Eligibility Criteria
How Do I Know If My Child Is Eligible?

Head Start/Early Head Start: Part-Week Option
(Child attends 2-3 days/week)
- Child is 6 weeks – 5 years old
- Child lives in Hennepin County
- Family receives MFIP cash, SSI, or meets income guidelines (see below)
- Children with diagnosed disabilities (and an IEP) are eligible regardless of income. Special needs or foster care children ages 6 weeks – 5 years who live in Hennepin County are also eligible.

Head Start: Full-Time Option
(Child attends 5 days/week)
- Child is 3–5 years old
- Child lives in Hennepin County
- Family is eligible for a child-care subsidy because the parent(s)/guardian(s) work or go to school, or because the child has diagnosed disabilities or special needs.

Early Head Start: Pregnant Mom Option
- Pregnant woman, any age
- Mom lives in Hennepin County
- Family, along with unborn baby, meets income guidelines

Early Head Start: Full-Time Option
(Child attends 5 days/ week)
- Child is 6 weeks – 3 years old
- Child lives in Hennepin County
- Family is eligible for a child-care subsidy because the parent(s)/guardian(s) work or go to school, or because the child has diagnosed disabilities or special needs.

Federal Income Guidelines 2016

Family Size	Max Income
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

For each additional person, add $4,160.

How To Enroll

Please bring the following forms:

- ✓ **Current Physical Examination and Immunization Records.** Fill out Section I of the enclosed Physical & Immunization Record. Have your doctor complete and sign the rest.
- ✓ **Dental Examination.** If your child has a dentist have them fill out and sign the enclosed Dentist Report.
- ✓ **Insurance Cards.** Bring your child's medical and/or dental insurance card.
- ✓ **Emergency Information.** Be prepared to provide names, addresses, and phone numbers of three emergency contacts.
- ✓ **Proof of Income.** Bring official documentation of income. For example: Minnesota Family Investment Plan (MFIP), Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Foster Care or Unemployment Compensation. If you are employed, bring a W-2 form, tax return, check stub, or other income verification.
  ** Pregnant mom enrollment only requires proof of income.*
- ✓ **If your application is not complete we will not be able to enroll your child.**

PICA Hotline
(612) 377-4444

La Crèche Early Childhood Centers, Inc.
1800 Olson Memorial Hwy
Minneapolis, MN 55411
(612) 377-1786

Program Application
2016/2017

Questions marked with a star (*) will not affect you as an applicant. They are voluntary to meet federal reporting requirements and to help us serve you better. All other questions are mandatory for enrollment.

Program Information

2016/2017 (School Year) | (Program) | (Possible Site) | Processing Application (Application Status)

Child Information

Child ID | First Name | Middle | Last Name | Birthdate | Age | Gender

***Ethnicity (check one):**
☐ Hispanic or Latino
☐ Not Hispanic or Latino

***Race (check all that apply):**
☐ American Indian or Alaska Native
☐ Asian
☐ Black, African, or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Household Information

Parent or Guardian First Name | Parent or Guardian Last Name | Relationship to Child | *Occupation

Other Guardian in Home First Name | Other Guardian in Home Last Name | Relationship to Child | *Occupation

Street Address

City | State | Zip | Home Phone

Source(s) of income (check all that apply):
☐ MFIP ☐ SSI ☐ SS ☐ GA ☐ Foster Care ☐ Other… _____

***Type of housing (check one):**
☐ Unsubsidized Rental Housing
☐ Home Ownership
☐ Institutional Care (i.e. Nursing Home, State Hospital, etc.)
☐ Section 8 or Other Rental Subsidized Housing
☐ Permanent Supportive Housing
☐ Shelter Plus Care / Bridges Rental
☐ Residential Treatment facility
☐ With Friends/Relatives: by choice
☐ With Friends/Relatives: could not find housing
☐ Transitional Housing Program
☐ Emergency Shelter

***Primary language used in household (check one):**
☐ Cambodian ☐ Hmong ☐ Oromo ☐ Somali ☐ Swahili ☐ Vietnamese
☐ English ☐ Laotian ☐ Russian ☐ Spanish ☐ Thai ☐ _____

***Language read by head of household (check one):**
☐ I do not read ☐ Cambodian ☐ Hmong ☐ Oromo ☐ Somali ☐ Swahili ☐ Vietnamese
☐ English ☐ Laotian ☐ Russian ☐ Spanish ☐ Thai ☐ Other

***Is a parent in the household currently:**
In School? ☐ Yes ☐ No If Yes, ☐ Full Time ☐ Part Time
In Training? ☐ Yes ☐ No If Yes, ☐ Full Time ☐ Part Time
Working? ☐ Yes ☐ No If Yes, ☐ Full Time ☐ Part Time

