

GREENWICH TOWNSHIP SCHOOL DISTRICT

Nehaunsey Middle School
415 Swedesboro Road
Gibbstown, NJ 08027
856-224-4920 ext 2140
Fax 856-224-5765
Dr. Jennifer Foley-Hindman, Principal

Broad Street School
255 West Broad Street
Gibbstown, NJ 08027
856-423-0490 ext 1131
Fax 856-423-7945
Alisa Whitcraft, Principal

Welcome to the Greenwich Township School District.
In order to enroll your student into our district, you will need to:

1. Make an appointment with the appropriate school.
2. Download and complete the appropriate packet at www.greenwich.k12.nj.us
3. If you do not have the technology to duplicate the enrollment packet, please stop at either school for a hard copy.
4. Along with the enrollment packet you will need to provide the following documents:
 1. Transfer card from previous school district
 2. Copy of birth certificate
 3. Copy of immunization records
 4. Copy of physical examination records
 - All students enrolling in school for the first time must have documentation of a completed medical examination completed and signed by a physician within the 365 days prior to the first day of the student's attendance at school
 - All students coming from out of the state or country must provide proof of a completed physical examination within 30 days of school entry
 - All other NJ students must provide documentation of a school entry medical examination
 5. Proof of custodial parent
 6. Release of records form
 7. 504 Plans and/or IEPs if applicable
 8. Residence Enrollment Questionnaire
 9. Proof of residency – MUST PROVIDE FOUR PROOFS

PROPERTY OWNERS – Tax bill, mortgage statement, or settlement statement and three other proofs – gas, electric, water, bank statement, etc.

RENTERS – Current lease with names of all residents in the dwelling (a new lease must be presented when it is renewed) and three other proofs - gas, electric, water, bank statement, etc.

LIVING WITH FAMILY MEMBER OR FRIEND – If you reside with a family member or friend, you will also need a verification of residency form completed and notarized. This form is located on the last two pages of this packet and needs to be renewed annually.

GREENWICH TOWNSHIP SCHOOL DISTRICT



GRADES PRE-K THROUGH 8TH

**If Pre-K, please review the next page entitled
“Parents with Preschool Children” prior to completing the enrollment packet**

If grades 5 through 8, please complete the laptop agreement form

Parents with Preschool Children

If you are a Greenwich Township resident and have a child between three and five years of age and suspect that he/she may be displaying a delay in any one of the following areas:

intellectual functioning
speech and language
social/emotional development
gross/fine motor skills

they are eligible for a **free screening** by the Child Study Team Staff.

The entire Broad Street registration packet **must** be completed **prior** to your calling for an appointment. After you have completed the registration packet, contact the Child Study Team Office to inquire about the schedule or to obtain additional information.

Remember, the earlier you recognize your child's special needs and seek professional help, the greater the possibility that your child can be helped to overcome a problem.

The Greenwich Township School District wants to find some very special Children!!

Call: Child Study Team at 224-4920, Ext. 2160

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RELEASE OF RECORDS PERMISSION

I hereby give permission for _____ to release all academic and health
(Name of School)

records on _____ to _____.
(Name of Student) (Name of School)

I also authorize the release of any Child Study Team evaluations, IEPs, or other relevant information for placement or evaluative purposes.

Parent/Guardian Signature

Date: _____

Student current address:

Telephone Number:

Student forwarding address:

Telephone Number:

School that student is transferring to/from:
Name: _____
Address: _____

County: _____
District: _____

Telephone Number: _____

GREENWICH TOWNSHIP SCHOOL DISTRICT
GIBBSTOWN, NJ 08027

STUDENT REGISTRATION

Please complete the following questions so that we may better know your child and be able to contact you in case of illness or emergency. Thank you for your cooperation.

Today's Date _____

Child's Name _____

Sex: ___M ___F

Racial/Ethnic (Check ALL that apply):

___ American Indian ___ African American ___ Asian

___ Caucasian ___ Hispanic ___ Pacific Islander

Date of Birth _____ City/State of Birth _____ Country of Birth _____

Student's Address _____

Father's Name _____

Mother's Name _____

Mother's Maiden Name _____

City of Birth _____

City of Birth _____

Father's Address _____

Mother's Address _____

Father's Cell # _____

Mother's Cell # _____

Father's email: _____

Mother's email: _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Work Address _____

Work Address _____

Telephone # _____

Telephone # _____

Number of children in family: Female: _____

Ages: _____

Male: _____

Ages: _____

With whom does the child live? _____

If student does not live with parent/s, custody papers WILL be required. Information of person/s student lives with (other than mother/father):

Name: _____ Relation: _____

Address: _____

IN CASE OF EMERGENCY NOTIFY:

1. Name _____ Telephone Number _____

Address _____ Relationship to Child _____

2. Name _____ Telephone Number _____

Address _____ Relationship to Child _____

Is your native language English? Yes ___ No ___ Specify _____

Has your child been under early intervention or Child Study Team/Basic Skills services?

Yes ___ No ___

Specify _____

Has your child had any speech remediations? Yes ___ No ___

Specify _____

Was your child on the free/reduced lunch program at his/her previous school?

___ yes ___ no ___ free ___ reduced

Is there anything about your child's health, habits, or behavior that you would like to comment upon? _____

FAMILY MEDICAL HISTORY:

DATE: _____

Do any of child's immediate family members have the following; if yes, please state sibling, mother, father, grandmother, etc.

	YES	NO	Family Members
Heart Disease	___	___	_____
Diabetes	___	___	_____
Cancer	___	___	_____
Sickle Cell Anemia	___	___	_____
High Blood Pressure	___	___	_____
Allergies/Asthma	___	___	_____

Has your child had or currently have any of the following?

