San Diego Regional Center (SDRC)
Request for Copayment, Coinsurance or Deductible
For Developmental Health Treatment Services

The following information is needed for review of your request for SDRC assistance with insurance copayments, coinsurance or deductible for developmental health treatment services for your child. **Completion of this form initiates the review process and does not assure SDRC copayment, coinsurance or deductible funding assistance.**

SDRC will be able to proceed with the review of your request when all of the below information has been received.

I. Client and Insurance information

Client Name:_____ DOB:_____ UCI:_____
Last First

Number of children in family who are regional center clients:_____

Number of family members in your household _____

Employed: Mother ❑ Yes ❑ No Father ❑ Yes ❑ No

Private Insurance Plan**:**_____
Type: ❑ HMO ❑ PPO ❑ POS

Secondary Private Plan (if applicable):_____
Type: ❑ HMO ❑ PPO ❑ POS

MediCal: ❑ Yes ❑ No If yes, BIC#:_____

PLEASE CONTACT YOUR INSURANCE COMPANY or HUMAN RESOURCES DEPARTMENT FOR THE FOLLOWING INFORMATION:
Your individual maximum out of pocket _____
The per day co-payment _____
The deductible on your plan if it is applicable to the service _____
The month your benefits re-set _____

II. Services for which you are requesting assistance: (Services must be related to the developmental disability/developmental delay; agreed to by the planning team; and included in the client's IFSP/IPP)

Type of Service_____
Name of Provider:_____ ❑ In Network ❑ Out of Network
Frequency of Service:_____

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Frequency of Service:_____

(over please)

III. Eligibility for assistance with copayment, coinsurance or deductible requires review of the annual gross income for your household.

Please enclose a copy of **one** of the following documents for income verification for each employed family member. Any other documentation cannot be accepted:

- Most current Federal income tax return
- Most current State income tax return
- Current W2 wage earners statement
- Current detailed Payroll stubs

IV. Please read the following information carefully:

- I agree to sign Authorization for Use or Disclosure of Information forms in order for SDRC to obtain information from my insurance company and the provider(s) of developmental health treatment services.
- I understand that I must meet the financial eligibility requirements in order for SDRC to fund my co-payment, co-insurance or deductible for developmental health treatment services.
- I understand that if I do not meet financial eligibility requirements, funding of my co-payment, co-insurance or deductible may be considered if I am able to demonstrate an extraordinary event, a catastrophic loss or significant unreimbursed medical costs. I understand that I must provide necessary information which verifies any financial need.
- I understand that my service provider must be a regional center vendor.
- I understand that SDRC funding of my co-payment, co-insurance or deductible will be at the in-network rate.
- I understand that the services for which I am requesting co-payment, co-insurance or deductible reimbursement must be on my child's IPP/IFSP.
- I understand that my signature below authorizes SDRC to make my required co-payment, coinsurance or deductible directly to the service provider.

Please return this form, signed, along with the following:

- A copy of the insurance card for the client (front and back)
- Verification of gross annual income (per above)
- Signed Authorization for Use or Disclosure of Information forms; one form completed for your insurance company and form(s) completed for your provider(s).

_____ _____

Signature of insured Date

_____

Print Name

Return forms in the enclosed envelope to:

San Diego Regional Center
Insurance Coordinator
4355 Ruffin Road
San Diego, CA 92123

rev 2.9.16