Pick Up/Drop Off

If the child will be transported to or from a different address from the household address above, specify:

Pick Up Address | Responsible Adult | Notes

Drop Off Address | Responsible Adult | Notes

PICA History

Referral Agency _____ School District _____

List any PICA/Head Start program(s) this child has attended in the past:

Program _____ School Year _____

List any PICA program(s) this child's sibling(s) have attended in the past:

Program _____ School Year _____

Family Status

Total number of adults and children in family: _____

***Who does this child live with (check one)?**

☐ Single parent-female ☐ Two Parents ☐ Relative
☐ Single parent-male ☐ Grandparents ☐ Foster care

Diagnosed Disabilities

	Yes/No	Description
Does your child have an ECSE Plan?	☐ Yes ☐ No	
Is there a significant diagnosed medical disability?	☐ Yes ☐ No	
Is there a significant mental health condition?	☐ Yes ☐ No	

Program Meals

The program you are applying for is Head Start. Depending on the session your child is enrolled in, he/she will have classes two or three days per week, for six hours per day.

Session Days	MON	TUE	WED	THU	FRI	Meals	
-	☐	☐	☐	☐	☐	Lunch	☒
-	A	A	A	B	B	Breakfast	☒
-	A	A	B	B	B	Snack	☒

If this is NOT correct, please indicate when your child will attend:

Session Days	MON	TUE	WED	THU	FRI	Meals	
-	☐	☐	☐	☐	☐	Breakfast	☐
-	☐	☐	☐	☐	☐	Snack	☐
-	☐	☐	☐	☐	☐	Lunch	☐

I certify that the information in this application is, to the best of my knowledge, complete and correct. I understand that providing false information could cause this application to be denied or cause my child's enrollment in this program provided by Parents in Community Action, Inc., to be suspended. I understand that completion of this application does not guarantee enrollment.

Signature of Parent/Guardian _____ **Date** _____

If the parent/guardian is under age 18, a parent or guardian over age 18 must sign:

Signature of Adult Parent/Guardian _____ **Date** _____

USDA is an equal opportunity provider and employer.

Copy to: Parent/Child Advocate file

Application Points ☐

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CHILD PHYSICAL

Child's Last Name	First Name	Middle Initial	Birth Date

Parent/Guardian Name	Address	Telephone #

Child's Medical Insurance Name	Child's Medical Insurance Number	MN Health Care ID

Early and Periodic Screening Diagnosis and Treatment (EPSDT) exam required.
Starred items (*) are required by Federal Head Start regulations and recommended by the American Academy of Pediatrics for children 3-5 years old.
Enter date if date of test is other than "exam date" recorded below.

TEST	DATE	RESULTS
A. PRESENT AGE*		
B. HEIGHT (CM)*		
C. WEIGHT (KG)*		
BMI		
D. BLOOD PRESSURE		
E. **HEMATOCRIT or HEMOGLOBIN* Result**		
F. HEARING (Type of Test)*		Pure Tone at 20dB
		1000Hz / 2000Hz / 4000Hz
RIGHT EAR		☐ Pass ☐ Fail / ☐ Pass ☐ Fail / ☐ Pass ☐ Fail
LEFT EAR		☐ Pass ☐ Fail / ☐ Pass ☐ Fail / ☐ Pass ☐ Fail
COMMENTS		

TEST	DATE	RESULTS
G. VISION (Type of Test)*		
ACUITY, R/L		
CORNEAL REFLEX		
COVER TEST		
COMMENTS		
H. OTHER TESTS (Complete or send past results)		
(1) TB		
(2) Sickle Cell		
(3) **Lead***		
(4) Ova & Parasites		
(5) Urinalysis		
(6) Other		

