Reset Form

ELECTRONIC DATABASE COLLECTION SYSTEMS
CONSENT FOR THE COLLECTION OF INFORMATION

State Form 55163 (1-13)
FIRST STEPS EARLY INTERVENTION SERVICES SYSTEM
CHILDREN'S SPECIAL HEALTH CARE SERVICES
MATERNAL CHILD HEALTH

INSTRUCTIONS: Please review the following information and have your intake/service coordinator discuss any questions that you may have before signing below.

Name of child *(last, first, and middle initial)*	Date of birth *(month, day, year)*

We are asking for your CONSENT for the RELEASE AND EXCHANGE of INFORMATION COLLECTED during the ENROLLMENT/SERVICE DELIVERY PROCESS.

The programs you are enrolling in are: the First Steps Early Intervention Service System, a program that ensures the provision of early intervention services to eligible children under thirty-six (36) months of age and their family; and/or Children's Special Health Care Services, a program that provides the primary, specialty, diagnostic, and dental related care for medically and financially eligible children zero to twenty-one (0-21) years of age; and/or the Maternal Child Health Clinics. Services available through this program partnership include screening, evaluation and assessment, service coordination, due process and procedural safeguards and a variety of early interventions, health and medical services that are made available based upon the needs of the child and family.

We are asking for permission as parent/legal guardian/emancipated minor/person eighteen (18) years of age or older, to collect demographic and service information about you and/or your child and store it electronically in the Indiana State Department of Health (ISDH) and/or Family and Social Services Administration (FSSA) database system(s). Based upon the information you collected during the eligibility determination and enrollment process, a multidisciplinary team will work with you to determine your child's needs for services. With your informed, written consent, only those health care professionals and service providers with a direct need to know and with authorized security clearance will have access to the electronic file or authorizations for eligibility determination services that are required and authorized by you as your child's parent/legal guardian. Statistical and program information, without any child or family identifying information, will be sent to State and Federal agencies that fund these services to meet various reporting requirements.

Individual designated and signed releases are maintained in your child's record at the local System Point of Entry/ISDH/Maternal Child Health (MCH) clinics that indicate individuals with whom you have given your information, written consent for reciprocal communications including the sharing and receipt of reports. The person(s) receiving this information has a legal and ethical duty to keep the information in a confidential and private manner, and will not release it to anyone else without your written permission unless allowed by law.

As legal guardian, you authorize the ISDH and/or FSSA database system(s) to distribute information collected during the eligibility determination/enrollment process and service delivery period with the following:

1. Indiana Family and Social Services Administration,
2. Indiana Departments of: Health, Education, and the Division or Disability, Aging and Rehabilitation Services.
3. U.S. Departments of Education, and Health and Human Services, for the purposes of financial/program audit and monitoring purposes as required by various Federal and State regulations.

By signing the consent form, you agree to allow information to be collected through the System Point of Entry or State intake personnel for the electronic database collection systems. All aspects of the data collection, maintenance and utilization are protected under the Family Education Rights and Privacy Act (FERPA). All personal information collected will be treated as confidential pursuant to I.C. 4-1-6 et seq., I.C. 5-14-3-4 and 410 IAC 3.2-10, 42 CFR §51a. As the parent/legal guardian, access to information stored in the database is also available to you upon request.

This authorization covers certain medical, social and financial information about the eligible child and family, unless an exception is noted below, including: child/family demographic information; health visit information; infant/child visit data; disability/risk factors/problems or factors that prevent the eligible child and family from receiving appropriate services or medical care; appointments made and services received; Individualized Family Service Plan (IFSP) activities, care plans and family financial eligibility information.

ENROLLMENT / SERVICE DELIVERY PROCESS

Your signature below means that you have read and understand the information for collection and sharing of data contained in this form. The consent will remain in effect no longer than twelve (12) months from the date of your signature, unless you revoke it earlier.

Signature of parent/legal guardian	Date *(month, day, year)*
Signature of witness	Date *(month, day, year)*