



Intermediate School District 917
Special Education Office
1300 East 145th St. Rosemount, MN 55068

Combined Consent To Share Data and Seek Payment for Individualized Education Plan (IEP) Health Related Services

Section 1: Complete if your child receives special education.

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 if your child has Medical Assistance (MA) or MinnesotaCare (MNC).

Intermediate School District 917, and the student's transportation district, will bill MA or MNC for the health related services your child receives. The type, amount, and frequency of services are in your child's Individualized Education Program (IEP). We need your signature to share data with the Minnesota Department 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.

In audits by DHS, or the U.S. Department of Health and Human Services (HHS), the data shared may also include your child's IEP, evaluation reports, service and attendance records, and medical orders.

- I understand the release to share data with DHS and HHS:**
- Starts on 9/1/11 and is good as long as my child is eligible for special education.
 - Can be changed or stopped by me at any time in writing.
- I understand:**
- The type, amount, and frequency of services are in my child's 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 IEP services will not change or stop.

Medical Assistance/MinnesotaCare Information

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

Medical Release

If your child receives **nursing or personal care assistant** services at school, we must get medical orders from your child's doctor or clinic. We need to tell the doctor or clinic your child's name, date of birth, why your child needs services, and the type(s) of health services your child receives during school hours. This release starts on 9/1/11 and is good for one year or can be stopped sooner in writing.

Name of Doctor/Clinic: _____
 Address: _____ City _____ State _____ Zip _____
 Phone number(_____) _____

NOTE: We need your consent each year to share data to get medical orders. Please initial and date here if we can share data to get orders for nursing and/or personal care assistant services. If your child's doctor or clinic information is new, please change above.
 Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____

My signature allows the district to release information: 1) to DHS to get paid from MA or MNC; 2) to DHS or HHS if there is an audit; and 3) to my child's doctor or clinic for medical orders if checked above.

Parent/Legal Representative Signature: _____ **Date:** _____

Section 3: Complete if your child also has Private Health Insurance and you AGREE the district can ask about coverage or bill the plan.

Intermediate School District 917 can:

Ask my insurance/HMO if they pay for the Individualized Education Program (IEP) services and assessments initiated below.

- I give permission to **ask** my insurance/HMO about these services from 9/1/11 to 8/31/12

Bill my insurance for the Individualized Education Program (IEP) health related services and assessments initiated below.

- I give permission to **bill** my insurance/HMO for these services from _____ to _____

Initial below, all the services you agree the district can ask about or bill:

<input type="checkbox"/> Assistive Technology Devices	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Nursing Services	<input type="checkbox"/> Speech-Language/Hearing Therapy
<input type="checkbox"/> Interpreter Services	

I agree:

To let the school district share education records needed in order to ask about or bill for the services initiated above.

- Records that may be shared include: IEPs, evaluation reports, service and attendance records, and medical orders needed for billing purposes and quality of care.

I understand:

- If my insurance/HMO does not cover the services, the district can bill Medical Assistance (MA) or MinnesotaCare (MNC).
- If I give permission only to **ask** my insurance/HMO and they do cover the service, the district **will not** bill my insurance/HMO and **will not** be able to bill MA or MNC.
- The information given to me about asking/billing my insurance for my child's IEP health-related services and the possible effects.
- My consent and release of information starts on 9/1/11 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.
- I will get a copy of this release.
- Laws that protect private information sometimes allow the information to be re-disclosed.
- I do not have to give information or sign the release and it will not change or stop the IEP services my child gets.

Please give us this information about your child's Private Health Plan

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: _____

Mom (32) Dad (33)

Other (G8)

My signature lets the district share information with my private health plan

Parent/Legal Representative Signature: _____ Date: _____