|  |
| --- |
| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**Division of Medicaid ServicesF-00315D (03/2017)  |
| **wRITTEN PRIOR NOTICE – additional assessment recommended** |
| Name – Child      | Date of Meeting / Notice      |
| Your child has been receiving services through the Birth to 3 Program. Through working with your family, we have identified the need for additional information about your child’s development. Therefore, we propose to: |
|       |
| Other options considered include: |
|       |
| This decision is based upon the information / reasons explained below. The **information** used to make this decision included (ex., screening tool, test, observation, medical reports, parent report, or other sources): |
|       |
| The **reasons** for this decision included (ex., screening results, test results, list of skills observed or not observed, diagnosis, or other reason): |
|       |
| You have the right to agree with or refuse the proposed action. Accompanying this letter is a copy of the parent and child rights statement and the actions to take if you do not agree with the proposed action. These are a brief review of the rights. If you would like a complete copy of the parent and child rights, please contact me. Feel free to call if you have any questions. |
| Name – Service Coordinator      | Telephone Number      |