tiny-k An Early-Intervention Network		Family Name	
		Address	
Enter Local tiny-k Program specific info here		City, State, Zip	
		Child's Name	
		DOB	
Date of Request:		Physician Name:	
Street Address:		City, State, Zip:	
Phone Number:		Fax Number:	
As specified in the child's Individualized Family Service Plan (IFSP), the child listed above qualifies and will receive early intervention services during the time period outlined in the IFSP (refer to the IFSP for specific services).			
If/as appropriate, the Early Childhood Intervention (ECI) program (local tiny-k program) may seek reimbursement from the Medical Insurance Carrier/ Kansas Medicaid/ KanCare for some or all of the early intervention services. In order to do that, however, the ECI must obtain the signature of a qualified health care provider.			
	The above-named child is appropriate to receive evaluation and treatment by qualified professionals as part of an early intervention program. I understand a responsible therapist will revise the program in keeping with the child's progress. Unless I note otherwise, I concur that the child's appropriate diagnosis is <b>Delayed Milestones</b> in Childhood, ICD 10 R62.0		
		Or	
	Alternate Diagnosis:	ICD-10-#	
		Or	
	I would like to be contacted further regarding this authorization/ prescription.		
	I would like to be contacted further regarding this authorization/ prescription.		
Your signature certifies the child requires all early intervention service(s) specified in the child's IFSP. In this regard, this document will serve as the required "Physician's Prescription" with respect to those services. This prescription must be renewed annually.			
For the period from: to			
Physician Signature		 Date	
Comm	ents:		

Please fax or mail to: [Program Name

[Program Name] [Contact Name] [Address] [City, State, Zip] [FAX #: ]