



Burlington County Institute of Technology
Jill Trainor
Director of Pupil Personnel Services

**Discover
Your
Potential**

Dr. Christopher J. Nagy
 Superintendent of Schools
 cnagy@burlcoschools.org

Dr. Ashanti Holley
 Assistant Superintendent
 aholley@burlcoschools.org

Mr. Eder Joseph
 Assistant Superintendent
 ejoseph@burlcoschools.org

Mr. Andrew Willmott
 Business Administrator/Board Secretary
 awillmott@burlcoschools.org

Special Education Medicaid Initiative (SEMI) Parental Consent form

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 public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including copays, deductibles, and loss of eligibility or impact on lifetime benefits.

Child's Name: _____

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

Parent/Guardian: _____

Date: ____/____/____

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

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.