

Dutchess PS Confirmation of Service Delivery						Mo/Yr _____
Child's Name (Last, First)		DOB:	Agency/Center-Based School or Independent Contractor		NPI #	School District:
Type of Service (SP/OT/PT/Psych/Nursing/etc.)		Print Name of Individual Service Provider/ Title / License Number/ NPI#				Frequency Duration
Date of Service	Start Time	End Time	Session Length	Session Code	Parent/Guardian Signature/Verifying Witness Signature	

Session Codes: P- Service; MU- Makeup; CA- Child Absent; TA- Therapist/Teacher Absent; S-CPSE meeting

I certify that on the dates above, the above named child received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process.

Therapist Signature: _____ Date: _____

Clinical Supervisor Signature: _____ Date: _____