REQUEST FOR COUNTY – PAID DIAGNOSTIC ASSESSMENT SERVICES

Family Name: ________________________________

Child Name: ________________________________

Request for Itasca County authorization to pay for a diagnostic assessment for this child based on the following: (Please check all that apply)

○ The family/child does not have insurance coverage for this service, or

○ Have insurance coverage but does not cover this service.

○ Child needs a diagnostic assessment to make an INITIAL eligibility determination for mental health services deemed medically necessary.

○ Other: ____________________________________________

Additional Notes:

Request made by: ________________________________
Date Forwarded to County: ________________________

Approved: YES ___________ NO ___________

Signature of County Representative __________________________ Date ___________

Equal Opportunity Employer

Dev; CDP; 2/23/2012