Rockland County Preschool 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/License Number/NPI#	Frequency	Duration

Date of service	Start time	End time	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 _____