



Parent Consent and Request for Early Intervention (EI) Services Through the Help Me Grow Program at the Ohio Department of Health

I/we understand that in order for the Ohio Department of Health (ODH) to pay for the part C early intervention service(s) identified on our Individualized Family Service Plan (IFSP):

- My child has received a developmental evaluation and assessment and has been determined eligible for part C early intervention services through the Help Me Grow (HMG) program;
- The service(s) are listed on our IFSP;
- We agree to use a provider from the approved HMG list;
- My family meets the financial eligibility guidelines established by rule 3701-08-10 of the Ohio Administrative Code which is the same financial eligibility guidelines for the Bureau for Children with Medical Handicaps (BCMh);
- The service(s) requested are not available through the county board of mental retardation and developmental disabilities (MRDD); and indicated such on the Service Not Available Certification form; and
- The service(s) requested are not covered by MRDD, BCMh, Medicaid, or other third party payer*
*NOTE: I/we understand if using our health insurance for the EI services will result in a financial loss, such as exhausting our lifetime coverage during the service period, discontinuation of the policy, or increased premiums, we may be determined unable to pay if we meet the financial eligibility criteria established by the ODH. We have signed the Use of Insurance Inability to Pay Statement.

Once approved, I/we will receive a letter of approval (LOA) from ODH with the approved number of units of service and a copy will be sent to our service coordinator.

If I/we do not meet the financial eligibility criteria, we will be offered a cost share program which will be explained in a letter from ODH; and upon meeting our cost share, the Help Me Grow program at ODH will pay for the part C early intervention service(s) for a determined period of time.

I/we understand that part C early intervention services are services designed to meet the developmental needs of our child. **Early Intervention services that are subject to the system of payment include:**

- a. **Assistive technology**
- b. **Assistive technology services**
- c. **Assistive technology devices (does not include a medical device that is surgically implanted, or the replacement of such device)**
- d. **Audiology services,**
- e. **Health services (does not include surgical or purely medical services)**
- f. **Nursing services**
- g. **Nutrition services**
- h. **Occupational therapy**
- i. **Physical therapy**
- j. **Psychological services**
- k. **Social work services**
- l. **Special Instruction**
- m. **Speech-language pathology and sign language and cued language services**
- n. **Vision services. (34 CFR 303.12)**

I/we understand that, the county HMG program shall provide transportation and related costs (e.g. parking) that are necessary to enable an eligible child and the child's family to receive early intervention services if no other payment source is available; and if respite services are determined to be needed by the IFSP team and no other payment source is available, the county HMG program shall provide the service.

I/we understand that the following services must be provided by the Help Me Grow program in my county at no cost to my family:

- **Child find;**
- **Developmental screening;**
- **Developmental evaluation and assessment;**
- **Family assessment;**
- **Development, review and evaluation of IFSPs for eligible children and their families;**
- **Provision of service coordination;**
- **Transition services;**
- **Provision of procedural safeguards and due process procedures for Part C eligible children and their families; and children with a suspected developmental delay or disability; and,**
- **Family support.**

I/we understand that we can refuse any service listed on the IFSP without compromising any other service through the Help Me Grow program that may benefit my child and family.

- ✍ We have completed the eligibility process, completed the initial IFSP and determined that there is a service needed with no other payment source for the service(s).
- ✍ We are requesting that the Ohio Department of Health, Help Me Grow program pay for the services as requested on the EI Application for Services and listed on our IFSP.
- ✍ We are including the following information as required:
 - EI Application for Services
 - Copies of relevant sections of our IFSP
 - Combined Program Application with required financial paper work (showing proof of income from work or wages:
 1. Copies of pay stubs for the previous month, or most recent four (4) week period;
or
 2. A letter from your employer stating the amount of your monthly gross income;
and
 3. A copy of the latest IRS 1040 tax form with schedule C or F.

Signed: _____

Relationship to Child: _____

**Send form and attachments to:
Ohio Department of Health
Bureau of Early Intervention Services, 5th floor
246 N. High Street
Columbus, Ohio 43215
Attn: EI Services Payment Application**

For Office Use Only

Date Received: _____ Processed by: _____