**Consent to Share Data and Seek Payment for Individualized Family Service Plan (IFSP)/Individualized Education Program (IEP) Health- Related Services and Evaluation Services**

Southern Plains Education Cooperative  Blue Earth Area  Fairmont Area  Granada-Huntley-East Chain  Martin County West  United South Central

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| **Section 1: Student Information** | | | |
| Child’s Name: | Child’s Birthdate: | | |
| Child’s Home Address: | City: | MN | Zip: |
| Parent/Legal Guardian Name: | Is your address the same as your child’s?  **YES**  **NO** |  | If No, please provide below |
| Address: | City: | MN | Zip: |
| **Section 2: Complete if your child is enrolled in a MN Health Care Program** | | | |
| The school district(s) indicated above will bill MA or MinnesotaCare for the health-related evaluation and IFSP/IEP services your child receives. The type, amount and frequency of services are in your child’s IFSP/IEP. We need your signature to share data with the Minnesota Department of Human Services (DHS) to bill for these services and evaluations. The information includes your child’s name, date of birth, member number, dates of service and type of service codes. If audited by DHS or the U.S. Department of Health and Human Services (DHHS), the data shared may also include your child’s IFSP/IEP, evaluation reports, documentation of service and attendance and medical orders.  I understand this is a release to share data with DHS and DHHS. It starts on \_\_\_/\_\_\_/\_\_\_ and is good for the evaluating of my child for IFSP/IEP services whether or not resulting in special education services, and while he/she is eligible for special education should he/she qualify for services.   * I can change or stop this release in writing at any time. * The type, amount, and frequency of services are in my child’s IFSP/IEP. * If I ask, I can get copies of all data shared with DHS or DHHS. * I can get a copy of this release. * Laws that protect private data sometimes allow the data to be re-disclosed. * If I do not give information to not agree to share data with DHS and DHHS, my child’s IFSP/IEP services will not change or stop. * For children with an IFSP: My child has an IFSP and I have received a copy of the state system of payments policy, which includes: (1) Consent to Share Data and Seek Payment for IFSP Health-Related Services; and (2) Written Annual Notice Related to Third Party Billing for IFSP Health-Related Services. This policy will be provided to me each time my consent is required.   **Child’s Minnesota Health Care Program Member Number: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_**  My signature allows the district to release information to: 1) DHS to get paid from MA or MinnesotaCare, and 2) DHS or DHHS in case of an audit.  **Parent/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | | |
| **Section 3: Complete if your child has Private Health Insurance Primary to MN Health Care Program** | | | |
| If your child is on MA or MinnesotaCare and your private health insurance does not cover the IFSP/IEP or evaluation services your child receives, the district may bill MA or MinnesotaCare\* but first we need information about your private health insurance coverage. The school district will use this information to determine if the private insurance company covers the IFSP/IEP health related and evaluation services your child receives, but will **NOT** bill the insurance company for any services.  *Name of Private Insurance Company*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Policy Holder/Member Name*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Child’s Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Relationship to child: Mother*  *Father*  *Other*  I understand:   * The district will use my private health insurance information to only determine whether or not my private insurance covers the IFSP/IEP health-related services and evaluations that my child receives, but the district will not bill the private insurance company. * If the private insurance does not cover the IFSP/IEP health-related services or evaluations my child receives, the school district can bill MA or MinnesotaCare. (see Section 2)   ***\*The districts in the cooperative of Southern Plains Education Cooperative do NOT bill private insurance companies. We will only use this consent to obtain a denial of coverage determination from the private health insurance plan.*** | | | |
| **Parent/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | | |
| **Section 4: Complete ONLY if you do NOT want the district to bill MHCP for your child’s IFSP/IEP health-related services.** | | | |
| Release or Consent Denied: I choose to not let the district:   * Share information with DHS to get paid for covered IFSP/IEP health-related services or evaluation services. * Ask my private health insurer if IFSP/IEP health-related services are covered. If the services are not covered, the school district can bill MA or MinnesotaCare. | | | |
| **Parent/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | | |