Putnam County Department of Health **C2 - FORM** **Month & Year of Service: _____**
Preschool Special Education Program **(Related Services Claim Form)**

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