NYT Kids

NEW YORK THERAPY

Placement Services, Inc.

Place the amount of time of the service along with any appropriate billing codes listed below:

I	Individual	MU	Make Up
G	Group	SC	School Closed
SAN	Student Absent Notified	SCR	Screening
SANN-I	Student Absent Not Notified IND	MP	Missing Prescription
SANN-G	Student Absent Not Notified GRP	C	Consult
PA	Provider Absent	E	Evaluation
CSE	CSE Meeting		

Therapist Name: _____

Therapist Profession: _____

Month: _____

District/Facility

Office: Port Jefferson

Name	Serv	Freq	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				

I certify that the above services were provided on the dates indicated and entered into IEP/Kinney

Therapist signature: _____

Parent Signature: _____

(Only applicable if services are delivered at home)