Joint Health Management Board
Fresno Unified School District

FRESNO UNIFIED SCHOOL DISTRICT
Employee Health Care Plan

PARTICIPANT QUESTIONNAIRE AND PHYSICIAN REPORT

The FUSD Employee Health Care Plan (the Plan) provides continuation of coverage for disabled dependent children over the age of 26. Per the FUSD Plan Booklet, **Disabled Child** means a dependent child (1) who is mentally or physically disabled, (2) who is incapable of self-sustaining employment, (3) who is dependent upon the employee/retiree for support and maintenance, (4) who is not married or in a domestic partnership, and (5) whose condition existed prior to such disabled child reaching the age of 26.

Instructions to FUSD participant: Please complete "Participant and Dependent Information" immediately below. Please provide Attachment A "Physician Report" to your dependent child's treating physician specializing in your dependent child's disability and ask them to complete it. Please return the completed "Participant Questionnaire and Physician Report" to: FUSD Benefits Department, 2309 Tulare Street, Fresno, CA 93721. The form(s) can also be emailed to FUSDBenefits@fresnounified.org or faxed to 559-457-3760.

If this is your initial request for Disabled Child coverage, all required documents and information must be submitted to the FUSD Benefits Department prior to the dependent child's 26th birthday.

Participant and Dependent Information	
Participant Information	**Dependent Child Information**
Name:	**Name:**
Address:	**Address:**
Primary Phone Number:	**Primary Phone Number:**

1.	Is your child mentally or physically disabled?	Yes	No
2.	Is your child incapable of self-sustaining employment?	Yes	No
3.	Is your child dependent on you for support and maintenance?	Yes	No
4.	Is your child married or in a domestic partnership?	Yes	No
5.	Did your child's disability exist prior to them reaching the age of 26?	Yes	No

I certify that the information provided herein is true and correct to the best of my knowledge, and that my child meets the Plan's definition of Disabled Child. I agree to provide supporting documentation such as, but not limited to, tax returns, statement of financial liability, or any other documents when requested by the Plan. I understand and agree that any **fraudulent** or **intentional misrepresentation** of a material fact herein may result in retroactive termination of my dependent child's coverage under the Plan and that I will be financially responsible for any and all claims paid by the Plan during the period in which my dependent child was not eligible for Disabled Dependent coverage.

I understand that I am required to notify the Plan within 60-days after my child no longer meets the definition of a Disabled Child, and that failure to provide such notice within the 60-day period will result in ineligibility for COBRA continuation coverage. I understand that if the failure to notify the Plan in accordance with the prior sentence is fraudulent or an intentional misrepresentation it may result in retroactive termination of my child's coverage and that I will be responsible for any and all claims paid by the Plan during the period in which my child was not eligible for Disabled Dependent coverage.

_____ _____

Participant Signature Date

ATTACHMENT A

PHYSICIAN REPORT

Instructions to the treating physician: FUSD asks that you complete this form to assist in determining eligibility for Disabled Child coverage/continued coverage under the plan for:

Name of child: _____

Per the FUSD Plan Booklet, **Disabled Child** means a dependent child (1) who is mentally or physically disabled, (2) who is incapable of self-sustaining employment, (3) who is dependent upon the employee/retiree for support and maintenance, (4) who is not married or in a domestic partnership, and (5) whose condition existed prior to such disabled child reaching the age of 26.

1.	Are you the child's treating physician? ( ) Yes ( ) No I have treated the child for the current disability from _____ to _____; at intervals of _____. I last examined the patient on _____.
2.	Is the treatment that you are providing for the child's disability within the specific education, experience, and the specific demonstrated competency for which you are licensed (i.e., is the treatment for the child's disability within the scope of your license)? ( ) Yes ( ) No
3.	Please state each of the child's physical or mental conditions, including diseases or injuries, which result in the child being disabled.
4.	With respect to each condition listed in your answer to #3 above, please indicate whether the child was younger than 26 when the condition(s), giving rise to the disability, began. Condition One: _____. ( ) Yes ( ) No Condition Three: _____. ( ) Yes ( ) No Condition Two: _____. ( ) Yes ( ) No Condition Four: _____. ( ) Yes ( ) No Please include additional information as an attachment to this form.
5.	Objective Clinical Findings/Detailed Statement of Disability. Please include this information as an attachment if you require additional room.
6.	Is the child dependent upon the Employee/Retiree for support and maintenance due to the disability? ( ) Yes ( ) No
7.	Is the child incapable of self-sustaining employment/independent living due to the disability? ( ) Yes ( ) No
8.	If the answer to #7 is yes, which of the child's conditions render the child incapable of self-sustaining employment/independent living?

9.	If the answer to #7 is yes, are there treatments which are in progress which would enable the child to be capable of self-sustaining employment/independent living? ( ) Yes ( ) No If so, what is the anticipated/estimated date when the child would be capable of self-sustaining employment/independent living?
10.	If the answer to #7 is yes, are there treatments available which have not been tried which would enable the child to be capable of self-sustaining employment/independent living? ( ) Yes ( ) No If so, why have they not been tried?

Based on your examination of the dependent child please select **only one**:

[] The patient DOES NOT have a physical or mental disability that satisfies the Plan's definition of Disabled Dependent, the definition of which is provided above.

[] The patient's current disability DOES render them incapable of self-sustaining employment and dependent upon the employee/retiree for support and maintenance, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by:

_____
Projected Date (Required)

Please do not leave the "Projected Date" blank. Answers such as "indefinite" or "don't know" will not suffice.

[] The patient's current disability is permanent or of extended duration and the patient is not and will not be capable of self-sustaining employment and will be dependent upon the employee/retiree for support and maintenance for the foreseeable future.

I certify that I am a licensed physician specializing in this dependent child's disability and based upon my examination of the patient, the above statements truly describe the patient's disability.

I am a _____
(Type of Physician) (Specialty)

licensed to practice by the State of _____.

Treating Physician Information

_____ _____
Name As It Appears on License **State License Number:**

Address:

_____
Phone Number

_____
Fax number

_____ _____
Signature **Date**

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(14-point Authorization)

Patient Name: _____ Health Records Number: _____
Date of Birth: _____ SSN# _____

I authorize the use or disclosure of the above-named individual's health information as described below:

1. The following individual or organization is authorized to make the disclosure: _____

2. The type and amount of information to be used or disclosed is as follows:

- □ The physical or mental conditions, including diseases or injuries, which result in being disabled.
- □ Objective clinical findings/detailed statement of disability
- □ Dependence on others for support and maintenance because of disability
- □ Capability of self-sustaining employment/independent living due to the disability
- □ Treatments which are in progress which would enable the capability of self-sustaining employment/independent living
- □ Age when the condition(s), giving rise to the disability, began
- □ Untried available treatments which would enable the capability of self-sustaining employment/independent living

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, received by, and used by the following individual or organization: the Fresno Unified School District's Benefits Department for the purpose of determining whether the District's health care plan will provide continuation of health benefits coverage for a disabled dependent children over the age of 26.

5. I understand I have the right to revoke this authorization at anytime. I understand if I revoke this authorization I must do so in writing and present my written revocation to the parties listed on 1. and 4. above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company or when the law is otherwise revoked. This authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment, payment or eligibility for my benefits. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand my disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. **I have read and understand this authorization and that I have been advised that I have the right to receive a copy of this authorization. A copy of this authorization shall be considered as valid as the original.**

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Signature of Witness
Relationship to Patient