Trenton, New Jersey
CENTRAL SERVICES BUILDING
108 North Clinton Avenue
Trenton, New Jersey 08609

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. Your child will continue to receive services at no cost to you under this new system. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

Please fill in the information below, sign the form and return it to the address indicated

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

NAME OF PARENT/GUARDIAN:_____

CHILD'S NAME:_____
(FIRST) (MIDDLE) (LAST)

ADDRESS:_____

CHILD'S MEDICAID NUMBER ____ _____ _____ _____ _____ _____ _____ _____ _____ _____

CHILD'S DATE OF BIRTH:_____/_____/_____

As parent/guardian of the above child, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Educational Program (IEP).

PARENT/GUARDIAN'S SIGNATURE:_____
(Parent or person in parental relationship)

DATE:_____
(Month/Day/Year)

Please return this form to
Trenton Public Schools
Department of Special Services
108 North Clinton Avenue, Room 309
Trenton, New Jersey 08609

CST USE:
CST Name (print):_____**CST Name (signature):**_____

***Initial Eval.**_____ ***Classification:**_____ _____ ***Placement:**_____ ***School:**_____

***Transportation: Regular**_____**Specialized**_____ **None**_____
***CST Team – Your signature verifies these items are in the IEP.**