Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
Not for use with Developmental and Assistive Therapy or Personal Care Services.

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: _____ Date of Birth: _____ Diagnostic Code: _____	Provider Name: _____ Provider Title: _____ SU/School: _____

Date (mm/dd/yy)	Activity/Procedure/Service Brief Description	Small Group or Individual	Minutes Per Session

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary.

DO NOT USE DITTO MARKS, ARROWS, PENCIL OR WHITE OUT.

Actual hours of 1:1 services provided during the billing period:	_____ hours
Actual hours of small group services provided during the billing period:	_____ hours

Progress note to be completed on back or attached

By signing below, I verify services were provided as documented above. I understand that this is a legal document and services documented above will be billed to Vermont Medicaid for federal reimbursement.

Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Supervisor Name (Printed): _____