



FET Information Form
CP Rochester

Name of child: _____ DOB: _____
Address: _____ Zip code: _____
Phone#: _____
SS#: _____ Medicaid#: _____

Service Coordinator name: _____
Agency: _____
Address: _____
City: _____ Zipcode: _____
Phone#: _____

Forms required for enrollment:

- *Copy of Notice of Decision
- *Copy of FLDDSO Approval letter

Please mail forms to Cheryl Garlock, CP Rochester
1650 South Avenue, Suite 400
Rochester NY 14620

Or fax#: (585)-295-1593

CP Staff Usage Only

Completed forms received: _____ yes _____ no
Billing instructions received: _____ yes _____ no

FET Session attended: _____ Date: _____
Group _____ Individual _____

Family Member signature: _____
Certified by: _____