Westchester County Department of Health
Early Intervention Program

PHYSICIAN ATTESTATION FOR TRANSPORTATION SERVICES TO CHILD/FAMILY RECEIVING EARLY INTERVENTION SERVICES

Child: _____ _____ DOB: _____
First Name Last Name

Parent/Guardian (or Foster Parent): _____ _____
First Name Last Name

Address: _____

_____

This attestation documents the above-named child/family's need for transportation necessary to enable the child and the child's family to receive Medicaid covered service(s) in the Early Intervention Program as included in the child's Individual Family Service Plan (IFSP).

Practitioner Signature: _____(original) Date: _____

Practitioner Name (Print):_____ Phone No.:_____

Practitioner Address: _____

New York State License No.: _____ NPI No.: _____

MEDICAID ☐ Yes