CPSE PORTAL

Suffolk County Preschool Confirmation of Delivery of Services

Service Month _____

Child's Name	**DOB**	**Type of Service**	**Frequency & Duration**
Agency Name	**NPI #**	**School District**	
Name of Individual Service Provider	**Profession**	**License**	**NPI**

Date of service	Start time	End time	Session Code: P, CA, TA, MU, P	Parent/Guardian Signature/Verifying Witness Signature

Service Codes: P-Service Provided, CA-Child Absent, TA-Teacher Absent, MU-Makeup, 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**: _____