Westchestergov.com

George Latimer, County Executive

CPSE

PROTOCOL MANUAL

Revised July 2018

DEPARTMENT OF HEALTH
Sherlita Amler, M.D., Commissioner

TABLE OF CONTENTS

Chapter 5- Assistive Technology

- Protocol for Obtaining AT Devices
- Information Form (PRE-AT-1)
- Justification Form (PRE-AT-2)

Chapter 6- Medicaid Documentation

- Required Documentation
- IEP (Special Transportation)
- Medicaid Training
- Useful Websites
- One-Time Medicaid Consent Form with Instructions
- Daily Session Note
    - Related Service
    - 4410 Program
- Preschool Prescription/Referral
- Speech Referral/Recommendation
- Psychological Counseling Referral
- Medical Referral for Evaluation
- "Under the Supervision of"– Psychological Counseling
- "Under the Direction of"
    - Speech Therapy
    - Occupational & Physical Therapy
    - Skilled Nursing

CHAPTER 1

EVALUATIONS

NYSED Preschool Evaluation Reimbursement
STAC-5 and Instructions:

http://www.oms.nysed.gov/stac/preschool/evaluation/home.html

STAC-5
Need for Justification

The CPSE chairperson must submit a justification letter, written on the school district's letterhead, along with the STAC-5 in the following circumstances:

1. When there is more than one psychological and/or social history in a year.
2. If duplicate evaluations are requested within a similar timeframe by one or more agencies (i.e. OT, PT, Speech).
3. For an evaluation of an Early Intervention child under the age of 2.9 years.
4. When "other" is used for an evaluation component.
5. For an evaluation request of a kindergarten eligible student**.**
6. In any other circumstance that may be questionable for NYSED's approval.

NYSED Publications on Evaluations:

http://www.p12.nysed.gov/specialed/publications/topics

Click on- *Evaluations*

CHAPTER 2

4410
CB Programs/SEIS Related Services

INTERIM LETTER OF PLACEMENT PROCEDURE

The Committee on Preschool Special Education prepares, an Interim Letter of Placement and the prior school District's IEP are typically used when a preschool student moves from one Westchester County School District to another. The interim Letter of Placement allows for services to continue based on the existing IEP, until such time as the receiving school district can hold its own CPSE meeting and generate an IEP. It is expected that the receiving school district will send a STAC and New IEP to the County within 30 school days of the date of the letter. Interim Letters of Placement may be used for both center based placement and related service programs, provided that the program or related service provider has or is willing to enter into contract with the Westchester County Department of Health.

PROCEDURE

When a child moves into a new school district and services mandated by the prior school district are to be continued, the receiving school district writes an Interim Letter of Placement to include:

- Date new school district took over jurisdiction for the child
- Name of district child is moving from
- The name of the 4410 program child attends or names of the individual(s) or agency(ies) providing the related services or SEIT services
- The projected date of the CPSE meeting
- The effective date of service for the new school district

The Interim Letter of Placement is sent to the County along with the prior school district IEP.

A copy of the Interim Letter of Placement and the prior school district's IEP and STAC-1 must be sent to the County and the service provider(s) expeditiously to ensure that services resume with as little interruption as possible.

- The new school district's IEP should be sent following the CPSE meeting. The Interim Letter of Placement will explain the discrepancy in the projected start date of service and the CPSE meeting date on the IEP.

Under certain conditions, an Interim Letter of Placement may also be used when the child moves into a Westchester school district from another county in New York State. Please contact the County regarding other scenarios on an individual basis.

INTERIM LETTER OF PLACEMENT

Westchester County Department of Health
145 Huguenot Street, 7th Floor
New Rochelle, New York l080l

Re: _____ DOB: _____

We have received a referral from _____informing us that the family moved into_____ from the _____ school district on _____.

Since _____ is a preschool special education student [ ] receiving or [ ] attending _____, we would like to continue his special education program or services with as little interruption as possible until such time as we can schedule a CPSE meeting. In order to continue in the current placement, our Committee on Preschool Special Education will approve an interim placement for thirty (30) school days. The effective date for the interim placement is _____.

During that time the Committee on Preschool Special Education will discuss with the program/service provider(s) the educational needs of this child so that we may appropriately meet his needs. We expect to hold a CPSE meeting on _____ to review the information, current placement and make recommendations to our Board of Education based on the outcome of this meeting.

If you have any questions about this matter or need further assistance, please feel free to call me at _____.

Sincerely,

CPSE Chairperson

NYSED Publications - Individualized Education Program (IEP):

http://www.p12.nysed.gov/specialed/publications/topics

Click on- *Individualized Education Program*

NYSED Preschool Service Reimbursement STAC-1 and Instructions

http://www.oms.nysed.gov/stac/preschool/service/home.html

NYSED Memorandum
1:1 Aide/Nurse/Interpreter Form for Preschool Students with Disabilities

http://www.oms.nysed.gov/stac/preschool/service/1to1_aide_memo.html

NYSED Request for Reimbursement for Partial 1:1 Aide, 1:1 Nurse, 1:1 Interpreter and Instructions

http://www.oms.nysed.gov/stac/preschool/service/1to1_aide_form_and_instructions.pdf

NYSED Memorandum
Child-Specific Allowance to Temporarily Exceed an Approved Special Class Size for Preschool Students with Disabilities—Revised August 2007

http://www.p12.nysed.gov/specialed/publications/preschool/psvariance807.htm

To access form click: *Word Format*

GENERAL REMINDERS
FOR CPSE CHAIRS REGARDING SEIS & RELATED SERVICES

- When two or more related services are mandated and SEIT is not involved, the school district is responsible for selecting one of the related service providers to serve as coordinator.

- SED permits one 30-minute coordination session per month when the related service provider serves as coordinator.

- When SEIT plus related services are involved, the SEIT serves as coordinator and "coordination" does not appear on the STAC.

- When a child is receiving two or more services and SEIT is added, "cut back" the end date on the STAC for the provider originally designated as coordinator to the last date of service in that capacity. End date must be before the start date of SEIT services. SEIT assumes the role of coordinator (see above).

- If a child no longer receives SEIT or related services due to declassification or the family moves out of district, etc., the school district shall "cut back" the original STAC-1 to the last date of service in your district. Submit the STAC and a revised copy of the IEP to the County.

- It is the school district's responsibility to inform the provider of a Termination of Coordination or a Termination of Service.

- If you are using the new STAC forms, the instructions indicate that "Coordination" should be listed on one of the "Indicate Rel Serv Type" lines. Please follow "Coordination" with the discipline of the provider, e.g., "Coordination (speech)."

- Multiple STAC's for the same term of service:
  1. When multiple STAC's must be submitted because a child received six (6) or more related services or has more than one SEIT provider, indicate "Multiple STAC's" across the top of each STAC followed by "Page 1 of 2", "Page 2 of 2", etc.
  2. In the rare instances where a child is Dual Programmed, i.e., receives a center based program plus SEIT and/or related services, submit one STAC for the center based program and a separate STAC for the related service and/or SEIT program. Write "DUAL PROGRAM" across the top of each STAC and number them "1 of 2" and "2 of 2." Submit the STAC's to the County at the same time whenever possible. If the dual program mandate occurs subsequent to the initial CPSE meeting, indicate "DUAL PROGRAM" on the new STAC and number it "2 of 2." Send with a copy of the previously submitted STAC indicating "DUAL PROGRAM", "1 of 2" on top.
  3. Requests for program changes for any child who fits the following definition MUST be accompanied by an original STAC-1 along with the required supporting documentation to effect a change.

     A Multiple STAC (a.k.a. DUAL STAC) child is:
     - A child who is dual programmed, i.e., mandated for center based and related services and/or SEIT. Two STAC's must be submitted in this case, one for the center based program and an additional STAC for the related service/SEIT program.
     - A child with six (6) or more related services. Since the 1st line on the STAC is to be used solely for SEIT or center based service, only five lines remain for listing related services. Therefore, two STAC's will be required.

- A child with more than one SEIT provider. Each SEIT provider must be listed on a separate STAC-1. Note: Related services may be included on the STAC's with the SEIT services on lines provided for this purpose.
  Write "AMM1" (Amendment 1) in the left margin of the STAC next to the change (Item 12). All amendments are to be initialed by the CPSE chair.

4 For subsequent changes write "AMM2", "AMM3", etc., in the left margin. If necessary, you may continue documenting the history of amendments on a blank, unsigned STAC attached to the copy of the original STAC. Write "continued" in lower right corner on first page and "continuation" on subsequent pages.

- Please remember that the BOE authorization date required at the bottom of the STAC-1 must be on or before the service start date.

- **In Item 12 on STAC, please do not complete "Number of Half Hour Sessions" or "Rate per Half Hour Session." This information will be calculated by the Computer Program.**

- Prescriptions: When physical or occupational therapy services are mandated either as a direct service or as consultation, the school district is responsible for sending a copy of the prescription to the provider AND to the County. By contract, physical and occupational therapy services require an appropriately written prescription, therefore, therapists will not be compensated for services rendered if:
  - A prescription is not in effect for the current term of service, or
  - The County has not received copy of the prescription for the current term of service.

  A **new prescription** is required on an **annual basis** even if the frequency and duration of service is not changed from one term of service to the next. School districts should review prescriptions annually. For contract purposes, a prescription is considered to be in effect for twelve months from the date the order was written, unless it refers to a specific school year. If the prescription submitted does not cover the entire IEP period, a new prescription must be obtained to avoid a disruption in services to the child, and compensation to the therapist.

  Therapists will not be compensated until the County has received a copy of the prescription for the current period of service. Prescriptions must:
  - Be written by a licensed physician, registered physician's assistant, or a licensed nurse practitioner (see definitions).
  - Be written on a prescription form OR on the letterhead of the appropriate licensed professionals. It may also be written on the School District's letterhead if the professional signing is employed by the school district or the school district has mailed out a copy of its form for completion by the appropriate professional.
  - Refer to the type of therapy being requested and either specify the frequency and duration

    OR

    Refer to the type of therapy being requested and refer to the IEP year, i.e,
    "Physical therapy as per the IEP for the school year 2000 – 2001" (even if written during the annual review for the coming summer or school term).

  Important Note: If an eligible service on the IEP requiring a prescription is subsequently changed through the CPSE process, a new prescription is required.

- As a general rule, providers need not be identified on the IEP although they must be identified on the STAC. One example of an exception to this rule would be where a child is recommended for the same service from different providers at different locations, such as:- Speech 2 x 45mins weekly at "facility" and Speech 2 x 45 minutes weekly at "home". In this scenario, we will assume that the providers are HTA and NWCSD (per the STAC). We do not however, know which provider will deliver the service at home and which provider will deliver the service at the facility. In this case it will be necessary to make that distinction on the IEP.

- Changes to the STAC may also necessitate changes to the IEP and vice versa, for example a change of frequency and/or duration will affect both documents. However a change in location will affect the IEP only and a change in provider should affect the STAC only.

- A Checklist for amendment must accompany any change to the STAC and/or IEP.

- A new STAC should be used to add services or make changes to services once all of the lines in Section 11 have been utilized. Please refrain from adding lines and/or cramming the information into that space. The STAC may become illegible and may result in a Discrepancy Letter being issued, a delay in issuing the Confirmation Letter or may even result in an incorrect Confirmation Letter being issued.

- The school year is defined as being September to June and the summer is July to August.

- Separate STACS must be used for different sessions, for example Summer 2005 may not be combined on the same STAC for School Year 2005 – 2005.

- Locations on the IEP must be specific, for example: home, school, camp, facility.
- "Special Location and "Integrated/Non Integrated" are not options for related services.

- Remember to designate a Service Coordinator on the IEP and/or STAC when SEIT is not recommended and two or more related service providers are involved.

- Include Annual Review on the IEP when necessary.

- The STAC and Checklist for Amendment require an original signature, preferably in blue ink.

GENERAL REMINDERS FOR PROVIDERS
OF SEIS AND RELATED SERVICES

- The school district gives authorization to deliver services to providers from the Municipal List of Related Service Providers.
  Note: Anyone working with a child in Early Intervention who will be continuing under 3 – 5, must wait for an authorization from the school district before starting services.

