

The following documents indicate who can complete/change information on the documentation logs.

<u>Color of Cell</u>	<u>Who Can Make Changes.</u>
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed and can modify information after the log is signed.
Yellow	Provider NOTE--if information is changed after the form is signed, the change must be initialed.
Grey	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed. Only the provider can modify information after the log is signed. NOTE--if information is changed after the form is signed, the change must be initialed.

In addition--While it is acceptable to make changes as indicated above, all changes must be reasonable. For example--The Medicaid clerk has the ability to modify the student information on the documentation logs. This does not mean that the Medicaid clerk can change the student's name on the log from Jimmy Smith to Bobby Brown (unless the student's name has actually changed from Jimmy Smith to Bobby Brown). Another example--If a documentation log states "Math" and the IEP service states "Reading", the Medicaid clerk could not change the service on the documentation log to match the IEP as Math and Reading are two different services.

Case Management Assurance

Student Information

Name:

Date of Birth (mm/dd/yy)

Diagnostic Code:

Provider Information

Provider Name:

Name of School:

Supervisory Union Name :

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.

_____ Hours

Provider Signature: _____ **Date:** _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name:

Date of Birth (Mo/Day/Year):

Diagnostic Code:

Provider Information

Provider Name:

Provider Title:

Supervisory Union:

Name of School:

IEP Service:

List the service being provided as it appears on the IEP. Add hours per week based on the IEP.

<u>IEP Activity</u>	<u>Individual or Group</u>	<u>Minutes Per Session</u>	<u>Sessions Per Week</u>	<u>Hours Per Week</u>

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes indicated in the IEP as a session. **If the minutes per session or group size are different then what is listed in the IEP, the actual minutes per session or group size should be indicated on the calendar.** For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.

DO NOT USE PENCIL OR WHITE OUT.

Month		Year					Month		Year				
Use this set of dates for a two-month billing period													
1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31				

Indicate the total number of hours of billable service provided during the billing period:	1:1 Service	Hours
	Small Group	Hours

Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Supervisor Name (Printed): _____

Personal Care Service Documentation Log

Student Information

Name: _____ Date of Birth (Mo/Day/Year): _____

Diagnostic Code: _____

Provider Information

Provider Name:

Provider Title:

Supervisory Union:

Name of School:

Service Dates: The numbered boxes below reflect the days of the month. Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT.

Month		Year					Month		Year				
Use this set of dates for a two-month billing period													
1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31				
Total hours personal care was provided during the billing period											_____	hours	

If the daily hours provided are consistently different than the time the student is at school, explain:

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

- | | | |
|----------------------------------------------------|--------------------------------------------------|-----------------------------------------------|
| 1. <input type="checkbox"/> Assistance w/Eating | 5. <input type="checkbox"/> Behavior Management | 9. <input type="checkbox"/> Assistive Devices |
| 2. <input type="checkbox"/> Assistance w/Toileting | 6. <input type="checkbox"/> Signing/Interpreting | 10. <input type="checkbox"/> Other: _____ |
| 3. <input type="checkbox"/> Assistance w/Dressing | 7. <input type="checkbox"/> Medication Admin. | _____ |
| 4. <input type="checkbox"/> Assistance w/Hygiene | 8. <input type="checkbox"/> Mobility/Safety | _____ |

Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Supervisor Name (Printed): _____

