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-UpNeeded_____

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 (#)_____

Parent's Insurance (Company/Policy#) _____

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

_____

Vision Resources
Sight for Students _____
Lion's Club _____

Dental Resources
Caring Program for Children_____

Special Needs
Primary Children's Hospital_____
Shriner's_____

Family Contributions_____

Community funds_____

County Commissioners_____

Other Funds _____

Idaho Migrant (Community Council of Idaho) _____

Community Action Emergency Fund _____

Church_____
Katie Beckett (Dept of H&W)_____

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