- The County will issue a "Letter of Receipt" which will confirm that the school district has informed us that they have selected and authorized the provider to deliver services. The specific services as mandated on the IEP will be listed on the "Letter of Receipt".

- A "Letter of Receipt" will also be issued for service amendments and termination of services. **Note**: It is the school district's responsibility to inform the provider of a termination of service or a termination of coordination prior to the County's issuance of the "Letter of Receipt".

- **The IEP and the STAC are the sources of information contained in the "Letter of Receipt." Providers will be paid for services reflected on the "Letter of Receipt" as issued unless documentation is received in support of a change**.

- Providers must request that a school district forward the relevant IEP and STAC as assurance of service delivery.

- Review the "Letter of Receipt" immediately upon receipt to make sure it agrees with your IEP and STAC.

- If the "Letter of Receipt" contains an error ("typo") as compared to the IEP, complete the box on the bottom of the confirmation. Return a copy of the "Letter of Receipt" along with a copy of the child's IEP to the Services Unit, underlining the section(s) of the IEP supporting your contention so that our payment records may be corrected.

- The provider is responsible for working with the school district to obtain a "Check List for Amendment" if the information contained in the "Letter of Receipt" differs from the STAC and the IEP. The school district must send the "Check List for Amendment" along with supporting documentation to the County so that our payment information can be corrected. A copy of the Check List for Amendment should also be made available to the provider.

- If a "Letter of Discrepancy" is received, it is the provider's responsibility to work with the school district to ensure that the appropriate documentation is submitted to correct any discrepancies. See the "Letter of Discrepancy" and the "SEIT/Related Service Check List for Amendments" for required documentation.

- Providers will not be paid for services rendered if they do not have a current executed contract with the Westchester County Department of Health's Children with Special Needs Unit.

- When two or more related services are mandated and SEIT is not involved, the School District is responsible for selecting one of the related service providers to serve as coordinator.

- SED permits one 30-minute coordination session per month when the related service provider serves as coordinator.

- When a child is receiving two or more services and SEIT is added, the SEIT assumes the role of coordinator. The school district is responsible for informing the related service provider originally designated as coordinator of the last date of service in that capacity. The school district sends the County a "Check List for Amendment" adding the SEIT services and indicating the end date for coordination for the provider originally designated as coordinator. The County then issues a "Letter of Receipt" to the providers terminating coordination services and confirming the start of SEIT.

- Providers who start delivering a service before the service start date requested by the school district or who do not follow frequency or duration or service location mandates on the IEP **"will not be paid for that service".**

- **Prescriptions**: When physical or occupational therapy services are mandated either as a direct service or as consultation, the school district is responsible for sending a copy of the prescription to the provider AND to the County. By contract, physical and occupational therapy services require an appropriately written prescription, therefore, therapists will not be compensated for services rendered if:
  - A prescription is not in effect for the current term of service, or
  - The County has not received copy of the prescription for the current term of service.

- A **new prescription** is required on an annual basis even if the frequency and duration of service is not changed from one term of service to the next. School districts should review prescriptions annually. For contract purposes a prescription is considered in effect for twelve months from the date it was written unless it refers to a specific school year. If the prescription submitted does not cover the entire IEP period, a new prescription must be obtained to avoid a disruption in services to the child, and compensation to the therapist.

- Therapists will not be compensated until the County has received a copy of the prescription for the current period of service. Prescriptions must:
  - Be written by a licensed physician, registered physician's assistant, or a licensed nurse practitioner (see definitions).
  - Be written on a prescription form OR on the letterhead of the appropriate licensed professionals. It may also be written on the School District's letterhead if the professional signing is employed by the school district or the school district has mailed out a copy of its form for completion by the appropriate professional.
  - Refer to the type of therapy being requested AND either specify the frequency and duration

OR

  - Refer to the type of therapy being requested and refer to the IEP year, i.e., "Physical therapy as per the IEP for the school year 2000 – 2001" (even if written during the Annual review for the coming summer or school term).

Important Note: If an eligible service on the IEP requiring a prescription is subsequently changed through the CPSE process, a new prescription is required.

PROCEDURES FOR SEIS AND RELATED SERVICE AMENDMENT

Important Note: Requests for program changes for any child who fits the definition outlined below **MUST** be accompanied by a STAC -1and an IEP.

Definition: A multiple STAC (a.k.a. Dual STAC) child is…

- A child who is dual programmed, i.e. mandated for center based and related services program and/or SEIT: Two (2) STAC-1's must be submitted in this case, one (1) for the center based program and an additional STAC-1 for the related service and/or SEIT program.
- A child with six (6) or more related services.: Since the first line of the STAC-1 is to be used solely for SEITor center based services, only five (5) lines remain for listing related services. Therefore, two (2) STAC-1's will be required.
- A child with more than one (1) SEIT provider must be listed on a separate STAC-1.

Note: Related services may be included on the STAC-1 with the SEIT services on lines provided for this purpose, but **not** on the center based STAC-1.

"A1" ADDITION OF A RELATED SERVICE (SEIT not involved)

- **Revised IEP reflecting changes:**
  - Designate Coordinator
  - May indicate which providers attend annual reviews
  - Indicate location of service (home/school or provider's site)
- **Copy of original STAC-1 reflecting addition:**
  - Write AMM 1, 2 etc. in left margin next to change and initial by chairperson (item12)
  - If 6 or more RS, send a 2nd STAC-1, write "MULTIPLE STACS (1 of 2)" and "(2 of 2)" at the top of each STAC-1 form respectively.
  - If Dual Program, send a 2nd STAC-1 write "DUAL PROGRAM (1 of 2)" and "(2 of 2)" respectively on each STAC-1.
- **Fill in Check List For Amendment form:**
  - Must be signed and dated by authorized representative of BOE on page 2
  - Indicate coordinator by discipline.
- **Send copies of prescriptions, as needed**

"A1" ADDITION OF SEIT SERVICE

- **Revised IEP reflecting changes**
  - SEIT becomes the Coordinator of services by definition. The CPSE may request on the IEP that the SEIT attend the annual review
  - May indicate which providers attend annual reviews
- **Copy of original STAC-1 reflecting addition:**
  - Write AMM 1,2 etc. in left margin next to change and initial by Chairperson (Item 12)
  - Remember to change "placement type" (Item 7)
  - Complete by following regular STAC-1 instructions

