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

Section 1: Complete if your child receives special education.

Child's Last Name: _____ First Name: _____ Middle Initial: ___ Birthdate: _____

Child's Home Address: _____

_____

City: _____ State: ___ Zip: _____

Parent 1 Name: _____

Is your address the same as your child's?:

☐ Yes ☐ No (If no, please provide.)

Address: _____

_____

City: _____ State: ___ Zip: _____

Parent 1 Phone Number(s)

Home: _____

Work: _____

Other: _____

Parent 2 Name: _____

Is your address the same as your child's?:

☐ Yes ☐ No (If no, please provide.)

Address: _____

_____

City: _____ State: ___ Zip: _____

Parent 2 Phone Number(s)

Home: _____

Work: _____

Other: _____

Section 2: Complete if your child has Medical Assistance (MA) or MinnesotaCare.

School District # _____ will bill MA or MinnesotaCare for the health related 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. 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 _____ and is good as long as my child is eligible for special education.
- 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 or do not agree to share data with DHS and DHHS, my child's IFSP/IEP services will not change or stop.

Minnesota Health Care Program (MHCP) 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 if there is an audit.

Parent/Legal Representative Signature: _____ Date: _____

Section 3: Complete if your child also has Private Health Insurance

For children with an IFSP: Your consent below is required when private health insurance is billed initially and whenever the IFSP is revised due to an increase (in frequency, length, duration or intensity) in the provision of services in your child's IFSP. (34 CFR §303.520(b)(1)(i)).

If your child is on MA or MinnesotaCare and your private health insurance does not cover the IFSP/IEP services your child receives, the district may bill MA or MinnesotaCare. So that we can determine if your insurance covers the services, we need information about your private health insurance coverage. The school district will use this information to determine if the private health insurance company covers the IFSP/IEP health-related services your child receives.

Name of private insurance company: _____
Policy Holder/Member's Name: _____
Group or Policy Number: _____
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 determine whether or not my private insurance covers the IFSP/IEP health-related services that my child receives.
- If the private insurance does not cover the IFSP/IEP health related services my child receives, the school district can bill MA or MinnesotaCare. (see Section 2).
- 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.

Parent/Legal Representative Signature: _____ Date: _____

Section 4: Complete if you do not want the district to bill MA, MinnesotaCare or any insurer 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.
- 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.

I understand

- By signing below, my child's IFSP/IEP services will not change or stop; and
- I can get a copy of this form.

Parent/Legal Representative Signature: _____ Date: _____