

COLLEGE OF SOUTHERN IDAHO HEAD START / EARLY HEAD START

Health/Dental and Special Needs Follow-Up Authorization Request

Child's Name _____ Parent's Name _____

Health/Dental Follow-Up Needed _____

Doctor/Dentist _____ Anesthesiologist/Therapist _____

Hospital _____ X-ray/Lab _____

Other _____

Funding sources that you and your FE can explore: ***please indicate those contacted and their response.*** (Use back of form if necessary.)

Medicaid/CHIP (#) _____

Family Contributions _____

Parent's Insurance (Company/Policy#) _____

Community funds _____

Military Insurance (Company/Policy#) Tri- Care Champus

County Commissioners _____

Other Funds _____

Vision Resources

Sight for Students _____

Lion's Club _____

Idaho Migrant (Community Council of Idaho) _____

Community Action Emergency Fund _____

Dental Resources

Caring Program for Children _____

Church _____

Katie Beckett (Dept of H&W) _____

Special Needs

Primary Children's Hospital _____

Shriner's _____

South Central Public Health District
Children's Special Health _____

- Cardiac Clinic _____
- Ortho Clinic _____
- Neuro Clinic _____

Reason for requesting Head Start funds: (Please be specific) _____

Family Educator _____ Date _____ Head Start Center _____ Center Supervisor _____ Date _____

Head Start is required by law to utilize Head Start funds for medical follow up only when all other sources of funding have been exhausted. Only Emergency Authorization may be processed by telephone. ***I understand that for Head Start to pay for follow up services, authorization must be obtained in advanced. Parent - please initial*** _____

Please return this request to Central Office for processing. Copies will be returned for child's file.

=====FOR OFFICE USE ONLY=====

Authorization for Head Start funding

P.O. # Amount To Whom For What Date

Health Specialist or EHS Coordinator _____ Date _____