- ❖ If 2 or more SEIT providers, fill out a new STAC-1 form for each provider, and write "DUAL PROGRAM (1 of 2)" and "(2 of 2)" respectively on the top of each STAC-1

- **Fill in Check List for Amendment form:**
  - ❖ SEIT is the Coordinator
  - ❖ Use "A2" if a previous coordinator was designated
  - ❖ Must be signed and dated by authorized representative of BOE on page 2

"A2" TERMINATION OF SERVICE

- **Revised IEP reflecting change:**
  - ❖ Terminate coordinator, if necessary
  - ❖ Add/Change coordinator, if necessary
- **Copy of the original STAC-1 indicating the end date of service:**
  - ❖ Write AMM 1,2 etc. in left margin next to change and initial by chairperson
- **Fill in Check List for Amendment form:**
  - ❖ Add/Change coordinator, if necessary
  - ❖ Terminate coordinator, if necessary
  - ❖ Note whether services were provided
  - ❖ Must be signed and dated by authorized representative of BOE on page 2

"B" CHANGE IN FREQUENCY OR DURATION OF SERVICE

- **Revised IEP reflecting changes**
- **Copy of the original STAC-1 indicating the end date of service and rewrite the service on new line indicating the new start and end dates**
  - ❖ Write AMM 1,2 etc. in the left margin next to change and initial by chairperson (Item12)
- **Fill in Checklist for Amendment form:**
  - ❖ Indicate change(s) and effective dates
  - ❖ Fill in "D" if locations change
  - ❖ Must be signed and dated by authorized representative of BOE page 2
- **Send copies of prescriptions, as needed**
- **For temporary changes see checklist for Amendment "B"**

"C" CHANGE OF PROVIDER

- **IEP**
- **Copy of the original STAC-1**
  - ❖ Put new end date for old provider
  - ❖ Rewrite service on a new line with start and end dates for new provider
  - ❖ Add new provider's name to line 11
  - ❖ Write AMM 1,2 etc. in left margin next to change and initial by chairperson
  - ❖ If 6 or more RS, send a 2nd STAC-1, write "MULTIPLE STACS (1 of 2)" and "(2 of 2)" at the top of each STAC-1 form respectively
  - ❖ If 2 or more SEIT providers, fill out a new STAC-1 form for each provider, and write "DUAL PROGRAM (1 of 2)" and "(2 of 2)" respectively on the top of each STAC-1

- **Fill in Check List for Amendment form:**
  - ❖ Indicate whether services were provided by old provider and if so, the last date of service
  - ❖ Signed and dated by chairperson on page 2

"D"CHANGE OF LOCATION OF SERVICE

- **Revised IEP indicating change**
  - ❖ Indicate frequency/duration by location (e.g.1x school, 1x facility or 1x home)
- **Fill in Check List for Amendment form:**
  - ❖ Indicate current and new location as well as effective dates for each discipline (specific multiple locations)
  - ❖ Signed and dated by chairperson on page 2
  - ❖ Do not send RS or SEIT to a center based program

"E" OTHER CHANGES; ADD/TERMINATE CONSULTS OR ANNUAL REVIEW

- **Revised IEP indicating change:**
  - ❖ Indicate the specific change taking place (e.g. speech therapist to attend annual review)
- **Fill in Check List for Amendment form:**
  - ❖ Indicate changes as well as effective dates
  - ❖ Signed and dated by chairperson on page 2

"F" WITHDRAWAL FROM SEIT/RELATED SERVICE PROGRAM

- **Submit Checklist for Amendment form:**
  - ❖ Submit a revised IEP and cut-back copy of the original STAC-1
  - ❖ Must be signed and dated by BOE authorized official on page 2

To: Westchester County Department of Health – Services Unit **Date: _____**

SEIT/RELATED SERVICE CHECK LIST FOR AMENDMENT

CHILD: _____ DOB: _____ SCHOOL DISTRICT _____

The following change(s) are to be made in the Related Services for the above referenced child:

TYPE OF CHANGE:

"A1" [ ] Addition of Related Service: Service(s) _____ Effective Date* _____
[] Addition of SEIT Service (see note) Effective Date *_____
[ ] Add [ ]Identify or [ ]Change Coordinator
Discipline of Coordinator _____ Effective Date* _____
[ ] Add [ ] Identify Counselor:
Discipline of Counselor: [] Social Worker OR [] Psychologist Effective Date* _____

Required Documentation: Revised IEP and copy of the original STAC-1 reflecting addition and Prescriptions if needed. Write"AMM1"** in left margin next to line being changed (Item 12 on STAC) and have change initialed by CPSE Chair. Change "Placement Type" on STAC-1 (Item 7).
*NOTE: If SEIT is being added to two or more related services, use box "A2" to terminate the original coordinator.

"A2" [ ] Termination of Service:
Service_____ Effective Date* _____ Were services provided? [ ] yes [ ] no
[ ] Termination of Coordinator:
Discipline _____ Effective Date* _____ Were services provided? [ ] yes [ ] no

Required Documentation: Revised IEP and copy of the original STAC-1 indicating change(s) to be made. Use box "A1" to add/change the coordinator, if necessary. Write "AMM1" ** in left margin next to change (Item 12) and have change initialed by CPSE chairperson. The copy of the STAC must be "cut back" by crossing out the original end date of service and writing in actual date services ended, if services were provided.
NOTE: It is the school district's responsibility to inform the provider of a Termination of Service and/or Termination of Coordination. (See District's Authorization for Related Services).

TYPE OF CHANGE:

"B" [ ] Increase/ [ ] Decrease in [ ] Frequency/ [ ] Duration of Service:
Service _____ Change From _____ To _____ Effective Date* _____
Service _____ Change From _____ To _____ Effective Date *_____
Service _____ Change From _____ To _____ Effective Date *_____

Required Documentation: Revised IEP, copy of the original STAC-1 indicating change(s) to be made. Write "AMM1"** in left margin next to change (Item 12) and have change initialed by the CPSE Chairperson. Revised prescription if needed. "Cut back" service by crossing out original end date of service on the copy of the original STAC and writing in new end date of service. Rewrite service on a new line indicating new start and end date. Notes: 1) New start date must be after end date of original service. 2) Complete "D" below if the change in frequency/duration Affects the Service Location.

