Bemidji Regional Interdistrict Council

Bagley, Blackduck, Cass Lake-Bena, Clearbrook, Gonvick, South Koochiching, Kelliher, Lake of the Woods, Laporte, Littlefork-Big Falls, Mahnomen, Waubun

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Brenda Story, Director

Consent to Share Data & Seek Payment for IFSP/IEP Health Related Services

Personal Data

Child's Name: Last _____ First _____ MI: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian Name(s): _____

Phone #'s: _____ (Home) _____ (Cell)

Complete if your Child has Medical Assistance (MA) or Minnesota Care (MNCare)

District # _____ will bill MA or MNCare 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 MN Dept of Human Services (DHS) to bill for these services. The data includes your child's name, date of birth, member number, dates of service and type of service codes. If audited by DHS, or the US Dept of Health & Human Services (DHHS), the data shared may also include your child's IFSP/IEP, evaluation reports, documentation of service, attendance and medical orders.

I understand the release to share data with DHS & DHHS:

* Starts on _____ 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 sign the release, my child's IFSP/IEP services will not change or stop.

MA / MNCare Programs Member Number (8 digits) _ _ _ _ _ _ _ _

My signature allows the district to release information to:

1) DHS to get paid from MA or MNCare, and

2) DHS or DHHS, if there is an audit.

Parent/Guardian Signature: _____ Date: _____

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 MNCare and your private health insurance does not cover the IFSP/IEP services your child receives, the district may bill MA or MNCare. 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 insurance company covers the IFSP/IEP health related services your child receives.

Name of private insurance company: _____

Policy Holder/Member 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 and 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/Guardian Signature: _____ Date: _____

Complete if you do not want the district to bill MA, MNCare 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 Guardian Signature: _____ Date: _____

WRITTEN ANNUAL NOTICE RELATING TO THIRD PARTY BILLING FOR IEP HEALTH-RELATED SERVICES

Before billing Medical Assistance (MA) or MinnesotaCare (MNCare) for health-related services the first time, and each year, the district must inform you in writing that:

1. The district will share data related to your child and health-related services on your child's IEP with the Minnesota Department of Human Services (DHS) to determine if your child is covered by MA or MNCare and whether those services may be billed to MA or MNCare.
2. Before billing MA or MNCare for health-related services the first time, the district must obtain your consent, including specifying the personally identifiable information that may be disclosed (e.g., records or information about the services that may be provided), the purpose of the disclosure, the agency to which the disclosure may be made (i.e. the MN DHS) and which specifies that you understand and agree that the school district may access your (or your child's) public benefits or insurance to pay for health-related services.
3. The district will bill MA or MNCare for the health-related services on your child's IEP. Minn.Stat.§125A.21,Subd.2(c)(1).
4. The district may not require you to sign up for or enroll in MA or MNCare or other insurance programs in order for your child to receive special education services.
5. The district may not require you to incur an out-of-pocket expense such as the payment of deductible or copay amounts incurred in filing a claim for health services provided, but may pay the cost that you otherwise would be required to pay.
6. The district may not use your child's benefits under MA or MNCare if that use would: decrease available lifetime coverage or any other insured benefit; result in your family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time your child is in school; increase your premiums or lead to the discontinuation of benefits or insurance; or risk your loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
7. You have the right to receive a copy of education records the district shares with any third party when seeking reimbursement for IEP health-related services. Minn. Stat. § 125A.21, Subd. 2(c)(2).

You have the right to stop your consent for disclosure of your child's education records to a third party, including the Department of Human Services, at any time. If you stop consent, the district may no longer share your child's education records to bill a third party for IEP health-related services. You can withdraw your consent at any time, and your child's IEP services will not change or stop. Minn. Stat. § 125A.21, Subd. 2(c)(3).

Excerpt from *Part B Notice of Procedural Safeguards Parental Rights for Public School Special Education Students*. http://education.state.mn.us/MDE/SchSup/ComplAssist/ProcSafe/index.html, Page 7, Revised April 2013