Clear Form

Minnesota Department of **Human Services**

DHS-5275-ENG 3-16

Health Plan Notification of Foster Care/Child Protection Placement with Authorization Form

This form was created in cooperation with county and health plan staff. For continuity among health plans and counties, DHS encourages (but does not mandate) county staff to use this form to notify a health plan of placement information or a change in placement.

Due to the high confidentiality surrounding these cases, the health plan will not release any information to foster parents without written authorization from the child's authorized representative/legal guardian. The authorization form must be sent to the health plan if the child's authorized representative wants the health plan to work directly with the child's foster parent(s).

A copy of the court order, or other legal document, giving the authorized representative the authority to act on the child's behalf must be faxed to the health plan with the authorization form.

The authorized representative should keep a copy of the signed authorization form for their records.

DATE OF THIS NOTIFICATION	PHONE NUMBER	NAME OF SOCIAL WORKER IN CHARGE OF CHILD'S CASE		
EFFECTIVE DATE OF ACTION	NOTIFICATION OF ◯ New placement ◯ Removal from placement ◯ Change of _____			
CHILD'S NAME		CHILD'S BIRTH DATE	PMI	CASE NUMBER

All information below is optional – at county's discretion

FOSTER PARENT	PHONE NUMBER
FOSTER PARENT ADDRESS	

I, _____, the authorized representative/legal guardian

of _____, authorize _____ to
(NAME OF HEALTH PLAN)

☐ Arrange transportation ☐ Receive medical reports ☐ Release MH and CD information ☐ File a complaint/appeal

☐ Schedule appointments ☐ Discuss claims issues ☐ _____

with/to the above mentioned foster parents. I understand that State and Federal privacy laws protect these records. These records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, the health plan will not be able to provide the service I am requesting. I may cancel this consent with written notice at any time, but that this written notice will not affect information the agency has already requested or released. I understand that I cannot cancel this release if it must be shared with heath care consultants, to pay claims, if fraud is suspected, or for quality review. I understand that those who receive these records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization.

This consent ends one year from the date I sign it, or other periods as provided by law.

SIGNATURE	DATE

Confidentiality Notice: The information contained on this form may be privileged and confidential and protected from disclosure. If the person receiving this form is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are herby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately.

Please fax to the appropriate health plan at:

Blue Plus 651-662-9216
HealthPartners 952-883-7666
Itasca Medical Care 218-327-5545
Medica.....952-992-3016
Metropolitan Health Plan 612-632-8618
PrimeWest Health 320-335-5223
South Country Health Alliance.....507-431-6328
UCare ..... 612-676-6501 Attn: Enrollment

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກໍາກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA4 (9-15)

ADA Advisory

For accessible formats of this publication, ask your county worker. For assistance with additional equal access to human services, contact your county’s ADA coordinator.