

Parent Release of Information

Child's Name: _____ Birthdate: _____

Permission is given for the tiny-k Early Intervention Program to share appropriate information concerning the above listed student with the Kansas Health Policy Authority so that tiny-k E.I., can, if applicable, seek reimbursement for any health-related services that are claimable under the Title XIX Medicaid Program or the Title XXI State Child Health Insurance Program.

In conjunction with the above, I understand that tiny-k E.I. may also need to obtain a "Physician's Prescription" for some/all of the health-related services that is provided to the child. In this regard, I hereby give permission for tiny-k E.I., if applicable, to share portions of the child's Individual Family Service Plan (IFSP) with a qualified health care professional in order to obtain such "Physician's Prescriptions".

Physician's Name: _____

Contact Information: _____

I understand that tiny-k E.I. is required to provide certain health-related services to any child who has an IFSP at no additional cost to the child's parents(s)/guardian(s). I also understand that my signature - or failure to sign this form - will not affect whether such services are provided to the child.

I understand all of the statements set forth above - and I hereby grant all of the above - referenced permissions for the period from July 1, 2009, through June 30, 2011.

Parent(s)/Guardian(s) signature(s): _____

Date: _____

Medicaid Billing Information

Child's Name: _____

(as it appears on the Medical card)

Medicaid Number: _____

Child's Social Security Number: _____

Child's Birthdate: _____ Sex: M or F

Child's current address: _____

Parent's Name: _____

Foster Parent's Name: _____

Name of Child's Doctor: _____

Doctor's Address: _____

Doctor's Phone Number: (_____) _____
(include area code)