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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**Division of Medicaid ServicesF-00315A (02/2017)  |
| **wRITTEN PRIOR NOTICE – no evaluation recommended** |
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| Name – Child | Date of Meeting / Notice |
|       |       |
| Your child was referred to the Birth to 3 Program as a child with a suspected delay. Therefore, we propose: |
|       |
| Other options considered include: |
|       |
| This decision is based upon the information / reasons explained below. The **information** used to make this decision included (e.g., screening tool, test, observation, medical reports, parent report, or other sources): |
|       |
| The **reasons** for this decision included (e.g., screening results, test results, list of skills observed or not observed, diagnosis, or other reason): |
|       |
| You have the right to refuse consent for an evaluation or service. Accompanying this letter is a copy of the Parent and Child Rights brochure which contains a brief review of the rights. If you would like a complete copy of the Parent and Child Rights document or have questions, please contact me. |
| Name – Service Coordinator | Telephone Number |
|       |       |