PHYSICAL EXAMINATION/ ASSESSMENT	Normal For Age	Abnormal	Not Evaluated
A. GENERAL APPEARANCE	☐ NA	☐ AB	☐ NE
B. POSTURE, GAIT	☐ NA	☐ AB	☐ NE
C. SPEECH	☐ NA	☐ AB	☐ NE
D. HEAD	☐ NA	☐ AB	☐ NE
E. SKIN	☐ NA	☐ AB	☐ NE
F. EYES:			
(1) External Aspects	☐ NA	☐ AB	☐ NE
(2) Optic Fundoscopy	☐ NA	☐ AB	☐ NE
G. EARS: (1) External & Canals	☐ NA	☐ AB	☐ NE
(2) Tympanic Membranes	☐ NA	☐ AB	☐ NE
H. NOSE, MOUTH, PHARYNX	☐ NA	☐ AB	☐ NE
I. DENTAL (1) Examine Teeth	☐ NA	☐ AB	☐ NE
(2) Examine Gums	☐ NA	☐ AB	☐ NE
(3) Referral to Dentist?	☐ Yes	☐ No	
J. HEART	☐ NA	☐ AB	☐ NE
K. LUNGS	☐ NA	☐ AB	☐ NE
L. ABDOMEN (Include hernia)	☐ NA	☐ AB	☐ NE
M. GENITALIA	☐ NA	☐ AB	☐ NE
N. BONES, JOINTS, MUSCLES	☐ NA	☐ AB	☐ NE
O. NEUROLOGICAL/SOCIAL	☐ NA	☐ AB	☐ NE
___ (1) Gross Motor	☐ NA	☐ AB	☐ NE
___ (2) Fine Motor	☐ NA	☐ AB	☐ NE
___ (3) Communication Skills	☐ NA	☐ AB	☐ NE
___ (4) Cognitive	☐ NA	☐ AB	☐ NE
___ (5) Self-Help Skills	☐ NA	☐ AB	☐ NE
___ (6) Social Skills	☐ NA	☐ AB	☐ NE
P. GLANDS (Lymphatic/Thyroid)	☐ NA	☐ AB	☐ NE
Q. DEVELOPMENTAL ASSESSMENT	☐ NA	☐ AB	☐ NE

Note to physician: Please fill out all items in Health Record.

Specify any condition that may result in an emergency situation:

How is child's overall physical status?

Specify type and dose of any current medication or therapies:

Describe any allergies:

Describe any dietary restrictions:

Describe any dietary recommendations:

Describe any diagnosed disabilities:

Please **print** or **type** physician or nurse practitioner's **name** and **telephone number.**

Print MD/NP Name _____
First Last

MD/NP Signature

Phone _____ Exam Date _____

FINDINGS, TREATMENTS, AND RECOMMENDATIONS. **Please Complete Individualized Child Care Plan (ICCP) for chronic health issues.**

Abnormal Findings/Diagnoses	Treatment Plan and Recommended Follow-Up or Results	Date

Child Care Immunization Form

Must be on file **before** a child attends child care

Name _____ Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in child care to be immunized against certain diseases or have a legal medical or conscientious exemption on file.

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease or laboratory evidence of immunity, and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status, section 2A to document medical exemptions (including a history of varicella disease), and 2B to document a conscientious exemption.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

Type of Vaccine DO NOT USE (✓)or(*)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year (*at 2-month intervals*) • 4th dose at 12-18 months • 5th dose at 4-6 years *Indicate vaccine type: DTaP or DTP*					5th dose not required if 4th dose was given on or after the 4th birthday
Polio (IPV, OPV) • 2 doses in the first year • 3rd dose by 18 months • 4th dose at 4-6 years			4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Haemophilius influenza type b (Hib) • 2-3 doses in the first year • 1 dose required at 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older					
Varicella (chickenpox) • Required for children 15 months or older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2-24 months • 3 doses in the first year • 4th dose after 12 months • At least 1 dose is recommended for children 24-59 months in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older					
Recommended					
Rotavirus (2-3 doses between 2 and 6 months)					
Influenza (annually for children 6 months or older)					

Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or conscientious)

1. **Certify Immunization Status.** Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:
For children who are 15 months or older and who have received all the immunizations required by law for child care.

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

_____
Signature of Parent/Guardian OR Physician/Nurse Practitioner/Physician Assistant/Public Clinic

_____Date

B. Children who are younger than 15 months:
For children who are younger than 15 months OR have not received all required immunizations.

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled, this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

_____
Signature of Physician/Nurse Practitioner/ Physician Assistant/Public Clinic

_____Date

2. **Exemptions to Immunization Law.** Complete A and/or B to indicate type of exemption.

A. Medical exemption:

No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician/nurse practitioner/physician assistant

_____Date

* History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____(year)

_____
Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)

B. Conscientious exemption:

No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s).

☐ I am opposed to all vaccines.
☐ I am opposed only to vaccines indicated below.

