NORTH DAKOTA EARLY INTERVENTION-PUBLIC (MEDICAID) ACCESS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1433 (2-2023)

Clear Fields

Name of Child	
Date of Birth	Date Completed

Application for North Dakota Medicaid:

I understand that it is my decision to apply for Medicaid for my child if he/she does not have Medicaid at the time of DD Program Management/Infant Development eligibility and at each annual review. I understand that if I choose to apply for Medicaid and my child is eligible, that Medicaid will be used for purposes of accessing the Home and Community Based Waiver. If, for some reason, my child's Medicaid is used to fund a Medicaid state plan service, my Early Intervention team will discuss this with me and obtain consent.

I am in agreement with completing an application for Medicaid. I acknowledge that I can withdraw this consent at any time.

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Parent or Guardian Signature	Date
Child's Social Security Number *	

* In compliance with the Federal Privacy Act of 1974, disclose of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Consent to Access Medicaid for Home and Community Based Waiver Services:

I give my permission to the Department of Health and Human Services (HHS) for Developmental Disabilities - Part C Early Intervention to access my child's Medicaid for the specified services listed in our Individual Family Service Plan. I understand that if I refuse consent, it does not relieve the Part C Early Intervention Program of its responsibility to work with me to find funding sources for the services on my child's Individual Family Service Plan.

I understand that by giving permission to seek payment from Medicaid for the services in my child's Individual Family Service Plan, information about my child's early intervention services may be shared in this process.

I understand that if I choose not to give consent, any benefits for which my child and family are entitled will not be affected.

I understand that I may revoke consent to access Medicaid for the services in my child's Individual Family Service Plan at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by notifying my DD Program Manager at the Regional Human Service Center.

I give permission for Developmental Disabilities - Part C Providers to access Medicaid funding for services provided to my child for Part C Early Intervention:

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Parent or Guardian Signature	Date

I decline permission for Developmental Disabilities - Part C Providers to access Medicaid funding for services provided to my child for Part C Early Intervention:

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Parent or Guardian Signature	Date