DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-00688 (03/2017)

REFERRAL TO WISCONSIN BIRTH TO 3 PROGRAM

Instructions: Complete this form and send to the county Birth to 3 Program where the child lives.

Note: To locate the county Birth to 3 Program contact information visit www.dhs.wisconsin.gov/birthto3/contacts.htm. Phone referrals may also be made.

CHILD INFORMATION

Child's Full Name (First, MI, Last)	Date of Birth	Sex ☐ M ☐ F

Child's Race (if known)
☐ American Indian/Alaskan Native ☐ Hawaiian/Other Pacific Islander ☐ Black/African American ☐ Asian ☐ White

Child's Ethnicity (if known)
Hispanic ☐ Yes ☐ No

Parent and/or Guardian Full Name (First, MI, Last)

Child's Home Street Address	City	State WI	Zip Code	County of Child's Residence
Primary Phone	Other Phone	Primary Language (if known)		

REFERRING PROVIDER INFORMATION

Name of Provider Making Referral

Provider Street Address	City	State	Zip Code	Office Phone	Office Fax

PROVIDER: Reason for Referral to county Birth to 3 Program
Check all the apply: **(Attach Screen Results)**
1) Concerning screen: ☐ ASQ ☐ ASQ:SE ☐ M-CHAT ☐ PEDS ☐ Other: _____

Possible delays in the following areas (please check all areas of concern):
☐ Speech/Language ☐ Gross Motor ☐ Fine Motor ☐ Adaptive/Self-Help ☐ Hearing ☐ Vision
☐ Cognitive/Problem-Solving ☐ Social-Emotional or Behavior
☐ Other Concerns: _____

PARENTAL CONSENT to Release Child's Medical, Developmental and, Educational Information to Referral Provider.
See back of this form for complete explanation of parental rights regarding consent.

I authorize the provider above to disclose medical information to the Enter County Birth to 3 Program Name & County relating to my child's possible developmental delay to assist the Birth to 3 Program to perform its duties and/or to coordinate the delivery of Birth to 3 Program services to my child. This authorization includes disclosure of information regarding developmental disabilities, mental illness, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

I authorize the county Birth to 3 Program to disclose my child's early intervention record resulting from this referral with the provider as indicated above. The purpose of the disclosure is to assist the Birth to 3 Program to perform its duties and/or to coordinate the Birth to 3 Program services for my child. This authorization includes disclosure described below with the following exception(s):

In accordance with the conditions listed on this form, I authorize the use and/or disclosure of my child's confidential information. Unless revoked, the authorization will remain in effect until the expiration time indicated below. Select only one:

☐ Authorization expires when my child's participation in the county Birth to 3 Program ends.
☐ Authorization expires as of _____ (specify expiration date).
☐ Authorization expires one year from the date of my signature on this release.

Parent/Guardian Signature	Date Signed	Print Name	Indicate Legal Authority of Person Signing ☐ Parent of Minor ☐ Legal Guardian

COUNTY BIRTH TO 3 PROGRAM: REFERRAL RESULTS TO REFERRING PROVIDER
Please complete this portion and return to the referring provider above. (check all that apply)

☐ Unable to locate the family.
☐ Child was screened and no evaluation recommended. ☐ Screening results enclosed.
☐ The child was evaluated on _____(date). ☐ Evaluation report enclosed.
☐ Eligible for program ☐ Participating in program ☐ Parents' choice not to participate or declined next steps
☐ Not eligible for program at this time ☐ Scheduled recheck ☐ Provided information on community programs

County Birth to 3 Program Contact Name	Contact Phone Number

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN REFERRAL PROVIDERS AND THE WISCONSIN BIRTH TO 3 PROGRAM

Who May Provide Consent?
Parental Consent is not required by the Wisconsin Birth to 3 Program to receive a referral; however the parent or legal guardian of the child must provide consent for screening, evaluation, and enrollment into the Birth to 3 Program and for disclosure of records. Foster parents **do not** have presumed legal rights to provide parental consent. The consent for release of information on this form authorizes the disclosure and/or use of the child's health or developmental information between the referring provider and the county Birth to 3 Program as identified on the referral form.

What are my parental rights?
I have the following rights with respect to this consent:

- You are not required to sign this authorization. Except as permitted under applicable law, refusal to sign will not affect treatment, enrollment, or benefits eligibility.
- You may revoke this consent, in writing, any time except for information already released as a result of this authorization. The written revocation must be given to the organization authorized to release the information.
- You have the right to inspect and, upon paying applicable fees, obtain a copy of the disclosed records.
- The information that you authorize to be released may be redisclosed by the recipient of these records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

Why is a consent form important?
Your child might be seen by other professionals who monitor your child's overall growth and development. Your child's health care provider sees your child at well-child visits and for medical treatment. Your child care provider sees your child interact with other children every day. Sometimes your child's health care and other service providers may need more information, like evaluation by other specialists, to best care for your child. The county Birth to 3 Program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care and other service providers and the county Birth to 3 Program so these providers can work together to help your child.

What is the purpose of consent form?
This consent form was developed to ensure compliance with all federal and state laws regarding the protection of medical and educational information. This consent includes the sharing of information as authorized under federal/state confidentiality laws, Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations and Family Educational Rights and Privacy Act (FERPA) guidelines. The purpose of the consent is to provide the county Birth to 3 Program with information to assist in the determination of the child's eligibility for early intervention services as well to ensure the child's health care provider receives information regarding the status of the child in the Birth to 3 Program. By authorizing the countyBirth to 3 Program to share pertinent information, you help to ensure that your health care and other service providers remain an active participant in your child's growth and development.

How will this consent be used?
This consent form will follow your child's referral to the county Birth to 3 Program as he/she is screened and/or evaluated to determine eligibility for the Birth to 3 Program. The information generated by this referral will become a part of the child's educational record. The county Birth to 3 Program will protect this information as prescribed by HIPAA, FERPA, and other federal/state confidentiality laws.

Family Educational Rights and Privacy Act (FERPA) 34 CFR §99.30
Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations 45 CFR §164