Washington State Department of CHILDREN, YOUTH & FAMILIES

ESIT System of Payments and Fees (SOPAF) Consent
Families with Medicaid/Apple Health for Kids CHIP

Date _____ ESIT Provider Agency _____

FRC/ESIT Staff Name _____ Phone Number _____

Section A: Identifying Information

Child's Legal Name _____ Date of Birth _____

Parent/Guardian Name 1 _____ Phone _____

Parent/Guardian Name 2 _____ Phone _____

Section B: Insurance Information

Type of Insurance	Insurance Name	Policy Number
Medicaid/ Apple Health for Kids CHIP		
Secondary Private Insurance		

Section C: Consent to Bill Medicaid or Apple Health for Kids CHIP (Check all that apply)

☐ **I give permission** for my ESIT Service Provider(s) to submit claims to Medicaid or Apple Health for Kids CHIP for initial and ongoing evaluation and/or assessment and all billable ESIT services on my child's Individualized Family Service Plan (IFSP) subject to Family Cost Participation (FCP). These services will be provided at no cost to my family.

☐ **I decline** access to Medicaid or Apple Health for Kids CHIP, and by denying access I understand that I may be responsible for a monthly participation fee.

☐ **I have both Medicaid and TRICARE or private insurance and give permission** for my ESIT Service Provider(s) to submit claims to my public benefits and private insurance for initial and ongoing evaluation and/or assessment, and all billable ESIT services on my child's IFSP subject to FCP. These services will be provided at no cost to my family.

I hereby affirm that:

- I provided information on this form that is accurate and complete.
- I agree to notify my ESIT Provider of any changes in my public benefits.
- I was not required to sign up for Medicaid/Apple Health for Kids/CHIP.
- I am responsible for any premiums related to my Apple Health for Kids/CHIP.
- I understand that by consenting to access to my public benefits my personally identifiable information will be shared with Medicaid.
- I understand I can deny access to my public benefits and decline to share my personally identifiable information with Medicaid.
- If I have both public benefits and private insurance - I understand that my public benefits have the right to recoup the costs from my insurance carrier. I also understand I must also complete the other appliable sections on this form.

Parent / Guardian's Signature(s)

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____