

Early Intervention Colorado

TO: Division for Developmental Disabilities, Early Intervention Colorado
4055 South Lowell Boulevard
Denver, Colorado 80236
FAX: 303-866-7680
EMAIL: JoAnne.Dionese@state.co.us

CCB Label (w/ Phone Number)

Insurance Declination Form

Name of Child: _____ DOB: _____

My service coordinator has explained the following information to me:

Yes No Use of my Private or Public Health Insurance for any and/or all of the early intervention services that are identified in my child's Individualized Family Service Plan (IFSP) must be considered prior to the use of any other public funding sources.

Yes No Provided me with a copy of **A Family Guide: Funding Early Intervention Services** brochure.

Please check one of the following circumstances that best describes your health insurance coverage.

- I decline to provide health insurance information to the Early Intervention Colorado program and/or was asked and could not or did not provide documentation from my insurer.
- My child is insured through a non-qualifying Private Health Insurance plan that is not covered under C.R.S. 10-16-104(1.3).
- My child is insured through a Public Health Insurance plan (e.g., Medicaid or Child Health Plan Plus (CHP+)).
- My child is insured through a qualifying health insurance plan that is covered under C.R.S. 10-16-104(1.3)*

Yes No My service coordinator explained the protections under the Coordinated System of Payment Law C.R.S. 10-16-104(1.3) that assures use of a qualifying Private Health Insurance Plan is at no cost to me and does not impact my benefit limits or impose a risk of my being refused insurance due to a pre existing condition.

I, _____ (Name of Parent/Legal Guardian), who can be reached at

Address: _____

Phone: _____ E-mail: _____

have declined to provide health insurance information and/or give permission to access funding through my health insurance coverage for the following reason(s):

Yes No I have been informed and understand that this Insurance Declination Form will be sent to the State Division for Developmental Disabilities, Early Intervention Colorado program.

Parent Signature _____ Date _____

Service Coordinator Signature _____ Date _____

Early Intervention Coordinator Signature _____ Date _____

For DDD Use Only:

Notes:

Follow-up Date: _____

* As defined within **C.R.S. 10-16-104(1.3)** and, "A Family Guide: Funding Early Intervention Services" brochure.