CHILD AND FAMILY CONNECTIONS
CONSENT FOR RELEASE OF INFORMATION

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

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

Cornerstone Participant ID # _____ CBO/EI # _____

I authorize the Child and Family Connections (CFC) office to release/obtain the information below: ☒ TO ☒ FROM

Name: _____

Address: _____

City, State & Zip: _____

Specific Information to be Disclosed if Available

Obtain	Release	Type of Information	**Description** (timeframe, date of service)
☒	☒	Developmental Reports	
☒	☒	Occupational Therapy Reports	
☒	☒	Physical Therapy Reports	
☒	☒	Speech/Language Reports	
☒	☒	Audiological Reports	
☒	☒	Vision Reports	
☒	☒	Medical Reports, Diagnosis, Prescriptions	
☒	☒	Program Eligibility & Financial Status	
☒	☒	Eligibility Information to Referral Source	
☒	☒	Other	

This information is needed for the following purpose(s): (check all that apply)

☒ Establish Early Intervention (EI) eligibility
☒ Develop an Individualized Family Service Plan (IFSP)
☒ Treatment, payment, healthcare operations
☒ Coordinate, monitor and implement EI services
☒ Facilitate transition
☒ Other: _____

This consent for disclosure is valid until: 06 (Month) / 30 (Day) / 2020 (Year)

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my consent is voluntary and that I may withdraw this consent by written request to the CFC above at any time, except to the extent that it has already been acted upon. I understand that my refusal to consent to disclosure will have the following consequences, if any: Inability to establish EI eligibility; develop an IFSP; coordinate, monitor and implement services; or facilitate transition.

Other consequences: None.

Parent/Guardian/Surrogate Printed Name: Janet Wukas Ahern, DCFS Guardianship Administrator

Parent/Guardian/Surrogate Signature: _____ Date 6/11/19

Witness Signature: _____ Date 6/11/19

Notice to Receiving Agency/Person:	***Send Information to:*** (enter name and address)
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.	Name: Office Name: Address: City: State: Zip Code:

CHILD AND FAMILY CONNECTIONS
WAIVER OF WRITTEN PRIOR NOTICE

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

Child's Date of Birth: (Month/Day/Year) _____ CBO/EI #: _____

SECTION 1: COMPLETED BY SERVICE COORDINATOR

I certify that two or more disciplines 1) reviewed all applicable and available developmental and, if appropriate, medical information, 2) either conducted developmental evaluations or reviewed existing, *current* developmental evaluations, and 3) concur on a recommendation regarding eligibility.

_____ _____

Service Coordinator's Signature Date

Based on the findings of the team of evaluators and in accordance with Bureau of Early Intervention policy, this child is/remains:

☐ **Eligible**

If eligible, the following criteria have been established:

- ☐ Eligible level of developmental delay (30% or more in one or more domains);
  - ☐ Measured by Department approved diagnostic instruments and standard procedures; or
  - ☐ Confirmed through informed clinical judgment of qualified staff based upon multidisciplinary evaluation & assessment if the child is unable to be appropriately and accurately tested by the standardized measures available.
- ☐ Physical or mental condition which typically results in developmental delay; and/or
  - ☐ At risk of substantial developmental delay, according to informed clinical opinion
    - ☐ Parent has been diagnosed with a Department-defined eligible medical condition, and/or
    - ☐ Three or more Department-defined at risk conditions have been met

SECTION 2: REVIEWED WITH, COMPLETED AND SIGNED BY PARENT/GUARDIAN

IF **ELIGIBLE**, OBTAIN PARENT/GUARDIAN INITIALS AND SIGNATURE:

1. The evaluation/assessment results have been sufficiently explained to me. _____ Initials
2. I am comfortable with my level of understanding about my child's development in all areas at this time. _____ Initials
3. I understand that I do not have to develop my child's Individualized Family Service Plan (IFSP) _____ Initials
4. I understand that if I choose to schedule my IFSP development meeting for another day, I will not jeopardize any covered Early Intervention (EI) services/supports that my child or family may need. _____ Initials

By signing below, I waive my right to written notice prior to eligibility determination and IFSP development, including the determination of appropriate early intervention services and supports. I understand that I have the right to dispute the determination of services/supports identified in the IFSP and can find information regarding the dispute process in the *State of Illinois Infant/Toddler & Family Rights under IDEA for the Early Intervention System* booklet.