Temporary [ ] Increase in [ ] Frequency/ [ ] Duration of service (Suggested use: When services start late due to scarcity of available providers or to accommodate difficulty in securing providers at any time)

Service	Freq/Dur Change From	Freq/Dur Change to	Effective Start Date*	Effective End Date*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Note: Temporary increase in freq/dur may be documented in comment section of IEP. No change of Start date on IEP or STAC required.

CHILD _____ DOB: _____ SCHOOL DISTRICT: _____

SEIT/RELATED SERVICE CHECK LIST FOR AMENDMENT - CONTINUED

"C" [ ] Change of Provider or [ ] Provider Determined:

Service	Effective Date*:	Previous Provider:	New Provider	Were Services provided by previous provider?	If yes, last date of service:
_____	_____	_____	_____	[ ] Yes [ ] No	_____
_____	_____	_____	_____	[ ] Yes [ ] No	_____
_____	_____	_____	_____	[ ] Yes [ ] No	_____

Required Documentation: Copy of IEP, and copy of the original STAC-1 indicating the change. When there is a change in provider, "cut back" the old provider's last date of service on the STAC and rewrite service on a new line indicating the new start and end dates. Take care to add the new provider's name where indicated on STAC (Item 11). Write "AMM1"** in left margin next to change (Item 12) and have change initialed by CPSE chairperson.

"D" Change of Location of Service (Home/School/Community site **OR** Providers Facility):
Service _____ Location-Current _____ New _____ Effective Date* _____
Service _____ Location-Current _____ New _____ Effective Date *_____

OR

Specify multiple location below:

New:
Service _____ Location-Current _____ Home/Comm./Sc.___ / wk Prov. Fac.___/wk Effective Date* _____
Service _____ Location-Current _____ Home/Comm./Sc. ___ /wk Prov. Fac.___ / wk Effective Date* _____

Required Documentation: Revised IEP indicating change.

TYPE OF CHANGE:

"E" Other Changes: (Add/terminate Consultation or Annual Review)
[ ] Consultation

Service:	Add	Terminate	Inc./Dec. in Freq./Dur. From	To	Effective Date*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

[ ] Annual Review Attendance
Service(s): _____ Add ____ Delete _____ Effective Date*_____

[ ] Method

Service:	Change in Method Requested	Effective Date*
_____	[ ] Ind. To Gp. [ ] Gp. To Ind.	_____
_____	[ ] Ind. To Gp. [ ] Gp. To Ind.	_____

Required Documentation: Revised IEP indicating the change.

CHILD _____ DOB: _____ SCHOOL DISTRICT: _____

SEIT/RELATED SERVICE CHECK LIST FOR AMENDMENT - CONTINUED

"F" Withdrawal from SEIT/Related Service Program:

Service	Provider	Freq./Dur.	Were Services Provided? Yes	No	Effective Withdrawal Date*
_____	_____	_____	___	___	_____
_____	_____	_____	___	___	_____
_____	_____	_____	___	___	_____
_____	_____	_____	___	___	_____
_____	_____	_____	___	___	_____

Reason for Withdrawal:

[ ] Child Transferred to Centerbased program [ ] Family moves out of County [ ] Child Declassified
[ ] Family Refused Services/Withdraws [ ] Family moved out of State
[ ] Family moved out of School District [ ] Cannot Locate Family

Required Documentation: Revised IEP, copy of original STAC –1 "cut back" to the last date of service.

* Effective date = Date that appears on District's Authorization for Related Services and on County's payment records.
** AMM1 = Amendment #1, subsequent amendments should be numbered AMM2, AMM3, etc.

For Additions or Termination of Services, Withdrawal from SEIT/Related Services, or Changes in Frequency/Duration

I certify that the preschool student with a disability herein named is being provided the educational services indicated and that such services have been recommended by the Committee on Preschool Special Education and the child is eligible for such placement in accordance with the Regulations of the Commissioner and Section 4410 of the Education Law.

_____ _____
(Authorized Representative of Board of Education) Date

For All Other Changes

I certify that the preschool student with a disability herein named is being provided the educational services indicated and that such services have been recommended by the Committee on Preschool Special Education and the child is eligible for such placement in accordance with the Regulations of the Commissioner and Section 4410 of the Education Law.

_____ _____
CPSE Chairperson Date

Westchester gov.com

George Latimer
County Executive

Sherlita Amler, M.D.
Commissioner of Health

RECEIPT OF SCHOOL DISTRICT'S AUTHORIZATION OF RELATED SERVICE

The service information below was taken from the copy of the child's IEP that we received from the school district and will be the basis for payment for services rendered. If this information differs from that which you received from the school district, it is your responsibility to work with the school district to obtain a "Check-List for Amendment," with supporting documentation, if appropriate, and send it to the County so that our payment information can be corrected.

Date:

To:

From: Westchester County Preschool
[ ] Allyson Gopaul
[ ] Sherry Hinkson
[ ] Patricia Sullivan-Brown

Term of Service: Child's Name: DOB: School District:

This letter serves as confirmation that the school district has informed us that you have been selected to provide a related service to the above-referenced child.

[ ] AMENDMENT, Change of [ ] Provider [ ] Location [ ] Frequency [ ] Duration [ ] Date of Services [ ] Adding a Service [ ] Other

Type of Service:
Start Date: End Date:
Duration: Frequency:
Location:
Method:

Coordinator of Services: Discipline of Coordinator:

Prescription Expiration Date:
Other Services:

[ ]To: WCDH **From:** _____ **Date:** _____

Based on the attached IEP from the above-named school district, this "Receipt" appears to be in error. Please correct your payment record for this service (see information underlined).
Note:

Cc: Child's File

CHAPTER 3

SERVICE PROTOCOLS

OVERVIEW OF RELATED SERVICE
AUTHORIZATION AND CONFIRMATION PROCESS

1. Initiation of Service

2. School District gives authorization to the provider from the Municipal list of Itinerant Related Service Providers

   - In a timely manner, school district sends the appropriate IEP and STAC and Prescription where necessary to the County.
   - County reviews STAC and IEP for compliance and agreement (see Information Required on the IEP in Support of Itinerant Related Service Request).
   - County sends "Receipt of School District's Authorization of Related Service" to provider with a copy to the school district to include: Type of Service, Start and End Dates of Service, Freq./Duration, Coordination, Location of service, etc.

