Washington State Department of CHILDREN, YOUTH & FAMILIES

ESIT System of Payments and Fees (SOPAF) Consent
Families With Tricare, Private Insurance, or No Insurance

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

Section C: Consent to Bill Insurance (Check all that apply or skip to Section D if you have no insurance)

☐ **I give permission** for my ESIT Service Provider(s) to submit claims to my TRICARE and/or private insurance for initial and ongoing evaluations and assessments to determine my child's eligibility for ESIT Services and I understand that I will not be responsible for any copays, coinsurance, or deductibles.

☐ **I give permission** for my ESIT Service Provider(s) to submit claims to my TRICARE and/or private insurance for services on my child's Individualized Family Service Plan (IFSP) subject to Family Cost Participation (FCP) and I understand that I will be responsible for any copays, coinsurance, or deductibles unless I have been determined to have the inability to pay or approved for a hardship exemption.

OR

☐ **I decline** the use of my TRICARE and/or private insurance for initial and ongoing evaluations and assessments to determine my child's eligibility for ESIT Services, and I understand that I will not be responsible for copays, coinsurance, or deductibles.

☐ **I decline** the use of my TRICARE and/or private insurance for services on my child's IFSP subject to FCP and I understand that I will be responsible for a monthly participation fee unless I have been determined to have the inability to pay or approved for a hardship exemption.

AND

☐ I have been made aware of the general categories of costs that my family may incur as a result of using my TRICARE and/or private insurance for evaluations and assessments, and services on my child's IFSP subject to FCP, such as:

- ☐ Co-payments, co-insurance, premiums, or deductibles,
- ☐ Loss of benefits due to annual or lifetime insurance caps,

The unlikely potential that:

- ☐ Using insurance may negatively affect the availability of coverage,
- ☐ Coverage may be discontinued, and/or
- ☐ Premiums may be affected.

I have been made aware that the general categories of cost may increase as a result of an increase in a services' frequency/length/duration/intensity, when my TRICARE and/or private insurance is used to pay for services on my child's IFSP subject to FCP.

I have been made aware that if I would like a detailed estimate of the potential costs, I can ask my Family Resources Coordinator (FRC) to assist me with obtaining that information or I can contact my insurance provider directly.

Section D: No Insurance (Check all that apply or skip to Section E. if Section C was completed)

☐ My family has no insurance and **I understand:**

- ☐ Initial and ongoing evaluations and assessments will be provided at no cost to my family.
- ☐ I may be responsible for a monthly participation fee for services on my child's IFSP subject to FCP unless I have been determined to have the inability to pay or approved for a hardship exemption.

Section E: Ability to Pay

I understand that I have the right to have an ability to pay determination and if declined, I will be responsible for my co-pays, co-insurance, and deductibles. I understand that, if initially declined, I can request an ability to pay determination at any time

☐ I request an ability to pay determination.

☐ I decline an ability to pay determination.

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 to my Insurance coverage.
- I am responsible for any premiums related to my TRICARE or Private Insurance.
- My FRC has explained SOPAF to me and has given me a copy of the SOPAF policy.
- 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.

Parent / Guardian's Signature(s)

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____