made2move:therapy4kids

Transfer of Services

Child's Name: ___________________________________ **DOB**: _____________

To Whom It May Concern:

My child____ was receiving services from__________________________________ for his/her therapy needs. He/She is not receiving therapy services from anyone else at this time. Therefore, I am requesting my child receive services from your facility.

________________________________ _________________

Name of Child Date of Birth

Address: _____________________ Phone#: ___________________

____

Last Date of Service: ___________Medicaid# _____________________

Signature of Parent/Guardian __________________________________

Date: _______________________

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