

# CALIFORNIA CHILDREN’S SERVICES (CCS) CONSENT FOR MEDICAL THERAPY PROGRAM SERVICES

\_\_\_\_\_ Medical Therapy Unit

\_\_\_\_\_ County

I hereby authorize California Children’s Services to provide the medically necessary physical therapy and/or occupational therapy services through the Medical Therapy Program for \_\_\_\_\_  
Child’s Name

These services may include therapy evaluation, treatment, monitoring, instruction, consultation, and periodic review by the Medical Therapy Conference team to assess the need for implementing, modifying, and/or continuing services.

I understand that I have the right to appeal if I disagree with the CCS-approved therapy plan and that a copy of the appeal process is attached to this form.

\_\_\_\_\_  
Signature of Parent, Caregiver, or Patient (if over 18 years of age)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of CCS Representative

\_\_\_\_\_  
Print name of CCS Representative

\_\_\_\_\_  
Date

*Original—File in CCS Case Record*

*Photocopy 1—File in Medical Therapy Unit Case Record*

*Photocopy 2—Parent copy*