## Westchester County Preschool Confirmation of Service Delivery

Mo/Yr\_

Child's Name (Last, First)	DOB:	Agency / Center-Based School or Independent Contractor		Contractor	NPI#		School District
Type of Service (SP/OT/PT/Psych/Nursing/etc.)		Print Name of Individual Service Provider/License Number/NP				Frequency	Duration
Date of service	Start time	End time	Session Code:	Parent/Guai	rdian Signat	ure/Verifying	Witness Signature
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Sassion	Codes: P- Service: MU	Makaun: CA Child A	heant: TA Theranist	Taschar Abse	nt· S CDSE	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