_____ _____
_____ _____

_____
Signature of parent or legal guardian

_____Date

Subscribed and sworn to before me this:
_____day of _____20___

_____
Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

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ICCP Record

ID	Child Name	Birth Date	Site	Class	Session

Physician treating child's condition:

Name _____ Title _____

Clinic _____

Address _____

Phone # 1 _____ Phone # 2 _____

1. Diagnosed Medical Condition: _____
   a. When was your child first diagnosed? _____ Is it an ongoing health issue? ☐ Yes ☐ No
   b. If yes, describe how often it occurs: _____
   c. What symptoms and behaviors does your child experience?
   _____
   _____
   d. List any restrictions at day care: _____
2. Treatment and Medications (Complete MEDICATION PERMISSION Form)
   a. Routine treatment(s) and medication(s):
   _____
   _____
   b. As Needed (PRN) treatment(s) and medication(s):
   _____
   _____
3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:
   _____
   _____
4. Child's knowledge:
   a. What is your child's understanding of the medical condition?
   _____
   b. Does your child understand about any restrictions at day care?
   _____
   c. Can your child tell the teacher when treatment and medication is needed? ☐ Yes ☐ No
   d. Does your child cooperate with treatment and medication? ☐ Yes ☐ No
5. Additional information and/or Health Care Provider's recommendations:
   _____
   _____
   _____
   _____

_____ Parent Signature/Date

_____ Health Care Provider Signature/Date

Asthma Action Plan

Site: _____ Room: _____

Patient Name: _____ # _____ Weight: _____ DOB: _____ Peak Flow: _____

Doctor or Nurse Practitioner Name: _____

Clinic Name: _____ Phone: _____

Asthma Severity: _____

Symptom Triggers: _____

Green Zone
"Go All Clear!"

-Breathing is easy
-Can play, work, and sleep without asthma symptoms

Peak Flow Range
(80%-100% of personal best)

_____ to _____

The **Green Zone** means take the following medicine(s) every day:

Controller Medicine(s): **Dose:**

_____ _____

_____ _____

_____ _____

Spacer Used:

_____

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity:

_____

Yellow Zone
"Caution..."

-Wake up at night
-Cough or wheeze
-Chest is tight

Peak Flow Range
(50%-80% of personal best)

_____ to _____

The **Yellow Zone** means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s): **Dose:**

_____ _____

_____ _____

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour follow RED ZONE instructions. If you are in the Yellow Zone for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone
"STOP!"
"Medical Alert!"

-Medicine is not helping
-Nose opens wide to breathe
-Breathing is hard and fast
-Trouble walking
-Trouble talking
-Ribs show

Peak Flow Range
(Below 50% of personal best)

_____ to _____

The **Red Zone** means start taking your Red Zone medicine(s) and to call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to the emergency room or call 911 immediately.

Reliever Medicine(s): **Dose:**

_____ _____

_____ _____

_____ _____

I give my permission for this asthma action plan to be used by the following, and for them to share information with each other about my child's asthma on year beginning today, so that they can work together to help my child manage his/her asthma. This plan, when signed and dated, may replace or supplement the school's/daycare's consent to administer medication form, and allows my child's medicine to be administered at school/daycare.

☐ My child's school/School Health Office _____
☒ My child's day care provider La Crèche
☐ Insurance case management/Education program _____
☐ My child's clinic/hospital _____
☐ Visiting nurse/Home care agency _____
☐ Coach _____

☐ Student may carry and use this medicine at school after approval by the School Nurse
☐ My child is allowed to self-administer medications

Date _____ Parent Signature _____

Entered By _____ MD/NP/PA Signature _____

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Child Emergency Card

Name | Birth Date | ☐ Female ☐ Male Gender

Address | City | Zip | Parent/Guardian First | Parent/Guardian Last

Pick Up Address | Pick Up Contact | Notes

Drop Off Address | Drop Off Contact | Notes

Child's Health Insurance | Health Insurance ID | MN Health Care ID | Child's Dental Insurance | Dental Insurance ID

Doctor's Office/Clinic | Doctor's Name

Address | City | Phone

Hospital

Address | City | Phone

Dentist's Office | Dentist's Name

Address | City | Phone

IN CASE OF EMERGENCY

THE FOLLOWING ADULTS ARE AUTHORIZED TO SERVE AS CONTACTS. MY CHILD MAY ALSO BE RELEASED TO THESE PARTIES.

Parent or Guardian First Name | Parent or Guardian Last Name | Relationship to Child

Other Guardian in Household First Name | Other Guardian in Household Last Name | Relationship to Child

Home

Full Name	Address	City/ST	Phone Numbers	Type
Relationship	School/Work name	School/Work Contact		
Full Name	Address	City/ST	Phone Numbers	Type
Relationship	School/Work name	School/Work Contact		
Full Name	Address	City/ST	Phone Numbers	Type
Relationship	School/Work name	School/Work Contact		

In case of medical/dental emergency I hereby authorize Parents In Community Action, Inc. (PICA) staff to take my child to a health facility for treatment. I also authorize any licensed medical practitioner to provide whatever treatment is deemed necessary. I accept responsibility for any costs arising from such treatment, which is covered by insurance and/or medical assistance.

