Early Support for Infants & Toddlers (ESIT)

Prior Written Notice, Consent to Access Public and/or Private Insurance, Income and Expense Verification Form

Date:		Early Intervention Program – LLA or Provider:	
FRC Name:		FRC Phone:	

Section A: Identifying Information

Child's Legal Name:	Last	First	Middle	Child's Date of Birth:	xx/xx/xxxx
Parent/Guardian's Name(s):				Phone:	

Section B: Public and Private Health Care Coverage's Prior Written Notice and Consent *for services subject to Family Cost Participation* (Completed by Parent - Check all that apply)

B.1. Apple Health for Kids / Medicaid (Public Health Care Coverage)

☐ **I give permission** for ESIT providers to submit claims to Apple Health for Kids/Medicaid (my public health care coverage) for IDEA Part C early intervention services that will be provided in accordance with my child's IFSP. I authorize ESIT to release personally identifiable information to Apple Health/Medicaid in order to request payment of benefits. I understand that if I have private health care coverage/insurance, Apple Health/Medicaid has the right to recoup the costs from my insurance carrier. I understand that I may revoke this permission at any time by notifying my Family Resources Coordinator.

☐ **I understand** that early intervention providers will obtain my consent if access to Apple Health for Kids/Medicaid will result in any of the following:

- A decrease in the available lifetime coverage or any other insured benefit for my child or other family members
- Result in paying for services that would otherwise have been paid for by Medicaid
- Result in any increase in premiums or cancellation of Medicaid for my child or other family members
- Risk the loss of eligibility for my child or other family members for home and community-based waivers based on total health-related costs.

☐ **I do not give permission** for ESIT providers to submit claims to Apple Health/Medicaid for the IDEA Part C early intervention services that will be provided in accordance with my child's IFSP. Due to this decision, I understand that I must complete Sections C and D of this form in order to establish my Monthly Fee. If I do not complete Sections C and D of this form, I understand I will be placed at the highest level on the Monthly Fee Schedule based on family size.

I agree to the terms of the payment option I have chosen and acknowledge receipt of the System of Payments and Fees Policy Parent / Guardian's Signature(s):	Date:

B.2. Private Health Care Coverage / Insurance					
Primary Insurance Name:		Policy #:		Group #:	
Secondary Insurance Name:		Policy #:		Group #:	

☐ **I have been made aware** of the general categories of costs that my family may incur as a result of using my private health care coverage/insurance for IDEA Part C early intervention services, such as:

- Co-payments, co-insurance, premiums, or deductibles
- Long term costs, such as loss of benefits because of annual or lifetime insurance caps under the family's Insurance policy
- The possibility that the use of insurance may negatively affect the availability of the family's insurance coverage
- The possibility that insurance coverage may be discontinued due to the payment for Part C early intervention services
- The potential that insurance premiums may be affected by the use of private insurance to pay for early intervention services

☐ **I give my consent** for ESIT providers to submit claims to my private health care coverage/insurance for the IDEA Part C early intervention services that will be provided in accordance with my child's IFSP. I authorize ESIT to release personally identifiable information to my private health care coverage/ insurance in order to request payment of benefits. I authorize my private health care coverage/ insurance to make payments to the ESIT provider. I understand that I may revoke this permission at any time by notifying my Family Resources Coordinator.

☐ **I do not give my consent** for ESIT providers to submit claims to my private health care coverage/insurance for Part C early intervention services that will be provided in accordance with my child's IFSP. I understand that I will be responsible for paying for these services based upon the Monthly Fee Schedule and criteria. I understand that I must complete Sections C and D of this form in order to establish my Monthly Fee. If I do not complete Sections C and D of this form, I understand I will be placed at the highest level on the Monthly Fee Schedule based on family size.

☐ **I waive completion** of Sections C and D of this form and understand that means I will be responsible for all co-pays, co-insurance and deductibles that result from the use of my private health care coverage.

I agree to the terms of the payment option I have chosen and acknowledge receipt of the System of Payments and Fees Policy Parent / Guardian's Signature(s):	Date:

B.3. No Public or Private Health Care Coverage

☐ **I have been made aware** that I will be charged a Monthly Fee based on family size and income because I do not have either private or public insurance (Apple Health for Kids/Medicaid) coverage to help pay for the IDEA Part C early intervention services that will be provided in accordance with my child's IFSP.

I agree to the terms of the payment option I have chosen and acknowledge receipt of the System of Payments and Fees Policy Parent / Guardian's Signature(s):	Date:

Section C: Documentation Used To Verify Annual Income (Completed by Parent)

All families requesting the inability to pay determination or all families requesting placement on the Monthly Fee Schedule based on family size and adjusted annual income, will need to provide proof of income. (Please note only one document type will be needed to demonstrate proof of income.)

Documentation Type: Select only one		Household Total Annual Income:
☐	Self-employed-other non-wage. Please include most recent IRS 1040 tax form.	
☐	Last two (2) consecutive pay stubs (gross income)	
	☐ Weekly amount	
	☐ Bi-weekly amount	
	☐ Monthly amount	
☐	Most Recent W2(s) and/or 1099(s) *(Form W2=line 1; 1099=total of lines 1, 2 & 3)*	
☐	Written Statement of Salary or Wages Attached (Must include company or employer's name, address, phone number, and supervisor or human resource staff signature.)	

Section D: Allowable Annual Expenses (Completed by Parent)

You *must provide* documentation with this form for **non-reimbursed** expenses incurred for the child and/or other family members **during the past twelve months or previous tax year.**

Allowable Non-Reimbursed Annual Expense Categories	Expense Amount
Medical, dental and mental health expenses including premiums, co-pays, co-insurance , deductibles and non-covered services	
Home Health Care provided by licensed Home Health agency	
Child Support/Alimony Payments	
Child Care Costs incurred while working or going to school	
TOTAL ALLOWABLE ANNUAL EXPENSES	

Total Number of Persons in Household (Family Size):	

Section E: Adjusted Annual Income and Inability to Pay Determination (Completed by FRC or EIS Staff)

Income, Expense, and Monthly Fee Information		
1.	Total Annual Income (as documented in Section C):	
2.	Allowable Annual Expenses (as documented in Section D):	
3.	Annual Expense Exemption (Line 1 - Total Annual Income multiplied by 0.10 or 10%):	
4.	Total Allowable Annual Expenses(Line 2 minus Line 3; if Line 3 is more than Line 2, enter 0 in line 4):	
5.	Adjusted Income for placement on Monthly Fee Schedule(Line 1 minus Line 4):	

Meets Inability to Pay Criteria if Line 5 is below 200% of the Federal Poverty Level for family size			
☐	Yes – For families with or without insurance, the family will not be required to pay co-pays, co-insurance, deductible or Monthly Fee. IDEA Part C or other agency funds may be used to cover these costs.	☐	No – For families with insurance, the family pays co-pays, co-insurance, and deductibles
		☐	No – For families without insurance or families who decline access to their insurance, the family is placed on the Monthly Fee Schedule. Monthly Fee: _____

Section F: Parent Confirmation

I hereby affirm that the information provided, reviewed, and documented on this form is accurate and complete to the best of my knowledge.

Parent / Guardian's Signature(s):	Date:

Section G: Staff Review of Income and Expense Verification Form

Reviewed By:

FRC or EIS Staff Signature:	Printed Name:	Date: