CHILD AND FAMILY CONNECTIONS
CONSENT TO USE PRIVATE INSURANCE/HEALTHCARE PLAN BENEFITS &
ASSIGNMENT OF RIGHTS FOR SPECIFIC SERVICES

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

Child's Date of Birth (Month/Date/Year): _____

EI Number: _____

Private Insurance/Healthcare Plan Benefits:
As an Early Intervention (EI) family, I understand my private health insurance/healthcare plan benefits (hereinafter referred to as "Plan") could be used to pay for certain EI direct services. I understand there are certain EI services which are provided at no cost through the Individuals with Disabilities Education Act (IDEA) Part C (See *CFC Notice of System of Payments and Fees*). I understand there is no charge to me or my Plan for Service Coordination, Evaluations, Assessments and the creation and implementation of the Individualized Family Service Plan (IFSP).

I understand I have been provided a copy of the *CFC Notice of System of Payments of Fees* explaining all potential uses and risks involved in my Plan's use or non-use and I understand I must allow EI to verify my Plan to determine potential use and coverage.

I understand that unless I possess an Employer Self-funded plan, I must allow EI, if appropriate, to submit claims for any covered services. If it is verified I possess an Employer Self-Funded plan, I understand EI must obtain my consent before submitting any claims to the plan for covered EI services subject to private insurance billing.

I understand that I am responsible for checking and confirming the coverage of my Plan and sharing any concerns with my Service Coordinator. I agree to cooperate with providing current and up-to-date Plan information and assist in whatever way necessary to ensure prompt processing of any claims submitted to my Plan including notification to providers of any rejections.

I understand that if my Plan sends payment(s) directly to me that I must forward any payment(s) to the EI provider involved. Failure to forward the payment(s) could result in legal action by the EI provider.

Employer Self-Funded Plans:
I possess an employer self-funded plan. By signing below, I agree to allow EI (or its' designee) to bill my plan for covered services and I consent to the assignment of rights of payment to EI (or its' designee). I understand I can decline the use of my employer self-funded plan benefits and, if I decline, my child will still receive EI direct services consented to on the IFSP Implementation and Distribution Authorization page. I also understand if I do consent, that I can revoke my consent at any time except to the extent it has already been acted upon.

Tax Savings Plan Benefits attached to my Private Insurance/Healthcare Plan
If I possess/utilize a Tax Savings Plan such as a Health Savings Account, Medical Savings Account, Health Reimbursement Account or any account utilizing pre-tax dollars for payment of allowable out-of-pocket medical services not otherwise paid by insurance, I understand I am required to provide my Service Coordinator with current information regarding any such account. Failure to disclose this information at any time in EI could result in lost funds from the accounts, which are not reimbursable by EI.

Waiver or Exemption of Use of Private Insurance/Healthcare Plan

I understand that even if EI (or its' designee) submits claims to my Plan that those services may not be covered. If the service is not covered by my Plan, OR if there are no insurance enrolled providers who can provide EI services, EI may waive or exempt the procedure for an EI provider to submit claims to my Plan. This will allow the EI provider to submit claims directly to EI for payment. I understand my Service Coordinator will inform me if any of my child's services will receive a waiver or exemption from private insurance/healthcare plan use. I understand I am responsible for understanding the deductible aspect of my private insurance/healthcare plan benefits.

I also understand that if I participate in Family Participation Fees AND EI pays for any services due to deductibles, waivers or exemptions, this may impact the amount of Family Participation Fees I owe. I understand I am not required to pay more than the maximum out of pocket calculated based on my ability to pay.

By specifying only certain services on this consent, I understand that I must still sign the Assignment of Rights form for those consented services to be billed to my private health insurance plans.

I also understand that if I possess an Employer Self-Funded Plan, that I may consent for only partial IFSP services to be billed to and/or paid for by my Private Insurance using the check list below to indicate which services I do and do not provide consent for,

Use this section for EMPLOYER SELF-FUNDED PARTICIPANTS as indicated on the benefits verification results page from the EI Central Billing Office

I allow or decline the Illinois Department of Human Services, EI Providers to submit claims to my private insurance for the specified service(s) for those boxes.

Allow	Decline	Service	Allow	Decline	Service
☐	☐	Speech Therapy	☐	☐	Speech Therapy Group
☐	☐	Physical Therapy	☐	☐	Physical Therapy Group
☐	☐	Occupational Therapy	☐	☐	Occupational Therapy Group
☐	☐	Social Work Therapy	☐	☐	Social Work Therapy Group
☐	☐	Psychological Therapy	☐	☐	Psychological Therapy Group
☐	☐	Nutrition Therapy	☐	☐	Assistive Technology (Durable Med. Equip.)
☐	☐	Audiology	☐	☐	Aural Rehabilitation (other related services)
☐	☐	Health Consult	☐	☐	Nursing
☐	☐	Vision	☐	☐	Other _____

Assignment Of Rights Of Insurance:

By signature below, I hereby assign the benefits from my Plan to be paid to my child's authorized EI provider(s) or its designee.

Parent's/Guardian's Printed Name: _____

Parent's/Guardian's Signature: _____ Date _____

Witness's Signature: Date:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.