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	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			

I certify that the above services were provided on the dates indicated.

Therapist Signature:_____

I certify that notes where entered into IEP/Kinney/Clear Track

Date]