ONONDAGA COUNTY HEALTH DEPARTMENT – SPECIAL CHILDREN SERVICES

Authorization of Preschool Related Services and Caregiver Signature Log

Child's Name _____ DOB: _____ Service Month _____

Type of Service _____ Provider's Name _____

Frequency _____ Profession _____

Individual/Group _____ NPI _____

STAC Service Period _____ License _____

	Mon	Day	Year	Time In	Time Out	CG Initials		Mon	Day	Year	Time In	Time Out	CG Initials
1. Svc Date		/	/				11. Svc Date		/	/			
2. Svc Date		/	/				12. Svc Date		/	/			
3. Svc Date		/	/				13. Svc Date		/	/			
4. Svc Date		/	/				14. Svc Date		/	/			
5. Svc Date		/	/				15. Svc Date		/	/			
6. Svc Date		/	/				16. Svc Date		/	/			
7. Svc Date		/	/				17. Svc Date		/	/			
8. Svc Date		/	/				18. Svc Date		/	/			
9. Svc Date		/	/				19. Svc Date		/	/			
10. Svc Date		/	/				20. Svc Date		/	/			

I certify the information I am going to submit will be true, accurate and complete. I understand that this information may be used for billing and payment and satisfaction of the claim will be from federal and/or state funds. I understand any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable Federal or State laws. Further, I certify all services I am reporting have been provided by or under the direction or supervision of a licensed professional of the healing arts, other licensed health care professional, or other licensed/certified practitioner acting within their scope of practice under state law. Finally, if after this submission I discover any error in it, I will immediately report such errors for adjustment.

_____ _____

Provider's Signature Date Parent / Caregiver's Signature Date

The assessment data must be forwarded to the CPSE Chair.

Reviewed By: _____ Date: _____