3. If a discrepancy is discovered upon the school district's initial submission of paperwork, the Services Unit will issue a "Letter of Discrepancy" to the provider with a copy to the school district. This letter will direct the provider to work with the school district to correct the discrepancy(ies).

   - The school district submits the required change(s), along with a "SEIT/Related Services Check List for Amendment," if appropriate, to the County and a copy to the provider. Once the required information has been received and the discrepancy corrected, Services issues a "Receipt" to the provider with a copy to the school district.

4. If a discrepancy is discovered when the provider submits a claim:

   - The Operations Unit will return the claim to the provider along with the "Letter of Discrepancy," requesting the provider to work with school district to clear up the discrepancy(ies). A copy of the "Letter of Discrepancy" will be sent to the school district.
   - If the discrepancy is a clerical error, the provider makes the change, attaches a copy of the "Letter of Discrepancy" to the corrected claim and resubmits the claim to the Operations Unit.
   - If the discrepancy requires an amendment from the school district to correct, it is the provider's responsibility to work with the school district to effect the change:
   - The school district submits the "SEIT/Related Service Check List for Amendment" form and required documentation to the provider.
   - The provider attaches a copy of the "Letter of Discrepancy" to the original claim and the documentation received from the school district and sends the package to the Services Unit.
   - Once the information has been received by the County and the discrepancy corrected, the Operations Unit or Services Unit documents on the "Letter of Discrepancy" the date the correction/update was received. "Payment Resumed" is checked in the "Payment Status" box and a "Receipt of School District's Authorization" is issued to the provider with a copy to the school district.

General Guidelines for Billing Preschool Program Services
(Updated March 5, 2015)

1. All invoices, billing forms and other required supporting documents, whether they are initial submissions or corrected resubmissions must be originals and contain appropriate original signatures in ink. To avoid confusion, it is suggested that billing forms be prepared using blue ink.

2. Billing forms that contain missing, inappropriate or photocopied signatures will not be accepted and will be returned to the provider for correction and resubmission.

3. Corrections on billing forms (*CL-2R*, etc) may be made only by crossing out and having the person making the correction sign or initial at the site of the correction. Forms will not be accepted if these corrections are not initialed. Please note: date of service(s) and service start and end times cannot be changed after submission to WCDH. No resubmission is allowed.

4. Documents containing erasures, write-over, white-out, or ditto marks (") will not be accepted and will be returned to the provider for correction and resubmission.

5. Billing forms that are prepared using pencil will not be accepted.

6. Billing forms should be complete, neat and legible. It is required that all sections of the billing forms be completed with the required information. If any information is missing, the billing form(s) will be returned to the provider for correction and resubmission.

7. Invoices should contain billing for multiple students whenever possible. However only one service type can be billed on an invoice for each month.

8. Children's names cannot be listed on the Westchester County Department of Health Provider Invoice form; any such invoice will be automatically rejected.

9. Invoices cannot cross calendar years and or school years (i.e. cannot bill for June 2007 and July 2007 on the same invoice or December 2007 and January 2008 on the same invoice).

10. The total service billing units (quantity) included in each invoice must not exceed 150 (units) for related service, and must not exceed 100 pages for all other service billings. Any invoice exceeding these limitations will be returned for resubmission.

11. 11" x 8 ½" letter size paper must be used for all billing documents. If paper of any other size is used in an invoice, it will be returned for resubmission.

12. Do NOT use staples in assembling invoice documents. Instead, use clips or rubber bands to batch invoices.

13. All billing documents must be single-sided. Any invoice containing a double-sided document will be returned to you for resubmission

Guidelines for Billing Center Based, SEIT and Evaluation Services

1. Guidelines for Billing Center Based Programs Services

- The following documents are required for claiming Center Based Service:
  - WCDH Invoice
  - List of children attending class for the month

- County invoice must include:
  - Service month
  - Description of program (e.g. full day 9100)
  - Total amount

- List of children attending class for the month must include:
  - Children's names (alphabetized)
  - Date of birth
  - Amount being billed for each child (must be at the most current certified SED rate)
  - Total amount billed

Each therapist must complete a session note for every session delivered and sign the notes with his/her name, license number and discipline. We recommend you use our Related Service Daily Session Note Form. (If you use your own form, it must contain the same information as our Related Service Daily Session Note Form.). Upon request from the WCDH Medicaid Team, service providers must submit copies of the requested daily session notes to WCDH upon receipt of the request.

2. Guidelines for Billing SEIT Program Services

- The following documents are required for claiming SEIT Service:
  - WCDH Invoice
  - List of children having SEIT service for the month

- County invoice must have:
  - Service date
  - Description of service (SEIT),
  - Total number of SEIT sessions
  - SEIT rate
  - Total amount being claimed

- List of children having SEIT service for the month must include:
    - Children's names (alphabetized)
    - Date of birth
    - Number of sessions
    - SEIT rates
    - Total amount billed

3. Guidelines for Billing CPSE Evaluation Service

- The following documents are required for claiming CPSE Evaluation Service:
    - WCDH Invoice
    - STAC-5(s)
    - List of children having evaluation service if you have more than 1 child per invoice, but should be limited to five children

- County invoice which must have:
    - Service date
    - Description of type of evaluation
    - Total amount being claimed

- STAC-5 :
    - Copy of STAC-5 from school district

- List of children having evaluation service for the month must include:
    - Children's names (alphabetized)
    - Date of birth
    - Type of evaluation
    - Total amount billed

Please Note: All resubmission(s) of evaluation services should be treated as a new submission, and therefore a new invoice should be created.

