Virginia Infant & Toddler Connection

Summary of Charges and Fees for the ____________ Early Intervention Services System

The following is an estimation of your insurance coverage, our contract rate for your service(s), and the maximum monthly amount you would be expected to pay should you choose to participate in our Ability-to-Pay program. If a service you receive is not listed on this chart, it is provided to you free of charge.

DOB: ____________________ ______Initial ______ Annual ______Revision: effective date:____________

Child's Name: ____ Service Coordinator: ________________________ **Today's date: _________________**

Insurance Carrier: Primary______________________________________ Ins. #_________________________
Secondary______________________________________ Ins. #_________________________
Tertiary______________________________________ Ins. #_________________________

Therapy Provider:
☐ ___________ ☐ ___________
☐ ___________ ☐ ___________
☐ ___________ ☐ ___________
☐ ___________ ☐ ___________
☐ ___________ ☐
☐ ☐

Insurance Coverage *(Estimate based upon review of your policy. Actual coverage will be determined by your insurer at the time of billing. Some information may not be available until after billing has occurred)*	**Billable Services / Charge** *(Cost of providing the listed service(s) while your child is in our Program)*		**Estimated Amount You Will Be Charged** *(see below)*	**Your Family's Monthly Cost Share Cap** ***(You will not be required to pay more than this amount)***
1. Annual Deductible: ________________ Met for Year: __________	**Developmental Services**	**$110 / hr**		
2. E.I. Benefit: _______ *If no, list reason (___ Self Insured Employer ___ Federal Government ___ Not licensed in Virginia)*	**Occupational Therapy**	***$150 / hr**		_______________
3. Explanation of non-coverage / change:	**Physical Therapy**	***$150 / hr**		
	Speech Therapy	***$150 / hr**		*Monthly Cap Expires:* _______________

I understand I will be charged the amounts listed in the "Estimated Amount You Will Be Charged" section for any of those early intervention services I receive. I will be expected to pay these charges up to, but not exceeding our family's maximum monthly fee cap if applicable, and that the charges are based upon an estimate of what my insurance will cover. If actual insurance coverage is different, I understand my account will be adjusted and I will receive a refund or additional charges accordingly.

Person completing form *(If CIIP staff, only sign below)*: ____ Phone: ____________________

Staff signature/date: ____________________________________/_______________ Parent signature/date: ____/_______________