Prior Notice and Consent

Student Name ____________________________  ID # __________  Date of IEP Meeting ________________

Prior Notice of IEP and Placement Decision

Fairfax County Public Schools (FCPS) proposes to implement this IEP and the placement decision as written. This proposed IEP and placement decision will allow the student to receive a free and appropriate public education in the least restrictive environment. This decision is based upon a review of current records, current assessments, and the student’s performance as documented in the Present Level of Performance. Additionally, other factors, if any, that are relevant to this proposal are outlined on the Information Related to Present Level of Educational Performance form of this IEP. When you were notified of the meeting to develop this IEP, you were provided a copy of the procedural safeguards that explains your rights. If you need assistance in understanding this information, please call Due Process and Eligibility 703-317-3000.

Initials here indicate that the parent(s) has read the above prior notice, as well as, other options considered and other factors related to the proposal, if any, before giving permission to implement this IEP and the placement decision.

Parent and/or Student Initials indicate receipt of the following:

- **Age of Majority Brochure** (to be given at the IEP meeting on or immediately preceding student’s 17th birthday)

  Student’s Initials _____
  Parent's Initials _____

- **Diploma Options and Requirements Information and Extended School Year Information**

  Parent’s Initials _____
  Student’s (age 18 or older ) Initials _____

I AGREE with the contents of this IEP. I have received a copy of Virginia Special Education Procedural Safeguard Requirements Under the Individuals with Disabilities Education Act. I have had an opportunity to participate in the development of this IEP.

_________________________  Parent Signature (or student age 18 or older)  Date __________

I DO NOT AGREE with the contents of this IEP. I have received a copy of Your Virginia Special Education Procedural Safeguard Requirements Under the Individuals with Disabilities Education Act. I have had an opportunity to participate in the development of this IEP.

_________________________  Parent Signature (or student age 18 or older)  Date __________

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or of the eligible student.
Parent Consent for Billing Medicaid or FAMIS for Covered Services

If your child is now or later becomes eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS), is evaluated for, receives, or is considered for, covered services written in an individualized education program (IEP), the federal government can help the school division pay for these covered services. The IEP team may also consider evaluations that were requested as part of the initial eligibility or reevaluation processes, or subsequent evaluations that were requested by the IEP team. Parental consent is necessary before the school division can seek reimbursement from Medicaid or FAMIS. Billing occurs at no cost to you, private insurance will not be billed, and your Medicaid/FAMIS benefits will not be affected. Your consent is entirely voluntary. If you do not give consent, it will not affect the delivery of your child’s services. If you have questions or concerns, please contact the FCPS Medicaid Program Manager at 571-423-4098. Or visit the Information Guide for Obtaining Parental Consent for Billing Medicaid or FAMIS for Covered Services Outlined in the IEP or IEP Addendum at: [http://www.fcps.edu/dss/sei/documents/index.shtml](http://www.fcps.edu/dss/sei/documents/index.shtml).

Procedural Safeguard: I understand my right to deny consent for Fairfax County Public Schools (FCPS) to release information regarding my child’s IEP services, for the purpose of seeking reimbursement through Medicaid/FAMIS. I understand that an assignment of a diagnosis code is required as part of the service delivery reimbursement, i.e., expressive language, fine motor, or a specific mental health condition. I understand that billing occurs at no cost to me. I understand that if I choose not to provide consent that this decision will not affect the delivery of these services to my child. I understand that my permission is voluntary and may be revoked at any time. I also understand that I have the right to request a copy of the records disclosed.

I CONSENT for FCPS to release information about my child’s placement(s) and/or participation in services or evaluations to participating physicians, other health care providers, the Department of Medical Assistance Services (DMAS), any DMAS billing agents, and any FCPS billing agents in order to process claims for reimbursement of Medicaid/FAMIS covered services or evaluations outlined in the IEP.

__________________________ ________________________
Parent Signature (or student age 18 or older) Date

I DO NOT CONSENT for FCPS to release information about my child’s placement(s) and/or participation in services or evaluations in order for FCPS to receive reimbursement for Medicaid/FAMIS covered services or evaluations outlined in the IEP.

__________________________ ________________________
Parent Signature (or student age 18 or older) Date