ACHIEVE BEYOND
Pediatric Therapy & Autism Services

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COORDINATION SUMMARY REPORT FORM CM-5A CONTRACT YEAR 2023-24

Student's Name: _____ DOB: 1/8/24 Date of Report: _____

Coordinator's Name: _____ Discipline: _____ Agency: Achieve Beyond

School District: _____ CPT Code: _____ ICD10 Code: _____

Indicate all Related Services listed on IEP: Speech_____ OT_____ PT_____ Other_Parent Trainer ____
None_____ **Please check off each service listed on the IEP

COORDINATION CONTACT DATES: Write in Month, year and circle or X out dates of contact.

MONTH_____ YEAR: _____

DATES: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 (parent/guardian) ** Check off dates of communication

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 (providers)

COORDINATION ACTIVITIES: Specify coordination activities. Include service coordination activities with related service providers. Discuss the general plan for the period and expected outcomes. Include issues effecting service delivery, and make a statement about the student's progress to date based on feedback from the therapists. List contact dates for conference/training with student's parent/training with student's parent/guardian. Include issues discussed, feedback about their feelings concerning their child's progress and the effectiveness of the activities they have been given to use with their child. Discuss CPSE attendance and summarize the discussion and outcome of the meeting. Reference dates in discussion, as appropriate.

-Date- Communication with Classroom Teacher. Include what was discussed.
*For example; porgress towards goals, strategies impletmented in the classroom, etc.)

-Date- Communication with all Services Providers listed on IEP.
*Even if the therapist has not been assigned. (ST, OT, PT. Parent Trainer, etc)
*Include child's progress towards goals in their services. You can also discuss how you can incorporate some of those skills during your work with the student

*** Please include all attempts to contact providers. If you havent made contact with the porviders for the month, please alert the CPSE Department. We will reach out to the School District..

-- Date- Communication with Parents.

-*Include the child's progress towards goals in the classroom. You can also discuss strategies used in the classroom, and how those strategies can be used in the home.

{ n/a } I certify that a copy of this report was sent to the student's school district on _____
{ KE } I certify that the indirect activities summarized above were performed on the dates indicated
The following must be completely filled in

PLEASE NOTE:
Speech services delivered by a TSHH MUST BE completed under the direction of a Speech and Language Pathologist. Occupational Therapy delivered by a COTA MUST BE done under the supervision of an OTR. Physical therapy services delivered by a PTA MUST BE done under the supervision of RPT. Licensed Practical Nurse must be under the supervision of a Licensed Registered Nurse. Licensed Master Social Worker must be under the supervision of a Licensed Clinical Social Worker.

Super Teacher	TSD	Achieve Beyond
Signature of Direct Service Provider	**License#/Cert.#/Designation**	**Name of Agency**

NPI#: 1316217870 **ASHA#:_____**

SLP providing Speech MUST include TSHH certification information

If as noted above the signature of the Clinician providing Under the Direction of, or under the supervision of MUST complete and sign the following:

Type of License of clinician providing direction/supervision	**License #**	**Signature of Clinician providing direction/supervision**