PUTNAM COUNTY VOUCHER

SHIP AND BILL TO:
DEPARTMENT: Early Intervention/Preschool
ADDRESS: 1 Geneva Road
Brewster, NY 10509

VENDOR NUMBER:

CLAIMANT NAME AND ADDRESS:

ORG CODE	OBJECT CODE	PROJECT CODE	AMOUNT

LIST ALL INVOICE NUMBERS AND ATTACH ALL ORIGINAL INVOICES AND RECEIPTS

INVOICE DATE	INVOICE #	DESCRIPTION	CONTRACT #	UNIT PRICE	AMOUNT
				TOTAL	

CLAIMANT'S CERTIFICATION

I, _____ CERTIFY THAT THE ABOVE ACCOUNT IN THE AMOUNT OF $_____ IS TRUE AND CORRECT; THAT THE ITEMS, SERVICES AND DISBURSEMENTS CHARGED WERE RENDERED TO OR FOR THE COUNTY OF PUTNAM ON THE DATES STATED; THAT NO PART HAS BEEN PAID OR SATISFIED, AND THAT THE AMOUNT CLAIMED IS ACTUALLY DUE.

DATE_____ SIGNATURE_____ TITLE_____

DEPARTMENT APPROVAL

THE ABOVE SERVICES WERE RENDERED OR FURNISHED TO THE COUNTY OF PUTNAM ON THE DATE STATED AND THE CHARGES ARE CORRECT.

_____
DATE AUTHORIZED OFFICIAL

APPROVAL FOR PAYMENT

AUDITED BY: _____

DATE: _____

Department of Health

Early Intervention and Preschool Programs
110 Old Route 6, Building #3, Carmel, NY 10512
Office (845) 808-1640
Fax (845) 808-4092

MaryEllen Odell
County Executive

Michael J. Nesheiwat, M.D.
Interim Commissioner of Health

PUTNAM COUNTY PRESCHOOL PROGRAM

PARENTAL PERMISSION FOR SIGN-OFF ON THERAPIST SESSION NOTES

I authorize _____ **to sign off on log notes for my**
(Name of Childcare Provider)

child_____ **prepared by:**
(Child's Name)

_____
(Name of Therapist)

_____ _____
Parent's Signature **Date**

10/2016

PUTNAM COUNTY CENTER BASED PROGRAM ATTENDANCE SHEET

_____

PROGRAM NAME

MONTH/YEAR_____ CAMPUS_____ TEACHER/CLASS_____

STUDENT	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	* OT	* PT	* PSY	* SP

Attendance Codes: Present = P Absent = A Snow Day = SD Holiday = H

Program is responsible to keep track of how many OT, PT, Psychological Counseling and Speech Sessions occur in month and record total for each student in appropriate box/es

I have reviewed this list of students and I have verified that the students listed above attended school and received the indicated services/sessions by appropriately certified professionals as mandated on their respective IEP's. As a 4410 program we are retaining documentation verifying that services were delivered as per our 4410 contract. For the purpose of claiming PSSHSP Medicaid reimbursement all services were direct with the student.

APPROVED BY_____ DATE_____

Name and Title

Putnam County Department of Health
Preschool Special Education Program

C2 - FORM
(Related Services Claim Form)

Month & Year of Service: _____

IEP Period: From _____ **to** _____ **Type of Service:** _____

AGENCY NAME: _____ **Type of License/Certification:** _____

Therapist Name: _____ **License#/Certification#:** _____

Child Name: _____ **DOB:** _____

IEP Service Schedule: _____ **Group or Individual** **Group Size:** _____
(frequency/duration/method) (Circle)

Name & Address of Service Delivery Site:

Service Dates	Start Time	End Time	Attend. Code*	Caregiver Initials	Amount Billed
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					

Service Dates	Start Time	End Time	Attend Code*	Caregiver Initials	Amount Billed
18.					
19.					
20.					
21..					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
31.					

