Early Start

You have a gap in services. Please fill out this report and submit to eibilling@earlystartinc.com or fax (718) 836-2242

Child: _____ **Therapist**: _____

Service: _____ **Dates of Absence**: ____/____/____ - ____/____/_____ *

(OT/PT/ST/SI/FT) *(Based on the Schedule)*

1. **Mark All That Apply:**

- ☐ 4 or more missed consecutive sessions
- ☐ 14 day gap in service
- ☐ 14 day gap in start date (please include F.T. 1x/month)

2. **Mark <u>One</u> of the Following:**

- ☐ Unexpected
- ☐ Expected

2a. If Expected:

Parents and OSC must be notified by the therapist of scheduled absence such as vacations/workshops/etc. ***at least 5 days in advance***.

Date Parent and OSC Notified of Expected Absence by Provider:_____/_____/_____ *

3. **Please specify reason:**

_____

_____

_____

_____

(ex: child/therapist illness, family vacation, child/family emergency, bad weather, etc.)

4. **Date Form Completed:** ** *(must match one of the dates marked with *)* ____/____/_____

FOR OFFICE USE ONLY BELOW THIS LINE – DO NOT MARK BELOW THIS LINE

Date Document Sent to OSC: _____/_____/_____ *(within 24 hours)*