



**FOR OFFICE USE ONLY:**

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_ Gen: \_\_\_\_\_

Family Number: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Start Date: \_\_\_\_\_ Grad Year: \_\_\_\_\_

**CPSE REGISTRATION**

Please be sure to submit the supporting documentation below with your registration forms along with any custody documentation if applicable. Please submit your completed paperwork by scanning/emailing to [registrar@niskyschools.org](mailto:registrar@niskyschools.org), or by dropping them off at the District Office which is located at 1430 Balltown Rd and is open Monday through Friday from 8:00am until 4:00pm. There is a locked mailbox just inside the door that you can place your forms in. You will receive an email from the Registrar's Office if anything is missing.

<b>Proof of Residence</b> (Must submit a minimum of 2, one from Row A and one from Row B)					
Row A	<input type="checkbox"/> Signed Lease OR Mortgage Statement	<input type="checkbox"/> Homeowners OR Renter's Insurance Bill	<input type="checkbox"/> Closing Statement OR Deed	<input type="checkbox"/> Contract of Sale	<input type="checkbox"/> Property Tax Bill/Receipt
Row B	<input type="checkbox"/> Utility or other bills	<input type="checkbox"/> Income Tax	<input type="checkbox"/> Membership documents based on residency	<input type="checkbox"/> Voter Registration documents	<input type="checkbox"/> Local, State or Government issued ID documents
	<input type="checkbox"/> Pay Stub	<input type="checkbox"/> Official driver's license, learner's permit or non-driver identification	<input type="checkbox"/> Sworn Statement by third-party (landlord, etc.)	<input type="checkbox"/> Evidence of Custody of Child (custody orders, guardianship papers, etc.)	<input type="checkbox"/> Other (Must be approved by Registrar before submittal)

<b>Proof of Birth</b> (Must submit one of the following)					
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Passport	<input type="checkbox"/> Driver's License	<input type="checkbox"/> School photo identification card with date of birth	<input type="checkbox"/> Consulate Identification card	<input type="checkbox"/> Local, State or Government issued identification cards or documents
<input type="checkbox"/> Military dependent identification card	<input type="checkbox"/> Hospital or health records	<input type="checkbox"/> Native American tribal documents	<input type="checkbox"/> Court orders or other court issued documents	<input type="checkbox"/> Records from non-profit international aid agencies and voluntary agencies	

<b>Proof of Parental Relationship</b> (Must submit one of the following)		
<input type="checkbox"/> Birth Certificate & parent photo ID	<input type="checkbox"/> Court custody documents & custodian photo ID	<input type="checkbox"/> Baptismal certificate & parent photo ID
<input type="checkbox"/> Court adoption documents & parent photo ID	<input type="checkbox"/> Court guardianship documents & guardian photo ID	<input type="checkbox"/> Notarized affidavit of emancipation

<b>Student Support Services</b>
<input type="checkbox"/> Release Forms

**PLEASE BE SURE THAT ALL OF THE ABOVE REQUIREMENTS HAVE BEEN MET BEFORE SUBMITTAL**

**FOR OFFICE USE ONLY:** Services: \_\_\_\_\_

\_\_\_\_\_  
**REGISTRAR'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**ZONE**



**FOR OFFICE USE ONLY:**

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_ Gen: \_\_\_\_\_

Start Date: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Services: \_\_\_\_\_

Child's Name \_\_\_\_\_

Primary Phone Number \_\_\_\_\_  Male  Female

Last Grade Completed \_\_\_\_\_ Grade Entering \_\_\_\_\_

Child's Permanent Address \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Last School Attended \_\_\_\_\_

Address of Last School \_\_\_\_\_

Name of Parent/Guardian #1 \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if not the same as above) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address: \_\_\_\_\_

Name of Parent/Guardian #2 \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if not the same as above) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address: \_\_\_\_\_

Has your child ever received **Special Education Services**? \_\_\_ Yes \_\_\_ No

Does your student have an **Individualized Education Program (IEP)**? \_\_\_ Yes \_\_\_ No

Please list all other children in the home (Birth to Age 18):

Name	Gender	Birthdate	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_

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

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one)

- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled up")
- In a hotel/motel
- In a car, park, bus, train or campsite
- Other temporary living situation (Please describe): \_\_\_\_\_
- In permanent housing

\_\_\_\_\_  
Print name of parent, guardian or student (for unaccompanied homeless youth)

\_\_\_\_\_  
Signature of parent, guardian or student (for unaccompanied homeless youth)

\_\_\_\_\_  
Date



Name of Child (Last, First, Middle): \_\_\_\_\_

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin regardless of race. Check the box that best describes your child. Check only ONE box.

- YES, Hispanic       NO, not Hispanic

2. Select one or more races from the following five racial groups. For question (2) check all that apply to your child. Check AT LEAST one box.

- AMERICAN INDIAN OR ALASKA NATIVE: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the peoples Hawaii, Guam, Samoa or other Pacific Islands.
- BLACK OR AFRICAN AMERICAN: A person having origins in any of the Black racial groups of Africa.
- WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Signature of Parent/Guardian: \_\_\_\_\_

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

**TO THE PARENT/GUARDIAN:** In accordance with Federal guidelines, the Niskayuna Central School District is collecting and recording the ethnic identity of students using Federal categories and definitions. All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status. This information will be used to:

- Report Information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Analyze differences in academic performance, attendance and completion of school

Please review the above information and be sure that you have checked the boxes that best describe your child. The Niskayuna Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with or is regarded in the community as belonging. Thank you for your cooperation.

### **CONFIDENTIALITY PROCEDURES AND REGULATIONS**

This form will be filed in the student's permanent record as confidential information. The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized disclosure access to student records and unauthorized release of any student record information identifiable by student name and student identification number

**NISKAYUNA CENTRAL SCHOOL DISTRICT**

Office of Student Support Services  
1301 Hillside Avenue  
Niskayuna, NY 12309  
Phone - (518) 382-2525 FAX – (518) 382-2526

***Consent to Obtain/Release of Information***

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

This consent to obtain and/or release information authorizes the Niskayuna Central School District's Special Education Programs and Services office to:

\_\_\_\_ Release Information/Records to

\_\_\_\_ Obtain Information/Records from

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

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person: \_\_\_\_\_ FAX: \_\_\_\_\_

**This consent and release includes any and all medical, psychological, or educational information they may have concerning the above referenced individual.**

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

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

**Niskayuna Central School District  
Committee on Special Education  
Student Support Services  
1301 Hillside Avenue  
Niskayuna, NY 12309**

October 7, 2021

**Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special  
Education and Related Services**

**This form has been adapted from the U.S. Department of Education's model Notification Form<sup>1</sup>**

**INTRODUCTION**

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/county to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district (or, for preschool students, the county) to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

**PARENTAL CONSENT**

**34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)**

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the school district will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

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<sup>1</sup> For the full Suggested Model for Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see: <http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/accomodelwrittennotification-6-11-13.pdf>

2. Consent to check with the New York State Department of Health: whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school district or county, for preschool, may use you or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

### **NO COST PROVISIONS**

#### **34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)**

The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for or enroll in a public benefits or insurance program in order for your child to receive a free appropriate public education.
2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.
3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:
  - a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
  - b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
  - c. increase your premium or lead to the cancellation of your public benefits or insurance; or
  - d. cause you to risk the loss of your child's eligibility for home and community-based waiver that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district or county, for the provision of preschool special education, to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see:

<http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parentalconsent.htm>

**Niskayuna Central School District  
 Student Support Services  
 1301 Hillside Avenue  
 Niskayuna, NY 12309 (518-382-2525)  
 Medicaid Consent**

Dear Parent/Guardian:

**Medicaid Insurance: Yes or No (Please circle)**

If your child has Medicaid Insurance please fill in the Client Identification Number (CIN) which consists of 2 letters, 5 numbers and 1 letter (Example AB12345C): **CIN:** \_\_\_\_\_ **OR Social Security Number:** \_\_\_\_\_

This is to ask your permission (consent) 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** \_\_\_\_\_ have received a written notification from the school district 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;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

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 Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_