_____ **X** _____ **=** _____
(sessions) **(rate)** **Grand Total Claimed**

Attendance Codes **SS = Scheduled Intervention** *Specify duration (30 min, 45 min, etc.) Example: SS/30* **FC = Session Cancelled by Family** **Coord = Coordination** **TC = Session Cancelled by Therapist** **M = Makeup**

To the best of my knowledge, services were provided on the dates and times specified above:

Parent/Caregiver Signature: _____ Date: _____

(*Written authorization from parent/guardian is required for Childcare Provider, etc. to review and sign)

I _____ do hereby attest that I am a NYS Licensed/Certified: _____
Signature of Therapist** **Title

and did provide the service as noted on this billing form. NPI#: _____

Speech-Language Pathologists providing service MUST include their TSSLD certification Information. TSHH must indicate Special Education Teacher designation. Both TSSLD and TSHH must have documentation on file with their agency.

_____(therapist/agency initials) A copy of the daily notes or the monthly/quarterly or (other time frame designated on IEP) progress notes have been submitted to the appropriate school district.

If the service was provided by a TSHH, COTA or PTA, LPN, LMSW, the therapist providing "under the direction /or supervision of" MUST sign the following: I have provided the "under the direction of," SED required supervision for the therapist signing above.

Print Name Signature of Licensed/Registered Therapist License#/Certification#/Designation NPI#

Revised 4/2015

RELATED SERVICE DAILY SESSION NOTE FORM

Page ____ of ____

Child's Name:_____ **DOB:**_____ **IEP PERIOD:** ___/___/___ **to** ___/___/___

(Full Name as it appears on the IEP) **Print Name of Agency:**_____

Service Type: _____ **Print Name of Provider:** _____

Attendance Code (Att. Code):	LOCATION OF SERVICE AS PER CHILD'S IEP:
Scheduled Session: **SS** Family Canceled: **FC** Therapist Canceled: **TC** Holiday: **H** Inclement Weather: **IC** Makeup Session: **M** Face to Face: **FF**	PLEASE PRINT THE FULL ADDRESS(ES) SERVICES TOOK PLACE:

Date: / / Start Time: End Time: # in Group ___ Individual ___ CPT Code _____
Att. Code: Makeup Date: / / Location:

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

Date: / / Start Time: End Time: # in Group ___ Individual __ CPT Code: _____
Att. Code: Makeup Date: / / Location:

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

Date: / / Start Time: End Time: # in Group ____ Individual ___ CPT Code: _____
Att. Code: Makeup Date: / / Location:

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

I have read the above service logs and agree that the services were delivered as written.

_____ Date: _____

Signature of ( ) Parent ( ) Guardian/Surrogate ( ) Child Care Provider * ( ) Other

* Provider is required to obtain written authorization from parent/guardian for childcare provider to review and sign record of service

If provider is a TSHH/TSSLD, COTA or PTA, LPN, LMSW, the therapist providing "under the direction of" or supervision MUST sign the following. I have provided the "under the direction of"/SED required supervision for the therapist signing above.

Signature of Supervising Therapist Licensed & Registered	Print Name	License#/Certification/Title	NP#

Rev. 10/14/16

PUTNAM COUNTY NEW YORK

RELATED SERVICE DAILY SESSION NOTE FORM

Related Service in **CENTER BASED PROGRAM** (e.g. within 4410 Program) **Page ____ of ____**

Child's Name:______________________________ **DOB:**_______________ **IEP PERIOD:** __/__/__ **to** __/__/__

(Full Name as it appears on the IEP) **Name of Program** ______________________________________

Service Type: ______________________________ **Print Name of Service Provider:**______________________________

Attendance Code (Att. Code): Scheduled Session: **SS**, Absent: **A**, Therapist Canceled: **TC**, Holiday: **H**, Inclement Weather: **IC**, Makeup Session: **M**, Discharged: **D**	**LOCATION OF SERVICE AS PER CHILD'S IEP** **PLEASE PRINT THE FULL ADDRESS SERVICES TOOK PLACE:**

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License # DATE

If provider is a TSHH/TSSLD, COTA or PTA, LPN, LMSW, the therapist providing "under the direction of" or supervision MUST sign the following. I have provided the "under the direction of"/SED required supervision for the therapist signing above.

Signature of Supervising Therapist Licensed & Registered	**Print Name**	**License#/Certification/Title**	**NPI #**

Administrator's Signature / Title	Date: