Infant & Toddler Connection of Virginia

Family Cost Share Agreement Form ____*Initial* ____*Revised* ____*Annual*

Child's Name: ____ **DOB:** ___________________

I understand that there are charges for services my child receives. I can choose not to provide financial information and pay all applicable co-payments, co-insurance, deductibles, and/or the full early intervention rate for services not covered by insurance. If this represents a financial hardship, I can provide financial information to determine a monthly maximum cap, based on the family cost share system. I can choose whether or not to use my medical insurance to pay for early intervention services.

USE OF MEDICAL INSURANCE (check all that apply)

☐ **Uninsured:** My child is not covered by any medical insurance.

- ❍ I want my service coordinator to help me apply for Medicaid.
- ❍ I want my service coordinator to help me apply for Family Access to Medical Insurance Security Plan (FAMIS).
- ❍ I am already in the process of applying for Medicaid or FAMIS

☐ **Health (medical) Insurance:** My child is covered by medical insurance. (If selected, check one)

- ❍ My insurance should be billed for covered services. I agree to pay for any applicable co-payments, co-insurance, deductibles and/or non-covered services in the manner indicated in the **CHARGES** option below.
- ❍ My insurance should NOT be billed for covered charges. I agree to pay for services in the manner indicated in the **CHARGES** option below.

☐ **Medicaid/FAMIS:** My child is covered by Medicaid or FAMIS and I understand Medicaid/FAMIS will be billed for covered services.

CHECKING FOR MEDICAID COVERAGE (If your child is not currently covered by Medicaid/FAMIS, check one)

☐ I give permission for my local early intervention system to routinely check to see if my child is covered by Medicaid or FAMIS.

☐ I do not give permission for my local early intervention system to routinely check to see if my child is covered by Medicaid or FAMIS

CHARGES (check one)

☐ **Full Charge:** I do not wish to provide financial information. I will pay all applicable co-payments, co-insurance, deductibles, and/or the full early intervention reimbursement rate for services not covered by insurance.

☐ **Discounted Fees** (If selected, check one)

- ❍ **Monthly Cap:** Documentation of my actual or estimated federal taxable income has been viewed. This determines the amount I will pay. I agree to pay charges (including all applicable co-payments, co-insurance and/or deductibles) up to, but not exceeding, my family's monthly cap of $_________ .
- ❍ **Fee Appeal** (If selected, check one):

  __The amount of the monthly cap as calculated on the family cost share fee scale is a financial hardship. My monthly cap is based on the additional financial information that is attached, **OR**

  __I am unable to document either my actual or estimated taxable income. Attached is a copy of my pay stub or my written statement certifying my income amount, as well as any additional financial information required.

  I agree to pay charges up to, but not exceeding, my family's monthly cap of $_________ .

☐ **Medicaid/FAMIS/No Income:** My child is eligible for Medicaid/FAMIS and/or I have no income at this time. Therefore I have an inability to pay, and will receive all of my child's early intervention services at no cost to my family. (If selected, check one)

- ❍ Copy of my Medicaid/FAMIS card is attached **OR** __ eligibility verified on ____________ by ________________________ .
- ❍ My written statement certifying that I have no income is attached.

Infant & Toddler Connection of Virginia

Family Cost Share Agreement Form *(page 2)*

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Child's Name: ____ **DOB:** ________________

FLEXIBLE SPENDING ACCOUNT (all families must check the box below)

☐ I understand that if I have a health care flexible spending account that automatically pays my family or the provider for out-of-pocket expenses (e.g., co-payments, co-insurance, deductibles, etc.), then the monthly cap documented in the Charges section above will apply only to those services not covered by my health insurance plan, and I am responsible for the full amount of any insurance co-payments, co-insurance and deductibles for early intervention services until I have used all of the money in my flexible spending account.

- Once I have used all of the money in my flexible spending account, the monthly cap will cover all services listed on my child's IFSP.
- I will notify my service coordinator when there is no money left in my flexible spending account or if I am able to change my flexible spending account so it no longer automatically pays my family or the provider.
- This policy does not apply to me if my flexible spending account works on a reimbursement basis (for example, I have to submit paperwork to get money from my flexible spending account) or if I have a flexible spending account debit card to pay for expenses like co-payments, co-insurance and deductibles.

STATEMENTS OF AGREEMENT AND UNDERSTANDING

- I have received a copy of *Notice of Child and Family Rights and Safeguards Including Facts about Family Cost Share*.
- I agree to notify my service coordinator of any changes in my financial information used to determine my cost of early intervention services, as well as any changes in my child's insurance or Medicaid/FAMIS status. I also understand that I should contact my service coordinator if, at any time, I have any questions or concerns about the family cost share process and/or the cost of early intervention services. I may file an administrative complaint, request mediation, and/or initiate an impartial hearing if disagreements regarding the fee cannot be resolved at the local level.
- I understand I will receive at least 30 days written notice of any changes in my early intervention service provider's schedule of charges.
- I understand that if I do not pay fees when due, services may be discontinued. Before services are discontinued, I will be contacted by my service coordinator.
- I understand that routine collection procedures, which may include the use of collection agencies, will be used to recover amounts due.
- I have received a copy of the full charges for early intervention services.
- I have read, understand and will comply with the terms in this agreement. I certify that the information I have provided regarding my financial status is complete and accurate to the best of my knowledge.

____ __________________________

Parent or Responsible Party Signature Date

____ ____________________________

Staff Signature Date

Infant & Toddler Connection of Virginia

INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

Child's Name: ____ DOB: ________________

I, ____, hereby authorize the
Parent or responsible party

____ to:
Names of provider(s) of early intervention services

__X__ release necessary information to the insurance company(ies) designated below and also to
__X__ request necessary information from the insurance company(ies) designated below:

____
Name(s) of Insurance Company(ies)

Necessary information may include my child's diagnosis, service dates and service types and all other information necessary to process my insurance claims for payment to this agency and to ensure coordination of care. I consent to the release of this information and understand that I may cancel my consent, at any time, by delivery of a written notice to the provider(s) of early intervention services to my child. The cancellation will be effective upon the date the notice is received.

I authorize payment of any insurance benefits to be made directly to:

____
Name(s) of Provider(s) of early intervention services

____ _____________________________
Parent or Responsible Party Signature Date

____ _____________________________
Staff Signature Date