(s) ☐ Adult Student Today's Date

Expiration date: _____ (Not to exceed one year from expiration date)

CHEHALIS-CENTRALIA STUDENT SUPPORT COOPERATIVE

ATTN: RECORDS CLERK
mthomas@chehalisschools.org
1265 S.W. PACIFIC AVENUE
CHEHALIS, WA 98532
PHONE (360) 807-7245 FAX (360) 748-8767

In accordance with the requirements of the Family Educational Rights and Privacy Act of 1974, I hereby acknowledge notification that the records of the above named student be transmitted to/from Chehalis-Centralia Student Support Cooperative. I have been notified of the right to inspect the records, request a copy of the records at my expense, and to have a conference to remove or correct any information that is inaccurate, misleading, or otherwise violated the student's right to privacy, or other rights. Information sent or received by the Chehalis-Centralia Student Support Cooperative may not be shared with any other party without the written consent of the parents or guardians, or the student, if eighteen (18) years old or older. However, information provided to the school district becomes part of the individualized record and may be forwarded to another school district. I understand that I may revoke this consent at any time and that this permission is only valid for one calendar year from the above date. This authorization releases the Chehalis-Centralia Student Support Cooperative and employees thereof from any indemnity arising from the release of confidential information.

Chehalis-Centralia Student Support Special Services

Student Developmental / Health / History Assessment Form

Student:_____ Birthdate:_____ Age:_____

Parent/ Guardian: _____ Primary Language: _____

Address: _____

Home phone:_____ Alternate phone:_____

* Student is living with:

( ) Father ( ) Stepfather ( ) Foster parents

( ) Mother ( ) Stepmother ( ) Other_____

Brothers: How many_____ Sisters: How many_____

Ages: _____ Ages: _____

* **Family history:** Does anyone in the family have a history of (check all that are appropriate):

____ Visual problems ____ Seizures or convulsion

____ Hearing problems ____ Intellectual disability (Mental retardation)

____ Speech problems ____ Heart disease

____ Emotional problems ____ Birth defects ____ Learning problems

Please explain any checked items above: _____

_____

* **Child's history:** Were there any complications during pregnancy? __ Yes ___ No

If yes, please provide more information: _____

_____

- During pregnancy, mother ___smoked __ alcohol ___ medications: _____
- Were there any complications during birth? ___ Yes ___ No

If yes, please provide more information: _____

_____

- Was baby kept in the hospital after mother was discharged? __ Yes __ No

If yes: for how long and why? _____

- Any medical diagnosis? ___ Yes ___ No

If yes, please explain: _____

- Age at which your child (use "N" for normal): spoke: Words ____ Sentences_____

Sat up _____ crawled_____ walked _____ toilet trained _____

- Compared to your child's siblings, s/he developed and learns: ___slower ____ ok ____faster
- Were there any significant delays in development (birth to 6 years) in these areas:

Self help skills (dressing, eating etc.) ( ) Yes ( ) No

Social skills (compliance, responsibility, peer relationships ( ) Yes ( ) No

***Past Illnesses**: ( ) Accidents ( ) Operations / Surgeries ( ) Seizures

( ) Allergies ( ) Serious head injury ( ) High fever

( ) Serious illness ( ) Chronic Ear infections: Did they have tubes? ___Yes ___No

( ) Epilepsy ( ) Diabetes

( ) Bleeding disorders ( ) Periods of unconsciousness ( ) Other

Please explain any marked items: _____

_____

- Is your child on medication? If yes, name and what for: _____
- Your child's general health is: ____ Good _____ Fair ____ Poor

→ over to next page

Chehalis-Centralia Student Support Special Services

* Does child have consistent problems with:

Physical	Conduct	Anxiety/Depression	Thought Process
( ) Vision	( ) high activity level	( ) Unhappiness/ depressed mood	( ) Bizarre ideas
( ) Hearing	( ) Distractible	( ) Apprehension/ worrying	( ) Disconnected, loose, fragmented language
( ) Speech / Language	( )Frequent inter-	( )Somatic complaints/ illnesses	( )Inability to express ideas
( )Motor development	( )Aggressiveness	( ) General nervousness	( ) Inability to deal with abstraction, environmental changes
	( ) Impulsivity –unable gratification	( ) Eating	( ) Unusual social to delay mannerisms/ behaviors
	( ) Lying	( ) Nightmares	
	( ) Stealing	( ) Sleep problems/ increased or decreased	
	( ) Difficulty with authority, rules, limits, laws	( ) Thumb-sucking, nail-biting or other nervous habits	
		( ) Bedwetting	
		( ) Unreasonable fears	
		( ) Difficulty with attention/ concentration	
		( ) Suicidal ideation	

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 experience (include grades, repeated grade, dates/location)

_____

_____

_____

Please provide any additional comments, concerns or background information that might assist us is working with your child: _____

_____

_____

Parent signature: _____ Date: _____

Student ID:
WA SSID:
Date of Birth:

Notification for the Disclosure of Student Information to the Washington State Health Care Authority

Centralia School District (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in Washington State Health Care Authority (HCA) program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to the HCA regarding the health services the School District provided to your child.

NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information 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
  - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

Giving your consent will cost you, the parent guardian, nothing, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

Please use the attached form to select your consent option.

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 Washington State Health Care Authority, Health and Recovery Services Administration. Billing HCA 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 SSID: _____

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, Centralia School District, will submit your student's name and birth date to the Washington State Health Care Authority (HCA) 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 Washington State Health Care Authority (HCA). If any additional Medicaid reimbursement services are added to the IEP, the school district will request additional consent. 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 _____.

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 HCA and to submit claims for allowable services.

☐ I do not give my consent to verify Medicaid eligibility with HCA 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