Parent/Guardian Signature | Date

In the event of an emergency, we will make every effort to contact you or one of the Emergency Contacts listed above.
Your child will NOT be released to anyone other than those adults listed on this form. Please allow 48 hours for changes to go into effect.

June 2016 - skc

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DENTIST EXAM & TREATMENT FORM

Child's Last Name	First Name	Middle Initial	Birth Date

Parent/Guardian Name	Address	Telephone #

Child's Dental Insurance Name	Child's Dental Insurance Number	Minnesota Health Care Programs #

Dear Parent/Guardian:

To ensure good oral health, every child one year and older must have a dental examination within the last six months, or no later than 90 days after the child starts school. If your child does not have a regular dentist, you may choose to have your child seen at PICA through Children's Dental Services.

If your child does have a dental provider, please have them complete the section below and bring it with you to registration.

Dentist Report

This child received the following treatment in my office:

- ❑ Dental exam
- ❑ X-rays TAKEN
- ❑ X-rays READ
- ❑ Cleaning
- ❑ Topical fluoride application
- ❑ Sealant
- ❑ Fillings
- ❑ Emergency
- ❑ Extractions
- ❑ Steel crowns
- ❑ Space maintainers
- ❑ Other, explain: _____

❑ **ALL treatments ARE complete.**

❑ **ALL treatments are NOT complete – the following is still needed:**

- ❑ TAKE X-rays
- ❑ READ X-rays
- ❑ Topical fluoride application
- ❑ Cleaning
- ❑ Sealant
- ❑ Fillings
- ❑ Extractions
- ❑ Steel crowns
- ❑ Space maintainers
- ❑ Other, explain: _____

Next Appointment DATE: _____

PRINT Dentist's Name	Dentist's Signature	Dentist's Telephone	Date of Exam

_____ _____

Parent Signature *Date*

HDR™
HEALTH DIMENSIONS REHABILITATION, INC.
Working Together...Making a Difference

1994 East Rum River Drive South, Cambridge, MN 55008 • (763) 689-5385 • (800) 243-5383 • FAX (763) 689-5558

INFORMATION REGARDING THERAPY SERVICES

Speech-Language Therapy, Occupational Therapy and Physical Therapy services are provided for children at **La Creche Early Childhood Centers** through **Health Dimensions Rehabilitation (HDR).**

I authorize HDR to screen my child after admission to La Creche Early Childhood Centers. The screening is a courtesy service arranged by La Creche Early Childhood Centers (you will not be charged for the screening). In addition, I authorize complete evaluation and therapy services if deemed necessary by HDR staff. Funding for these services are explored through insurance and other resources. I understand that evaluation results and therapy recommendations will be provided.

Child's Name: _____ Parent/Guardian: _____

Child's Soc. Sec. #: _____ Parent/Guardian Soc. Sec. #: _____

Address: _____

Child's Date of Birth _____ Phone: _____

Type of Insurance *(check one):*

☐ Medical Assistance (MA) ☐ MEDICA ☐ Metropolitan Health (MHP)

☐ Health Partners ☐ U-Care ☐ Other: _____

Policy #: _____

Does your policy have a deductible or does it pay only a part of the service?

☐ Yes ☐ No Amount: _____

I give permission to contact my child's physician to discuss screening results and obtain physician's order to complete a full evaluation.

Child's Physician: _____

Clinic: _____ Phone: _____

I certify the above information is a complete and accurate account of all medical insurance policies covering my child and will notify you of any changes. I authorize the release of information for exchange between La Creche Early Childhood Centers and HDR staff to address any needs of my child, and as needed to process any claims. Your signature authorizes HDR to provide therapy at the stated rates and to release information to any insurance company, adjuster, or their representative, to determine the payment of benefits.
ASSIGNMENT OF BENEFITS: Your signature also authorizes direct payment of medical benefits to HDR. If the patient's current policy prohibits direct payment to the provider of service, your signature directs the insurance company to issue payment for these services in the patient's name, to Health Dimensions Rehabilitation, Inc., 1994 East Rum River Dr. S., Cambridge, MN 55008. Your signature indicates that you have received a copy of HDR's Privacy Notice.
I agree to pay for services rendered to this patient that are not covered by private insurance/HMO or due to a lapse in coverage.

_____

Signature of Parent/Guardian Date

Please detach Privacy Policy and keep for your records