BSACAP Authorization for Medical/Dental Services

Child Name: _____ **Center: _____**

FSW Name: _____

❑ **Requesting Mileage Assistance** ❑ **Requesting Other Assistance**

Check One	Status	Information
❑	**Medicaid / K-Chip**	HS can pay nitrous fee
❑	**Private Insurance with dental insurance coverage**	HS can pay co-pays
❑	**Private Insurance- with no dental coverage**	HS can pay all dental fees
❑	**No Insurance**	HS can pay all dental fees

This form must be completed and sent to the Grantee Health Services Manager for approval before child has been to a medical or dental appointment if financial assistance is being requested. If it is indicated on COPA that the child is income eligible for Head Start services and does not have a medical card, K-Chip, or other insurance coverage, a statement from Community Based Services must be attached in order to process the request. When Head Start funds are used for medical/dental/ travel, all other sources of funding must have been exhausted.

Please list any additional comments you may have regarding the family situation in the section below. If known please give doctor's name, location, date, time and purpose of appointment.

Comments: _____

_____

Family Service Worker **Date**

_____ _____

Grantee Health Manager **Date** **Grantee Director** **Date**

❑ **Approved** ❑ **Disapproved** **Date Returned to FSW _____**