CONTRACTING AGENCY: NY THERAPY

PROVIDER SESSION NOTES

MONTH: ____________________

YEAR: ____________________

Student's Name (last,first),	DOB	School District	IEP Dates of Services
Name of Service Provider/License number	NPI #	Supervising Provider/License #	ICD9 Code(S)
Service Type: □ OT □PT □SP □ Counseling □ABA □Parent Training □ Resource Room/Home Instruction	RX Received date	**Exact Location of Service**	Frequency and Duration

Session Code Key:

P	PROVIDED
SAN	STUDENT ABSENT WITH NOTICE
SANN	STUDENT ABSENT WITHOUT NOTICE
PA	PROVIDER ABSENT
MU	MAKE UP
MP	MISSING PRESCRIPTION
SC	SCHOOL CLOSED

Your notes will be returned if they do not reflect student IEP goals

***Provider signature and date required after each session note
*** Supervisor signature and date required when services are provided by OTA or CFY
***Authorized signature **MUST BE** obtained when services are provided **OUTSIDE** of the public school setting. The signature of school personnel must be obtained for services provided within the public school setting when required by the office of PPS.

Session Date ___________ Time In _________Time Out_________ □ Individual □ Group Group Size:______Session Code:_____

Session Notes: Activity (Including objectives and measures of success) and response(s) of the child: CPT Code________ Minutes:_______

CPT Code:________Minutes:_______

CPT Code:________Minutes:_______

Progress (Check one)
□ Progress
□ Limited Progress
□ No Progress

Provider Signature:____ Date / /
Supervisor Signature: _______________________________________ Date / /
Parent/Staff/Teacher Signature:_______________________________ Date / /

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Supervisor Signature: _______________________________________ Date / /
Parent/Staff/Teacher Signature:_______________________________ Date / /

My Signature above verifies that the services were provided on the dates indicate. I understand that this information may be used for Medicaid claiming purposes and must accurately reflect services provided

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