	YES	NO		YES	NO
1. High fevers	___	___	16. Anemia	___	___
2. Seizures	___	___	17. Diabetes	___	___
3. Head Injury	___	___	18. Ringworm	___	___
4. Sutures (Stitches)	___	___	19. Arthritis	___	___
5. Broken Bones	___	___	20. Epilepsy	___	___
6. Operations	___	___	21. Heart trouble	___	___
7. Hospitalizations	___	___	22. Kidney problems	___	___
8. Allergies	___	___	23. Frequent ear infections	___	___
9. Chicken Pox	___	___	24. Frequent headaches	___	___
10. Mumps	___	___	25. Eczema	___	___
11. Measles	___	___	26. Asthma	___	___
12. German Measles	___	___	27. High Blood Pressure	___	___
13. Scarlet Fever	___	___	28. Lyme Disease	___	___
14. Rheumatic Fever	___	___	29. Hepatitis	___	___
15. Fifth Disease	___	___			

**IF YES, PLEASE DESCRIBE

Does your child have any hearing difficulties? Yes ___ No ___ Specify _____

Does your child wear glasses? Yes ___ No ___ Specify _____

Does your child take medication that would be necessary during school hours? Yes ___ No ___
Names of Medications _____

Has your child had routine dental checkups? Yes ___ No ___

Does your child have health insurance? If so, name of company _____

Date of your child's last medical exam: _____

Date of your child's last lead blood test and results: _____

Date of first Polio immunization: _____

GREENWICH TOWNSHIP SCHOOL DISTRICT

ENROLLMENT RESIDENCY QUESTIONNAIRE

Parent/Guardian Name: _____

Date: _____

Please list all children living with you up to age 21. Please include children of all ages and if they are attending an educational program.

Name	Date of Birth	School Attending and Grade (or High School Graduate)

Phone Numbers: _____

Current Address: _____

Previous Address: _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

Section A: Current Living Situation

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this section. Please check all that apply:

- _____ Sharing housing with relatives or other due to lack of housing
- _____ Living in a shelter or transitional living program
- _____ Living in a motel, hotel, park or campground due to lack of adequate housing
- _____ Living in a car or RV or in a public place
- _____ Living in substandard housing
- _____ Awaiting foster care placement
- _____ Parents are migrant workers
- _____ Moving from place to place
- _____ None of the above

School/Schools of origin (school attended when last permanently housed):

I, _____, have been consulted about the school placement that I prefer for my child (check or mark next to appropriate box)

_____ to attend school in the district of last attendance

_____ to attend the district in which we are currently residing

I certify that the information provided here is true and correct. I understand that the Greenwich Township Public School Homeless Liaison has the right to determine who is eligible.

Signed:

Date:

Section B - To be completed by Homeless Liaison:

_____ Homeless

_____ Not Homeless

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Greenwich Township Homeless Liaison Signature:

Date:

Notes/Comments:

Medicaid Annual 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 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
- Nursing
- 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.

Method of Delivery: (check one) ___ Mailed to parent(s) ___ Emailed to parent(s) ___ IEP meeting ___ Hand Delivered

*Greenwich Township School District
415 Swedesboro Road
Gibbstown, NJ 08027*

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

Please sign and return this form to the address listed above

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.

GREENWICH TOWNSHIP SCHOOL DISTRICT
Gibbstown, NJ 08027

AFFIDAVIT OF RESIDENCE BY PARENT
PURSUANT TO N.J.S.A. 18A:38-1(b)

I, _____, of full age, being duly sworn according to law on oath deposes and says:

1. My natural child, _____, and I are currently residing at _____ with _____ in the School District of Greenwich Township, New Jersey.
2. I am aware that I am making an Affidavit (sworn statement) and that I may be subject to penalty for false swearing in the event any of the aforesaid is willfully false or fraudulent. I am further aware that I may be subject to pay tuition or other school charges of the Greenwich Township School District if the facts stated above are not true. This affidavit is given pursuant to the requirements of N.J.S.A. 18A:38-1 (b).

PARENT/GUARDIAN

PARENT/GUARDIAN

Sworn and Subscribed
before me on this _____
day of _____, 20_____

A Notary Public of the State of New Jersey.
My commission expires:

GREENWICH TOWNSHIP SCHOOL DISTRICT
Gibbstown, NJ 08027

AFFIDAVIT OF RESIDENCE BY GREENWICH TOWNSHIP RESIDENT
PURSUANT TO N.J.S.A. 18A:38-1(b)

I, _____, of full age, being duly sworn according to law on my oath deposes and says:

1. I am an adult residing and domiciled within the School District of Greenwich Township, New Jersey, and live at the following address: _____.
2. I am seeking admission to Greenwich Township School District for a minor child who resides with me with his/her parent/guardian.

NAME OF MINOR: _____

NAME OF PARENT/GUARDIAN: _____

3. The minor child and parent/guardian aforesaid have resided with me since _____, and will continue to reside with me until _____.
4. I am making this Affidavit (sworn statement) to induce the Greenwich Township School District to admit _____ as a student without charge since the aforesaid child and parent/guardian are residing with me.
5. I will inform the Superintendent of Schools if there is any change in the above-stated statement.
6. I am aware that I am making an Affidavit (sworn statement) and that I may be subject to penalty for false swearing in the event any of the aforesaid is willfully false or fraudulent. I am further aware that I may be subject to pay tuition or other school charges of the Greenwich Township School District if the facts stated above are not true. This Affidavit is given pursuant to the requirements of N.J.S.A 18A:38-1 (b).

PARENT/GUARDIAN

PARENT/GUARDIAN

Sworn and Subscribed
before me on this _____
day of _____, 20_____

A Notary Public of the State of New Jersey.
My commission expires:

** Completion of this form does not guarantee approval. This must be renewed annually **