



Infant & Toddler Connection of Virginia

Family Cost Share Agreement Form

_____ Initial _____ Revised

Child/ren's Name(s): _____ DOB: _____

I understand that I will be charged for services my child receives. I can choose not to provide financial information and pay all applicable co-payments, 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).
- 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, 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 believe use of my insurance will result in a financial loss such as a decrease in available lifetime coverage, escalation of premium, or discontinuation of the policy. I agree to pay for any applicable co-payments, deductibles and/or non-covered services in the manner indicated in the **CHARGES** option below.
- My insurance should NOT be billed for covered services. I agree to pay the full early intervention rate 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.

CHARGES (check one)

- Full Charge:** I do not wish to provide financial information. I will pay all applicable co-payments, 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 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 on 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 \$_____.
- No Fees:** My income is below the level that requires completion of Federal income tax forms and/or my income qualifies my child for Medicaid/FAMIS. Therefore I have no ability to pay any fees, and will pay nothing for my child's early intervention services. (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.
- Opting to Delay Services:** I was given 30 calendar days from the date I signed the IFSP to provide income information since I was unable to provide that information prior to IFSP development. That 30-day period has ended and I have been given the option to provide income information, select the Full Charge option above, or delay further services, other than those available at no cost, until I can provide income information. I choose to delay further services, other than those available at no cost, until I can provide income information.

STATEMENTS OF AGREEMENT AND UNDERSTANDING

- I agree to notify my service coordinator of any changes in the financial information used to determine the 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 appeal 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 have read, understand and will comply with the terms in this agreement. 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 will be used to recover amounts due.
- I have received a copy of the full charges for early intervention services.
- 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

INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS (Optional)

I, _____, hereby authorize the
Parent responsible party

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

- release necessary information to the insurance company(ies) designated below and also to
- 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. 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