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:		**Provider Name:**	
Date of Birth:		**Provider Title:**	
Diagnostic Code:		**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) _____