



Student Update Form

Campus Attending:

- Pine Hills
- Seminole
- West Orange
- EO/ Bailes
- Osceola
- Transitional Learning Academy
- Downttown/BETA

Legal Name of Child: _____ Other Names/Nicknames _____

Parent/Guardian Name: _____

Phone: _____ Alternate Phone: _____

E-Mail Address: _____

Mother's Employer: _____ Title/Job _____

Father's Employer: _____ Title/Job _____

Home Address: _____
Street City Zip

Has your address changed in the last year? No Yes (if yes, complete below)

Please confirm if your child lives in the county where the school is located:

- Yes
- No

I am interested in my child receiving additional therapy services (in addition to therapy on their IEP) Please select all that apply:

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Behavior Therapy

Funding Information: (You are responsible for notifying us immediately with changes)

My child currently has the following type of funding/insurance for therapy services:

(Include a copy of the front and back of your insurance card)

- Children's Medical Services/ CMS
- Prompt Pay (\$45/30 minute session)
- Medicaid MediPass (Gold Card)
- Healthy Kids/ KidsCare
- Medicaid HMO: Name: _____
- Commercial Insurance: Name: _____

IEP/Medicaid School Match Consent & Authorization

I authorize UCP and/or the school district to release and exchange my child's relevant information to agencies of the State of Florida which would allow UCP/School District to verify Medicaid eligibility, bill Medicaid and reimbursable certified school match services referenced on my child's IEP and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive referenced on his/her IEP whether or not I give consent.

Parent Signature: _____ Date: _____