Guidelines for Billing Related Services

1. Related Service Billing Document Preparation:

- Related Service Daily Note Forms must be prepared and signed by the service provider with the license number included after each daily service session. Service providers are also required to include their signature and license information at the bottom of the last page of the Related Service Daily Note Form for the month.

- The service provider must provide an accurate license number in accordance with their discipline and should sign and print their names exactly as they appear on their license/certificate. If the special educator has a certificate number from SED this will serve as their professional license number. If there is no certificate number, please do not indicate the social security number.

- If the agency is using a CFY (Clinical Fellow Year) or TSHH/TSSLD (Teacher of the Speech and Hearing Handicapped/Teacher of Students with Speech and Language Disabilities), a licensed Speech Language Pathologist (SLP) must supervise and cosign the daily session notes as well as the CL-2R Form. Please note, per your contract, that the supervising SLP must complete an "Under the Direction Of" Form and Log for each CFY or TSHH/TSSLD. An "Under the Direction Of" Form and Log must also be completed for services provided by a Licensed Master Social Worker, Occupational Therapy Assistant and a Physical Therapist Assistant.

- Do not attach the Related Service Daily Note Forms to your monthly billing submission. When the Westchester County DOH Medicaid Team requests the daily session notes the related service provider must submit photocopies of the notes upon receipt of the request.

- Service dates must be listed sequentially and in chronological order on the *CL-2R Form*, including the date and time of the session. Documents with out-of-sequence entries will not be accepted and will be returned to the provider for correction and resubmission.

- Absences and cancelled sessions must be noted on the billing form as per the instructions for completing the form. In accordance with contract requirements make-up sessions must be provided within thirty (30) days from the missed service date and must be documented on the billing forms.

- Invoices are to be submitted on a monthly basis. All billing forms that are attached to an invoice are to be prepared on a monthly basis for each student and for each service type.

- All services delivered for a particular type (i.e. PT, OT and Speech) must be billed at one time on a single billing form.

- The billing sheets must be attached to the same invoice when the same type of service for a child is provided by different therapists.

- As you are aware, any service provided by unqualified personnel will be rejected; no resubmission is allowed and such action may result in termination of your contract.

2. Related Service Billing Document Submission

- The following documents are required for claiming Related Service:

    - WCDH Invoice (white and yellow copy only)
    - WCDH *CL-2R Form*
    - A copy of the *Letter of Confirmation* for the first month submission of a service in each school term

- Billing must be submitted within three (3) months after receiving the letter of confirmation from WCDH.

- Corrected invoices and billing forms must be resubmitted to WCDH within forty five (45) days from the date of the *Rejection Letter*. When resubmitting invoices and billing forms, a copy of the *Rejection Letter* must accompany the resubmission as well as the original billing form(s). Corrected resubmissions received after the 45-day deadline will not be paid.

- Services rendered and billed for that are not in accordance with the information contained in your WCDH *Letter of Confirmation* will not be paid. This includes but is not limited to the following examples:
    - Services delivered prior to the Start Date on the *Letter of Confirmation*
    - Services delivered after the End Date on the *Letter of Confirmation*
    - Exceeding the frequency on the *Letter of Confirmation*
    - Service delivery at a location different from that listed in your WCDH *Confirmation Notice*.
    - **Please note** – if you deliver services in an office and you do not have up-to-date insurance coverage, the services will not be paid for.

- "Service Provider License Sheet" MUST BE ATTACHED AS A COVER SHEET TO PROVIDER INVOICES.

    - *The Service Provider License Sheet* needs to be completed by provider/agency to denote who delivered the services that are being billed and what their license/certification number is. (If the provider is an independent individual contracting directly with the County, this form does not need to be completed). The agency needs to attest that the individuals listed, are the individuals who delivered the service. A list of "Abbreviations for Disciplines" provides abbreviations that can be used - note example:

Provider Name (Print only)			Discipline	License / Certificate Number
Last	First	Middle		
Smith	John	P.	OT	000000

- Therapists must update their state license information with the correct name (e.g. they cannot sign their married name when their state license is in their maiden name). Therapists must consistently use one name (the one on their professional certificate) to sign as the therapist delivering the service.

- Nicknames should not be used (e.g. "Nicki rather than Dominque").

- For all Special Educators, please indicate certification numbers on the *Service Provider License Sheet* but do NOT list it if the certification number is the social security number.

- Please make a copy of the certificate and attach this to the billing sheet if a Special Educator does not have a certificate number (old certificate).

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
145 HUGUENOT STREET
NEW ROCHELLE, NEW YORK 10801

SCHOOL DISTRICT:

EDUCATIONAL ANNUAL REVIEW

Name:
Date of Birth:
Date of Report:
C.A.:

Instrument(s) Used:

BACKGROUND INFORMATION

PRESENT LEVELS OF PERFORMANCE (PLEPS)

Academic Achievement, Functional Performance and Learning Characteristics:

(Levels of knowledge and development in subject and skill area including activities of daily living, level of intellectual functioning, adaptive behavior, expected rate of progress in acquiring skills and information and learning style)

Rate of Progress:

Understanding of Basic Concepts:

Readiness Skills: (Reading, Math, Writing)

Daily Living Skills:

Language Skills:

Student Strengths, Preferences, Interest:

Academic, developmental and functional needs of the student, including consideration of student needs that are of concern to the parent:

Student needs to…

Social Development:

(Degree and quality of the students relationships with peers and adults; feelings about self; and social adjustment to school and community environments.)

Social:

Student Strengths, Preferences, Interest:

Social development needs of the student, including consideration of student needs that are of concern to the parent:

Student needs to…

Physical Development:

(Degree (extent) and quality of the student's motor and sensory development, health, vitality, and physical skills or limitations which pertain to the learning process.)

Health:

Sensory:

Fine Motor:

Gross Motor:

Student Strengths, Preferences, Interest:

Physical development needs of the student, including consideration of student needs that are of concern to the parent:
Student needs to…

Management Needs

(Management Needs – The nature (type) and degree (extent) to which environmental modifications and human or material resources are required to enable the student to benefit from instruction.)

2015-2016 OBJECTIVES AND PROGRESS

IEP Goals

1.

2.

3.

Current Progress:

1.

2.

3.

