Suffolk County Preschool Confirmation of Service Delivery | Mo/Yr_____

Child's Name (Last, First)	DOB:	Agency / Center-Based School or Independent Contractor	NPI #	School District
Doe, John		Achieve Beyond	1043498363	

Type of Service (SP/OT/PT/Psych/Nursing)	Print Name of Individual Service Provider / License Number/NPI #	Frequency		Duration
SEIT	Smith, Jane	3	x	60

	Date of service	Start time	End time	Session Code:	Parent/Guardian Signature/Verifying Witness Signature
1	1/2/17			H	Does not require Parent Signature
2	1/4/17	1:00pm	2:00pm	P	Requires Parent Signature
3	1/6/17			TA	Requires Parent Signature
4	1/9/17	1:00pm	2:00pm	P	Requires Parent Signature
5	1/9/17	2:05pm	3:05pm	MU for 1/6/17	Requires Parent Signature
6	1/11/17	1:00pm	2:00pm	P	Requires Parent Signature
7	1/13/17	1:00pm	2:00pm	P	Requires Parent Signature
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This sample shows a case for SEIT 3x60 weekly where the provider's regular schedule is Monday, Wednesday, Friday 1-2pm.

MOST COMMON SESSION CODES:

Provided=P
Make-up=MU (include date that you are making up)
Therapist Absence=TA
Child Absence=CA
Holiday=H
School Break=SB
Snow Day=SD

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 AND CREDENTIALS***

Therapist Signature _____