OFFICE OF SPECIAL SERVICES
P.O. Box 450/625 Route 517, Vernon, NJ 07462
Phone: 973-764-2935 Fax: 973-764-0078 Web: www.vtsd.com

Deborah Merrill
Director of Special Services
dmerrill@vtsd.com

Adam Kendler
Supervisor PSD-5
akendler@vtsd.com

Cheryl von Salzen
Supervisor 6-12
cvonsalzen@vtsd.com

Special Education Medicaid Initiative (SEMI) Parental Consent form
Vernon Township School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act,34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

Child's Name:_____

Child's Date of Birth: _____/_____/_____

Parent:_____ Date:____/_____/_____

I give consent to bill for SEMI: Yes ☐
No ☐

This consent can be revoked at any time by contacting the administrator at your child's school.