



Remote Early Intervention (Remote EI) Consent and Prior Authorization (PA) Request Form

Family Consent for the Use of Remote EI:

*I understand that my visits will be completed remotely using the phone or a secure video connection.
I have been given technical assistance to make this happen effectively.
I understand that my family cost participation fee (if applicable) will be billed for Remote EI visits.
I understand that I can revoke this consent at any time.*

Printed Name: _____

Signature: _____ Date: _____

~~~~~  
Birth to Three Program ONLY email SECURELY to [CTBirth23@ct.gov](mailto:CTBirth23@ct.gov) as required  
(PA waived during COVID-19 PHE except for audio only EITS.)

|                                                                                                                                                                                                                                                       |                                                       |                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| Program Name:                                                                                                                                                                                                                                         | Child's Name:                                         | Birth to Three Number:                                                                                                                                |
| Start Date:                                                                                                                                                                                                                                           | Proposed End Date:                                    | Service Type:<br><input type="checkbox"/> Eval/Assmt <input type="checkbox"/> IFSP<br><input type="checkbox"/> EITS <input type="checkbox"/> S@NC F2F |
| <input type="checkbox"/> IFSP: Section Six (unless waived)                                                                                                                                                                                            |                                                       |                                                                                                                                                       |
| Reason:<br><input type="checkbox"/> Immune Compromised Home:<br><input type="checkbox"/> Workforce Shortage:<br><input type="checkbox"/> Declared State of Emergency<br>Provide more details below for each selection:                                |                                                       |                                                                                                                                                       |
| Which technology will be used and if not on the OEC list how you determined HIPPA Compliance<br><input type="checkbox"/> HIPAA Compliant Web-Based Application: _____<br><input type="checkbox"/> Phone<br><input type="checkbox"/> Other (Describe): |                                                       |                                                                                                                                                       |
| <b>Office of Early Childhood Only:</b>                                                                                                                                                                                                                |                                                       |                                                                                                                                                       |
| Date request received:                                                                                                                                                                                                                                | <input type="checkbox"/> Approved                     | Authorized Signature and Date:                                                                                                                        |
| Date returned to program:                                                                                                                                                                                                                             | <input type="checkbox"/> Denial Reason:               |                                                                                                                                                       |
|                                                                                                                                                                                                                                                       | <input type="checkbox"/> Need Additional Information: |                                                                                                                                                       |

I revoke this consent:  
Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_