Arizona Department of Economic Security
Arizona Early Intervention Program (AzEIP)

Public Insurance Benefits

Child's Name: _____ Date of Birth *(MM/DD/YYYY)* _____ I-TEAMS ID _____

Primary Care Physician (PCP) Name _____ PCP Phone Number (###) ###-#### _____

Clinic Name _____ Clinic Address or Cross Streets _____

I agree the following information or support was provided:

- My Service Coordinator, _____, reviewed with me A Family's Guide to Funding Early Intervention Services in Arizona, *(GCI-1086A)* which describes AzEIP's system of payments. I have received a(n) Select Method _____ of the booklet per my request.
- My service coordinator reviewed with me the Child and Family Rights in the Arizona Early Intervention Program, GCI-1070A which describes my child and family rights with AzEIP. I have received a(n) Select Method _____ of the booklet per my request.
- My Service Coordinator explained that AzEIP services are always provided with no co-payments or out-of-pocket costs to families.
- I understand that if I decline to share my information, my family's early intervention services will not be denied or delayed.
- My Service Coordinator has explained how Early Intervention services are funded in Arizona with AzEIP partner agencies and that not consenting to share my information may limit access to other services provided by those partner agencies.
- It was explained to me that I have the right to change my mind about sharing my child's information at any time. I understand that any change will apply only to services provided after I notify my SC of my decision.
- I was offered a copy of this completed Public Insurance Benefits form.

Parent/Guardian Initials: _____

I understand my responsibility to:

- Share a copy of any Explanation of Benefits (EOB) or Notice of Action (NOA) I receive for my child's AzEIP services, upon request.
- Contact my health plan if I need specific information about my child's insurance coverage.

Parent/Guardian Initials: _____

I consent to share my child's personally identifiable information and early intervention records with AHCCCS and any AHCCCS health insurance plan in which I am now enrolled or may be in the future, and to have this information used to bill for covered services.

Parent/Guardian Initials: _____

If applicable, the reason I decline to share my Personably Identifiable Information *(completed by parent/guardian*: _____

I would like help from my Service Coordinator to learn how to obtain health insurance. ○ Yes ○ No

Parent/GuardianSignature: _____ Consent Date : _____

This consent will expire when all my child's early intervention services have been paid and appeals resolved by AHCCCS and its Health Plans unless I sign a new Public Insurance Benefits form.

See page 2 for EOE/ADA disclosures

Child's Name _____ Date of Birth *(MM/DD/YYYY)* _____ I-TEAMS ID _____

AHCCCS Health Plan Information *(if currently enrolled)*	
Health Plan Name	Insured's Date of Birth
Member's AHCCCS ID	Member's Name* *(as written and spelled on insurance card)*
If AHCCCS ID is not available, other Policy Number	
Coverage Start Date*	Coverage End Date* *(Leave blank if unknown)*

A Family's Guide to Funding Early Intervention Services in Arizona
des.az.gov/sites/default/files/legacy/dl/GCI-1086A.pdf