

Preschool Confirmation of Delivery of Services

					Service Month	
Child's Name Agency Name Name of Individual Service Provider		DOB	Type of Service		Frequency & Duration	
			School District		_1	
		Profession		Lie	cense NPI	
Date of service	Start time	End time	Session Code: P, CA, TA, MU		Parent/Guardian Signature/Verifying Witness Signature	
	ove, the above named	child received the s	ervices noted and that de		xists and is maintained on file ions governing the Medicaid	
herapist Signature					Date:	
irector Signature					Date:	