Janet Wukas Ahern, DCFS Guardianship Administrator _____ 6/11/19

Parent/Guardian Printed Name Parent/Guardian Signature Date

R05/01/2016

CHILD AND FAMILY CONNECTIONS
PARENTAL CONSENT AND ABILITY TO DECLINE SERVICES

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

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

CBO/EI #: _____

Your child has been referred to the Illinois Early Intervention (EI) Program to determine whether he/she has a developmental delay or disability. The Illinois EI Program is required to obtain informed, written consent before conducting a family assessment and the initial evaluation/assessment. This is obtained through your signature below.

I understand I do not have to agree to each of the EI services offered or to any of the services. However, failure to accept such services may prohibit the developmental opportunities for my child. I understand that I may withdraw this permission in writing at any time except to the extent that it has already been acted upon. I understand my refusal to grant permission or withdrawal of permission will result in a discontinuation of participation in the Illinois EI program.

Notice and Consent for Family Assessment
A family assessment will be conducted to help determine the resources, priorities, and concerns of the family and to identify the supports and services necessary to enhance the family's ability to meet the developmental needs of the child.

- ☒ I give my consent to the Child and Family Connections (CFC) office to administer a Family Assessment.
- ☐ I do not give my consent to the EI CFC office to administer a Family Assessment.

Notice and Consent for Initial Evaluation/Assessment
A multidisciplinary evaluation will be conducted by at least two qualified individuals from different disciplines. Your participation in the evaluation process is strongly encouraged. You know your child best and can provide important information about your child. The evaluation is a comprehensive view of how your child is doing in the developmental areas of physical, cognitive, communication, social or emotional and adaptive. How the evaluation/assessment is performed will vary based on the needs of your child. It may include the review of medical/developmental records, parent interviews, child observation and administration of evaluation instruments. The evaluators will discuss this process with you.

- ☒ I give my consent to the EI program to conduct an Initial Evaluation/Assessment.
- ☐ I do not give my consent to the EI program to conduct an Initial Evaluation/Assessment.

Child and Family Early Intervention Rights
My child and family's EI Rights have been explained to me and I understand them. EI will provide a copy of the document entitled, *State of Illinois Infant/Toddler and Family Rights under IDEA for the Early Intervention System,* which describes these rights, the procedures the EI Program follows and the steps I can take to assure that my EI rights are guaranteed. As explained in the document, I understand I have a right to disagree with the decisions made by EI staff, the CFC and any provider, and I may file a State Compliant, request Mediation or a Due Process Hearing.

System of Payments and Fees

EI will provide a *CFC Notice of System of Payments and Fees* to each family which contains information regarding the use of private insurance and/or All Kids benefits, participation in Family Participation Fees, EI services provided at no cost and EI Services which are subject to Family Participation Fees, private insurance billing and/or All Kids reimbursement.

Parent/Guardian Printed Name:	Janet Wukas Ahern, DCFS Guardianship Administrator	
Parent/Guardian Signature:	[signature]	Date 6/11/19
Witness Signature:	[signature]	Date: 6/11/19

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.

CHILD AND FAMILY CONNECTIONS
CONSENT TO USE PERSONALLY IDENTIFIABLE INFORMATION (PII) & BILL PUBLIC BENEFITS

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

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

CBO/EI Number: _____

PII Collection/Usage

I hereby grant permission for my Child and Family Connections (CFC) to collect the necessary Personally Identifying Information (PII) related to my child and family for the purpose of determining eligibility and related services under Early Intervention (EI). I understand this information will be stored electronically and in a hard copy case record. EI utilizes a data system that collects records on a wide range of health care services to individuals. Those services include Women, Infants and Children (WIC); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; EI; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois. The data system is maintained by the Department of Human Services (DHS) and the Illinois Department of Public Health (DPH). Using data, DHS and DPH may learn your child is participating in EI but cannot access detailed information regarding these services. Necessary aggregate information, without any client's name, may be sent to federal agencies that fund these programs. The data system user with access to the system has a legal and ethical duty to keep the information confidential and private and not release it to anyone without your consent or unless required by law.

