

# Early Intervention Services Application

Bureau of Early Intervention Services, 246 North High Street, Columbus, Ohio 43215



**PLEASE PRINT**

*Child's name (last, first, mi)			Case number (Program use only)		
*Address			*County		
*City		*State	*ZIP		
*Child's birthdate	Social Security number (child's)	*Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		*Ethnic group	Ohio resident <input type="checkbox"/> Yes <input type="checkbox"/> No
*Parent's/Legal guardian's name (last, first)		*Parent's/Legal guardian's name (last, first)			
*Address		*Address			
*City	*State	*ZIP	*City	*State	*ZIP
Social Security number			Social Security number		
*Home phone (     )	*Work phone (     )	*Home phone (     )	*Work phone (     )		

**EI Services Requested**

Category of service	Name and address of provider	Provider number	Frequency	Source of payments

Recommendations (Include/attach evaluation recommendations and assessment results, Sect. III (A, B, C, D) of IFSP)

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*Service coordinator's signature		*Date	Provider number (Program use only)	
*Service coordinator's name		*Agency name		
*Address		Telephone number (     )		
*City	*State	*ZIP		
Name of person completing form if different from service coordinator				
*Primary diagnosis	I.C.D. code	*Secondary diagnosis	I.C.D. code	
Name of primary care physician		Name of primary care dentist		

**\*DATA REQUIRED IN ORDER TO PROCESS**

<b>Child's name</b>	<b>ET ID#</b>
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**Insurance Information**

* Health insurance coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
* Health insurance coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
Dental insurance coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier number	Begin date	End date	
Dental insurance company name		Name of insured		
Vision care insurance coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier number	Begin date	End date	
Vision care insurance company name		Name of insured		

* Medicaid eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	* Medicaid recipient/Billing number	Begin date	End date	S.S.I. eligible <input type="checkbox"/> Yes <input type="checkbox"/> No
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I hereby authorize the managing physician or service coordinator listed above to submit this application to the Ohio Department of Health, Bureau of Early Intervention Services (BEIS)/Bureau for Children with Medical Handicaps (BCMh), for services for the child named on the front of this application. I authorize BEIS/BCMh to release confidential information concerning the client's medical condition and treatment, any and all financial information and third-party coverage to the Help Me Grow program located in the county where the client lives or receives treatment and to health care and service providers, facilities and third party payors (and their agents and employees) for the purposes of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of any and all information concerning the client's medical conditions and treatment, including if applicable, the client's HIV testing or diagnosis of AIDS or AIDS-related conditions.

I certify and attest that all the information given by me on this form and other BEIS/BCMh application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to BEIS/BCMh of any and all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom these claims or amounts were paid.

This release authorization is effective from the date of my signature and will remain in effect until such time as I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law.

I have read this authorization to release information and fully understand its contents.

* Parent's/Guardian's signature	*Date
*Print name	*Relationship to child

**For Program Use Only**

Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Program	Code	Effective date
Denial reason		Code	Expiration date
ODH staff			Date

**\*DATA REQUIRED IN ORDER TO PROCESS**