Hainesport Township School District

Mr. Joseph R. Corn
Superintendent
jcorn@hainesport.k12.nj.us

Mrs. Cora Schiers
Confidential Secretary
schiers@hainesport.k12.nj.us

Form R-1

Proof of Residency/Domicile

The Hainesport Board of Education has policies and procedures related to "Proof of Domicile" for students who attend Hainesport Township School. These policies and procedures are based upon New Jersey Statutes Annotated 28-2.5 and New Jersey Administrative Code 18A: 38-1. A procedure requiring proof of current domicile in Hainesport is mandatory for all new registrants at the time of registration.

> *Domicile is defined as "an individual's true, fixed, and permanent place or home to which whenever absent he or she has the intention of returning." Whether a family is renting an apartment, purchasing a home, or moving in with another Hainesport resident, concrete proof of domicile as defined by N.J.S.A.18A:38-1 et seq. shall be provided before the pupil is enrolled into Hainesport Township School.*

Any false or fraudulent statements, answers or declarations contained in Affidavits or in the application for admission may render the applicant personally liable to the Hainesport Board of Education for the payment of tuition for any period of unlawful attendance. Tuition rates are determined annually in June for the next school year.

Applicants who fraudulently allow a child to use residence or who fraudulently claim to have given up custody may be charged with a Disorderly Persons Offense. If the applicant is convicted of such an offense, the applicant may be fined up to $1,000.00 and/or be imprisoned for up to six months. Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A.2C:28-2. If convicted for such a crime, the applicant may be punished by a fine of $7,500.00 and/or imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understand the contents of this notification.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

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Form R-2

Registration Data Form for School Year 2022-2023

Student Information:			**Registration Date:**
Last	***First***	***Middle***	**Grade Level:**
Date of Birth:	**Gender:**		**City of Birth:**
Home Phone:	**U.S. Citizen:**		**Race/Ethnicity:**
Primary Language Spoken at Home:			***Mailing Address (if different from Home Address):***
Street:			
City:	**Zip Code:**		
P.O. Box # if applicable:			

Siblings		
Name:	**Name:**	**Name:**
Date of Birth:	**Date of Birth:**	**Date of Birth:**

Parent(s)/Guardian(s)	
Parent/Guardian #1	**Parent/Guardian #2**
Name:	**Name:**
Relationship:	**Relationship:**
Address (leave blank if same as student address):	**Address (leave blank if same as student address):**
Street:	**Street:**
City:	**City:**
Zip Code:	**Zip Code:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Work Phone:	**Work Phone:**
Email Address:	**Email Address:**
Employer:	**Employer:**
Student Health Insurance Provider:	

Emergency Contacts		
Name:	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**
Home Phone:	**Home Phone:**	**Home Phone:**
Cell Phone:	**Cell Phone:**	**Cell Phone:**

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Form R-3

NJ FamilyCare Act Form

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private, or other?

☐ NO. My child does not have health insurance.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b). NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit http://www.njfamilycare.org/default.aspx to apply online or call 1-800-701-0710.

☐ YES. My child has health insurance.

Doctor _____
Name/Address

Phone _____

Dentist _____
Name/Address

Phone_____

Hospital _____
Name/Address

Phone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and to authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____
Signature of Parent(s)/Guardian(s) Date

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Student Health History Questionnaire
(*to be completed by Parent/Guardian*)

Student's Name _____ Date of Birth_____

Date of Last Physical Exam _____ Last Eye Exam _____ Last Dental Exam _____

Child's Physician _____Physician's Phone Number_____

Please "x" if a close family member has had:

Diabetes _____ Heart Disease _____ Asthma _____ High Blood Pressure _____
Scoliosis _____ Allergy (list) _____
Other_____

Please "x" if child has had:

___	Anemia	___	Frequent colds	___	Asthma
___	Frequent earaches	___	Pneumonia	___	Frequent sore throats
___	Chickenpox	___	Frequent stomach aches	___	Strep Throat
___	Frequent vomiting	___	Frequent diarrhea	___	Frequent constipation
___	Scarlet Fever	___	Meningitis	___	Rheumatic Fever
___	Lyme Disease	___	Heart Problems (murmur)	___	Past concussions (number)
___	Head or Neck Injury	___	Seizures/Seizure Disorder	___	Headaches
___	Trouble with vision	___	Glasses worn	___	Trouble with hearing
___	Hearing Aid	___	Problems with speech	___	Operations
___	Orthopedic problems	___	Chronic Illness	___	Tendency to bleed easily
___	Use of adaptive aids (braces, wheelchair, etc.)				
___	Tuberculosis/positive Mantoux test				
___	Problems with toileting/bedwetting				

Allergies your child has, Type of allergy (environmental, food, insect bite/sting, medication):
_____

_____

Type of allergic reaction:
_____

_____

Medication(s) used to treat reaction:
_____

_____

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Medications:
Please list any medications (prescription or over the counter) your child is taking regularly and reason for taking.

_____

_____

Birth and Early Development:

Birth Weight: _____ Was the baby full term? Yes_____ No _____

Cesarean delivery: Yes____ No ____ Cesarean Delivery Scheduled _____ Emergency _____

Explain any problems during pregnancy, birth or neonatal period:

_____

_____

At what age did your child:
Crawl _____ Stand unassisted _____ Walk _____
Speak _____ Speak in sentences _____ Feed Self _____
Become toilet trained _____

About Your Child:
Please "x" if your child:
Bites Nails _____ Sucks fingers/thumb _____ Has trouble sleeping _____

Describe any fears your child has (e.g., the dark, loud noises, etc.)