The detailed information collected will be used only for purposes permitted by the Individuals with Disabilities Education Act (IDEA) Part C EI Services Act which includes referrals, eligibility determinations, EI services provision and claiming. My Service Coordinator, service providers and DHS and its designees, may see and discuss the information with each other for the purposes listed above. I understand if I transfer to a new CFC office within Illinois, my information will be transferred to the new CFC office without requiring further consent.

Public Benefits Assurances and Billing/Usage

If I am currently enrolled in All Kids and/or later become enrolled in All Kids while in EI, I hereby grant permission for my CFC to collect and share the above collected PII for the purposes of billing, care coordination and analysis with the Department of Healthcare & Family Services (HFS), the State agency responsible for the administration for All Kids. Additionally, if I am not currently enrolled but later become enrolled in All Kids, I grant permission for my CFC to do the aforementioned actions with PII as well as submit claims for reimbursement to HFS.

I understand the following assurances:

- EI services, as specified in my child's IFSP, and to which I have consented, cannot be denied due to my refusal to disclose my child's PII to HFS, the state agency responsible for the administration of All Kids. If I would like to withdraw my consent, I will notify my Service Coordinator.
- If I am not currently enrolled in All Kids but later become enrolled and do not consent to allow EI to bill All Kids for reimbursement for services rendered, EI must still make available those services on the IFSP to which I have provided consent.
- The use of All Kids for EI services will not (1) decrease available lifetime coverage or any other insured benefit for myself or my child under All Kids; (2) result in me paying for services that would otherwise be covered by All Kids; (3) result in any increase in premiums or discontinuation of All Kids for myself or my child; and (4) risk loss of eligibility for myself or my child for home and community based waivers based on aggregate health related expenditures.
- I will not incur premiums, co-pays or deductibles as a result of using All Kids for EI services.

- If I have private insurance, All Kids requires the use of my private insurance as the primary insurance. I will be given the document entitled Notice to Consent to Use Private Insurance/Healthcare Benefits & Assignment of Rights to sign.

In addition, this disclosure allows the release of information from DHS to HFS about a child, including name, All Kids recipient identification number, date of birth, and information about a child's referral to and eligibility for EI, including services received and other referrals made by EI. HFS may also share information with my child's assigned primary care provider/doctor (PCP), whom I identified on my IFSP as a team member, and treating doctors within the group, for care coordination. Care coordination allows my child's PCP to be notified of my child's EI assessment, eligibility for services and services received. HFS may also use the information for analysis purposes and to measure the quality of the care coordination process between the PCP and EI. Information and reports resulting from data analysis will not be released with any personally identifying information about my child.

Private Insurance Collection and Use of PII

I understand my consent is necessary for EI, or its' designee, to share PII with my private health insurance plan for purposes of benefits determination, billing and claiming.

Consent

I am making this consent within the legal limits of my authority. To revoke my consent, I will contact my Service Coordinator.

I understand that my child's records are required to be maintained for a period of six (6) years and will be destroyed at my request or at the end of that period unless legal action is pending.

☒ I give my consent to collect, store and utilize personally identifying information with the parties identified above and for the purposes outlined above.

☐ I do not give my consent to collect, store and utilize personally identifying information with the parties identified above and for the purposes outlined above.

ONLY COMPLETE THIS SECTION IF NOT CURRENTLY ENROLLED IN ALL KIDS.

☐ If I am not currently enrolled in All Kids but later become enrolled in All Kids while in EI, I consent to the use of my All Kids benefits as outlined above.

☐ If I am not currently enrolled in All Kids but later become enrolled in All Kids while in EI, I do not consent to the use of my All Kids benefits as outlined above.

Parent/Guardian Printed Name: Janet Wukas Ahern, DCFS Guardianship Administrator

Parent/Guardian Signature: _____ Date: 6/11/19

Witness Signature: _____ Date: 6/11/19

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.