Date Expires _______________ **Current Presenter** ______________________________ **ID** ______________________

St. Cloud Area School District 742
Consent to Seek Payment for Special Education Health Related Services

The district is required by Minnesota law to ask you annually about your child's health insurance. If you give this information, the District may be able to get more funds to serve children with special needs. If you decide not to provide this information, the services on your child's IEP/IIIP/IFSP will not change in any way.

Section 1: Complete this section if your child receives special education or is being assessed for special education.

Last Name:	First Name:	Middle Initial:	DOB: / /
Parent Name:	MHCP#:	Social Security#: – –	

Section 2: Complete this section if your child is covered by Medical Assistance (MA) or MinnesotaCare (MNCare). This may include eligibility for MA through waiver programs, TEFRA, or PMAP:

____ I agree to allow the district to share education records with the MN Department of Human Services and auditing agencies as needed to get payment for IEP health related services. Records that can be shared include: Individualized Education Program (IEP), Individual Interagency Intervention Plan (IIIP), Individual Family Service Plan (IFSP), documentation of health related services, diagnostic assessments, and medical orders. My signature below allows the district to share records as long as my child receives IEP health related services.

____ The District **may not** share my child's education records for the purpose of third party billing.

Section 3: Complete this section if your child is covered by MA or MNCare <u>AND</u> private health insurance. This will give the district consent to <u>ASK</u> about required documentation and coverage. The District will <u>NOT</u> bill your private health insurance.

____ I agree to allow the district to ask my health insurance if they would cover the following IEP/IIIP/IFSP health related services for the current school year. I understand that this documentation is necessary to allow the school district to bill MA/MNCare for services my private health insurance does not cover (check services that apply; permission for all services will be assumed unless specific services are checked).

____ Assistive Technology ____ Mental Health Therapy ____ Nursing or PCA Services
____ Occupational Therapy ____ Physical Therapy ____ Speech Language/Hearing Therapy

Section 4: Complete this section if your child is <u>ONLY</u> covered by private insurance.

____ I give permission to the school district to bill my private insurance for the following IEP/IIIP/IFSP health related services provided, and authorize payment directly to the district. I agree to let the school district release education records for the current school year which include: Individualized Education Program (IEP), Individual Interagency Intervention Plan (IIIP), Individual Family Service Plan (IFSP), documentation of health related services, diagnostic assessments, and medical orders that are needed for billing purposes and quality of care. I understand my consent for billing and release of information are needed each year, that a copy of this permission will be placed in my child's school record, and that I may take away my consent at any time.

____ I choose not to provide information to the school district regarding my private insurance at this time.

Section 5: If your child has private health insurance and you gave consent for the school district to inquire about coverage, provide the following information. Please complete this section if you said yes to sections 2 and 3.

Health Insurance Company:		
Policy Holder Name:	Policy Holder Employer:	
Policy Holder DOB: / /	Policy#:	
Company Mailing Address:		
Company City:	Company State:	Company Zip:

Section 6: Complete this section if your child will be receiving Personal Care Assistant services from a District paraprofessional and/or Nursing Services. Physician's orders are required annually to bill MA/MNCare.

____ I give permission to the district to contact my child's physician to obtain authorization for Personal Care Assistant services from a District paraprofessional and/or Nursing Services provided to my child during school hours.

Physician:	Clinic/Facility:	
Mailing Address:	Phone:	
City:	State:	Zip:

<u>Parent/Guardian Signature and Date Required</u>

I understand the information given to me about seeking payment from my insurance for my child's IEP health related services. I understand my consent for release of information related to private insurance, personal care assistant services and/or nursing services is valid for one year from the signed date. I can stop the agreement in writing at anytime. I can ask for and get copies of all information shared.

Parent/Guardian Signature: ____ Date: ____________________

Form not completed: ☐ Refuses to Sign ☐ No Response to Requests ☐ Other ____________________