_____

_____

What is your child's usual bedtime? _____

Would you consider your child:
Usually quiet and reserved _____ Almost always active _____ Sometimes quiet and sometimes active _____
Your child is: Right handed _____ Left handed _____

Is there any additional information that you think would assist us in planning an educational program for your child?

_____

Parent/Guardian Signature _____ Date _____

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Form R-5

Acknowledgement of Required Documentation for Immunizations & Physical Examination

New Jersey State Law requires the following immunizations:

- DTap (3 doses)
- Polio (3 doses)
- MMR (2 doses)
- Hepatitis B (3 doses)
- Varicella (1 dose on or after 1 year of age or proof of disease by physician)
- Meningococcal (1 dose upon entering 6th grade)
- Tdap (1 dose upon entering 6th grade)

I, the undersigned, hereby acknowledge that I have read and understand that if I do not provide an up-to-date and doctor certified immunization record for my child by August 31, 2022, my child will be excluded from school until such time that I provide this documentation.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

A physical exam is required within 365 days of entrance to school and must be presented *by August 31, 2022*.

I, the undersigned, hereby acknowledge that I have read and understand that if I do not provide proof from a doctor that my child has had a physical examination within the previous 365 days, by August 31, 2022, my child will be excluded from school until such time that I provide this documentation.

_____ _____

Signature of Parent/Guardian Date

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Form R-7

Request for Student Records Form
(If Applicable)

Date: _____

To: _____

_____

_____

Phone# _____ Fax# _____

The following student(s) have been enrolled in Hainesport Township School. Please forward all **Academic Records, Health Records**, **Discipline Records**, **Standardized Test Scores, Prereferral Plans/Paperwork** and **Child Study Team Records (including Speech and 504 documentation)** as soon as possible.

For: _____ Grade: _____ DOB: _____
Student Name

_____ Grade: _____ DOB: _____
Student Name

_____ Grade: _____ DOB: _____
Student Name

Please forward records to: Sabrina Glogowski, Registrar
Hainesport Township School
211 Broad Street
Hainesport, NJ 08036

I hereby give my permission for the release of my child's/children's records.

_____ _____
Parent's/Guardian's Signature Date

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Form R-8

New Jersey Home Language Survey

Purpose

The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information

Student Name: _____

Date of Birth (MM/DD/YYYY): _____

Current Address: _____

Survey Questions

1.) List all languages used in the student's home:

_____

2.) Was the first language used by the student a language other than English?

_____ **No** _____**Yes**

3.) Does the student speak or understand a language other than English?

_____ **No** _____**Yes**

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English ***most of the time***?

_____ **No** _____**Yes**

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English ***most of the time***?

_____ **No** _____**Yes**

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Form R-9

Registration Checklist & Submission Form

The following forms must be completed and submitted at the time of registration:
(All forms are mandatory unless otherwise stated)

- ⬜ **Form R-1, Proof of Residency/Domicile**
- ⬜ **Form R-2, Registration Data Form for School Year 2022-23**
- ⬜ **Form R-3, NJ FamilyCare Act Form**
- ⬜ **Form R-4, Student Health History Questionnaire**
- ⬜ **Form R-5, Acknowledgement of Required Documentation for Immunizations & Physical Examination**
- ⬜ **Form R-7, Request for Student Records Form *(if applicable)***
- ⬜ **Form R-8, New Jersey Home Language Survey**
- ⬜ **Form R-9, Registration Checklist & Submission Form**

The following documents must be presented at the time of registration:

- ⬜ **Original Birth Certificate or Letter from DCP&P**
- ⬜ **Four (4) proofs of residency/domicile from the following:**
  - ⬜ *Property tax bills, deeds, contracts of sale, leases, mortgages, signed letters from landlords and other evidence of property ownership, tenancy or residency*
  - ⬜ *Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location*
  - ⬜ *Court orders, State agency agreements and other evidence of court or agency placements or directives*
  - ⬜ *Receipts, bills, cancelled checks and other evidence of expenditures demonstrating personal attachment to a particular location, or where applicable, to support of the student*
  - ⬜ *Medical reports, counselor or social worker assessments, employment documents, benefit statements, and other evidence of circumstances demonstrating, where applicable, family or economic hardship, or temporary residency*
  - ⬜ *Affidavits, certifications and sworn attestations pertaining to statutory criteria for school attendance, from the parent, guardian, person keeping an "affidavit student," adult student, person(s) with whom a family is living, or others as appropriate*
  - ⬜ *Documents pertaining to military status and assignment*
  - ⬜ *Any business record or document issued by a governmental entity*
  - ⬜ *Any other form of documentation relevant to demonstrating entitlement to attend school*
  - ⬜ **IEP/Evaluation Reports (if applicable)**

The following documents must be submitted on or before August 31, 2022:

- ⬜ **Up-to-date, doctor certified immunization record**
- ⬜ **Proof from a doctor that the child has had a physical examination within the previous 365 days**

I, the undersigned, hereby acknowledge that I am lawfully permitted to register the above child at the Hainesport Township School District.

_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

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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. This information may be disclosed only to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

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

Please complete the section below.

Child's Name: _____ Birthdate: _____

I have received the Notification Regarding Parental Consent Form and confirm that I am able to provide informed consent.

Parent/Guardian Signature: _____

As parent/guardian of the child named above, 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).

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 co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

I give consent to bill for SEMI: □ YES □ NO Date: _____

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

Revised January 2022 SEMI Parental Consent

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Medicaid Notification Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and the New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover? Evaluations, Psychological, Counseling, Speech Therapy, Audiology, Occupational Therapy, Physical Therapy, Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Spring/Annual Review Period 2022

Method of Delivery (specify): Registration Packet