Midwest Special Education Cooperative #398 203 S. Columbia Avenue, Morris, MN 56267 Toll free 1-877-949-2667 or 320-585-2242	**Consent To Seek Payment for IEP Health Related Services**

Your child's school is asking for your help to access more funding for our children with special needs. The district is required to ask you for this information. We hope you will give it your careful consideration. You are not required to fill out this form. If you do or do not to fill out this form, the services on your child's Individualized Education Program (IEP) will not change in any way.

Section 1: Complete this section if your child is eligible for special education and receives health related services.

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

Birthdate: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Parent(s') Name(s): _____

Parent(s') Address: _____

_____

Parent(s') Phone Number(s): home _____ work _____ other _____

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

Medical Assistance/MinnesotaCare Release

District # _____ will bill MA or MC for health related services given to my child. To do this, the district will give required information for payment to the Minnesota Department of Human Services (DHS). This information includes my child's name, date of birth, MA/MC member number, dates covered services are given, and a code for the type of service. If DHS audits the payments made to the district for my child, the information released may also include my child's IEP, IEP health related services documentation, and medical orders. This release starts on _____ and is good as long as my child is eligible for special education or until I tell the district in writing to stop. I can tell the district to stop at any time. If I ask, I can get copies of all information shared with DHS.

My signature below lets the district release information to DHS to get paid.

Parent/Legal Representative Signature: _____ Date: _____

Medical Assistance/MinnesotaCare Information

Minnesota Health Care Programs Member Number # ___ / ___ / ___ / ___ / ___ / ___ / ___ / ___

Social Security # _____ - _____ - _____ If I give my child's social security number, it will only be used to check my child's eligibility for MA or MC.

Participating Districts:

Browns Valley #801, Chokio-Alberta #771, Clinton-Graceville-Beardsley #2888, Cyrus #611, Hancock #768, Herman-Norcross #264, Morris Area #769, West Central Area #2342 and Wheaton #803

A copy is as valid as an original.

Section 3: Complete if your child has both Medical Assistance (MA) or MinnesotaCare (MC) and Private Insurance and you want to give the district consent to ASK your private plan about coverage but NOT to bill your private insurance.

Private Insurance Consent and Release

My child is covered by both private insurance and MA or MC. (This includes children eligible for MA through waiver programs or TEFRA.)

I give permission to district # _____ to **ask** my insurance if they would pay the district for the following Individualized Education Program (IEP) health related services provided from _____ to _____ *(initial all that you agree the district can ask about*):

___ Assistive Technology Devices
___ Mental Health Services
___ Nursing Services
____ Occupational Therapy
____ Physical Therapy
____ Speech-Language/Hearing Therapy

I agree to let the school district share education records needed in order to **ask** about coverage of the services initialed above. Records that may be shared include: IEPs, documentation of health related services and medical orders needed for billing purposes and quality of care.

I have read and understand the information given to me about asking my insurance about coverage for my child's IEP health-related services and the possible effects. I understand my consent for release of information starts on _____ and is valid for one year from this date. I can stop this agreement in writing at any time before the year is over. I can ask for and get copies of all information shared.

My signature below lets the district share this information with my health plan only to ask about coverage.

Parent/Legal Representative Signature: _____ Date: _____

Private Health Plan Information

Name of Insurance Company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurance Type: ☐ Health Maintenance Organization (HMO) ☐ Group (GP) ☐ Champus (CH)
☐ Preferred Provider Organization (PPO) ☐ Individual Policy (IP) ☐ Other (OT): _____

Is this an employer-sponsored plan? If yes, name of employer: _____

Group or Policy # _____ Student's Insurance ID # _____

Policy Holder's Last Name: _____ First Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Relationship: ☐ Mother (32) ☐ Father (33) ☐ Other (G8)

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A copy is as valid as an original.

Section 3 (continued): Complete if your child has both MA/MC and Private Insurance and you want to give the district consent to ASK your private plan about coverage but NOT to bill your private insurance.

Medical Assistance/MinnesotaCare Release

District # _____ will bill MA or MC for health related services given to my child. To do this, the district will give required information for payment to the Minnesota Department of Human Services (DHS). This information includes my child's name, date of birth, MA/MC member number, dates covered services are given, and a code for the type of service, my name, date of birth and insurance information. If DHS audits the payments made to the district for my child, the information released may also include my child's IEP, IEP health related services documentation, and medical orders. This release starts on _____ and is good as long as my child is eligible for special education or until I tell the district in writing to stop. I can tell the district to stop at any time. If I ask, I can get copies of all information shared with DHS.

My signature below lets the district release information to DHS to get paid.

Parent/Legal Representative Signature: _____ Date: _____

Medical Assistance/MinnesotaCare Information

Minnesota Health Care Programs Member Number # ___ / ___ / ___ / ___ / ___ / ___ / ___ / ___

Social Security # _____ - _____ - _____ If I give my child's social security number, it will only be used to check my child's eligibility for MA/MC.

If your child receives Personal Care Attendant Services (Paraprofessional) please see the attached medical release that allows us to notify your primary care physician of the PCA services being provided during the school day.

Section 4: Complete if you do not want the district to: share information with the Minnesota Department of Human Services, bill your private health plan, or ask your private health plan.

Release or Consent Denied

I choose to not let the district:

- ☐ Share information with the Minnesota Department of Human Services
- ☐ Bill my private health plan
- ☐ Ask my private health plan about coverage

I understand by signing below there is no impact on the IEP services my child receives.

Parent/Legal Representative Signature: _____ Date: _____

Section 5: Complete if you want the district to STOP sharing information, asking about coverage, or billing your private plan.

Revocation

- ☐ I want the district to **stop** sharing my child's education records with my child's doctor or clinic starting _____.
- ☐ I want the district to **stop** asking my health plan about coverage starting _____.
- ☐ I want the district to **stop** billing my health plan starting _____.
- ☐ I want the district to **stop** sharing my child's educational records with the Department of Human Services starting _____.

I understand by signing below there is no impact on the IEP services my child receives.

Parent/Legal Representative Signature: _____ Date: _____

Participating Districts:
Browns Valley #801, Chokio-Alberta #771, Clinton-Graceville-Beardsley #2888, Cyrus #611, Hancock #768, Herman-Norcross #264, Morris Area #769, West Central Area #2342 and Wheaton #803