_____

Name of Teacher Date

Special Education Itinerant Teacher
NYS Certificate Number

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
145 HUEGONOT STREET
NEW ROCHELLE, NEW YORK 10801

SCHOOL DISTRICT:

RELATED SERVICE PROGRESS UPDATE

NAME: **DATE OF REPORT:**

PROVIDER:

RELATED SERVICE: Physical Therapy/Occupational Therapy **DOB:**

SCHOOL DISTRICT: **SERVICE MANDATE**

Functional Performance and Learning Characteristics:

Student Strengths, Preferences, Interests:

***Academic, developmental and functional needs of the student*:**

Physical development needs of the student, including consideration of student needs that are of concern to the parent (parental concerns will be discussed at the meeting)

Current IEP Goals and Progress

_____

NYS #

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
145 HUGUENOT STREET
NEW ROCHELLE, NEW YORK 10801

SCHOOL DISTRICT:

SPEECH & LANGUAGE ANNUAL REVIEW

Name:
Date of Birth:
Date of Report:
C.A.:

Instruments Used:

BACKGROUND INFORMATION

PRESENT LEVELS OF PERFORMANCE (PLEPS)

The following progress has been noted since the start of the school year:

Receptive Language

Expressive Language

Articulation and Phonological Skills

Pragmatics

Student's Strengths, Preferences, Interests:

Physical development needs of the student, including consideration of student needs that are of concern to the parent (parental concerns will be further discussed at the meeting):

2015-2016 IEP OBJECTIVES AND PROGRESS

IEP Goals

1.

2.

3.

4.

5.

Current Progress:

1.

2.

3.

4.

5.

_____

Therapist Date
Speech Language Pathologist
NYS License #
ASHA #
NPI #

Westchester County School Districts Annual Review Report

Revised 12/2015

RELATED SERVICE PROGRESS UPDATE

NAME: **DATE OF REPORT:**

PROVIDER:

RELATED SERVICE: Physical Therapy/Occupational Therapy **DOB:**

SCHOOL DISTRICT: **SERVICE MANDATE**

Functional Performance and Learning Characteristics:

Student Strengths, Preferences, Interests:

***Academic, developmental and functional needs of the student*:**

Current IEP Goals and Progress

_____

NYS #

WESTCHESTER SCHOOL DISTRICTS – PRESCHOOL – EXTENDED SCHOOL YEAR SERVICES (ESY)
Fillable version ~ DOCMENTATION TO DEMONSTRATE SUBSTANTIAL REGRESSION

All children are expected to regress after breaks in service. Substantial regression is defined in NYSED REGULATIONS as a student's 'inability to maintain developmental levels due to a loss of skill or knowledge during the months of July and August. This loss of skill or knowledge is of such severity as to require *an inordinate period of review at the beginning of the school year (at least eight weeks of re-teaching) to reestablish and maintain IEP goals and objectives that were mastered at the end of the previous school year.*'

Preschool Providers do not always have an opportunity to observe a 10 week summer break. Instead, they observe student performance after school vacations, weekends, and/or absences/illnesses. The CPSE must determine if the criteria for substantial regression have been met on a case by case basis, using the data provided to them.

To support their recommendation, Providers should attach copies of progress notes and other forms of data, as appropriate (e.g. anecdotal notes, graphs, charts, pre-post testing, criterion referenced testing, etc.)

APPROVAL FOR SUMMER SERVICES IS A CPSE DECISION BASED ON A REVIEW OF ALL RELEVANT DATA.

***** *Type in Starred Boxes*

Student Name: *		**Provider Name:** *		**Service:** *
Skills/Objectives Met Before Absences (based on IEP Goals)	**Date/Length of Absence**	**Skills After Absence**	**Time to Recoup Goals, Objectives, Skills**	**Re-Teaching Strategies**
*	*	*	*	*
*	*	*	*	*
*	*	*	*	*
*	*	*	*	*

WESTCHESTER SCHOOL DISTRICTS – PRESCHOOL – EXTENDED SCHOOL YEAR SERVICES (ESY)
Fillable version ~ DOCMENTATION TO DEMONSTRATE SUBSTANTIAL REGRESSION

1. Explain how the loss of skill(s) was determined. *	
2. Explain how the skill was re-established and how you monitored this process. *	
3. Were there any management issues that needed to be resolved after the break in services? How long did it take for these to be resolved? *	
4. Any additional information you would like the CPSE to consider. *	
Person Completing Form: *	**Title:** *
Type & Frequency of Current Service: *	

SIGNATURE OF PERSON COMPLETING FORM: **DATE:**

(Signature must be hand written – Print completed form and then sign and date)

STUDENT NAME: DATE:

SUGGESTED IEP GOALS (for next school year)

Goal: What the student will be expected to achieve by the end of the school year and include the following:
Variable (if applicable to specific goal, i.e. distance, duration, number, repetition)
Criteria: Measure to determine if the goal has been achieved
Criteria Period: Time frame in which the criteria measurement is to occur.
Method: How progress will be measured
Schedule: How often progress will be measured (i.e. weekly, monthly)
Responsibility: Who is responsible for the service?

Benchmark: Each goal should have at least 1 benchmark and include the following
Variable: (if applicable to specific goal, i.e. distance duration, number, repetition)
Month: The month the benchmark is to be achieved by
Criteria: Measure to determine if the goal has been achieved.

**** Final goals are developed at CPSE Meeting; these are suggestions to be given to & discussed at CPSE***
**** Type in white starred boxes. No limit to how much you can type in each box***

GOAL: *****
BENCHMARK/S:*

GOAL	Variable (if applicable)	Criteria	Criteria Period	Method	Schedule		Responsibility
Goal # *(if known)* *	*	*	*	*	*		*
BENCHMARK	Variable *(if applicable)*	Criteria	Month	Benchmark	Variable *(if applicable)*	Criteria	Month
Benchmark 1 # *	*	*	*	Benchmark 2 # *	*	*	*

GOAL: *
BENCHMARK/S:*

GOAL	Variable	Criteria	Criteria Period	Method	Schedule		Responsibility
Goal # *(if known)* *	*	*	*	*	*		*
BENCHMARK	Variable *(if applicable)*	Criteria	Month	Benchmark	Variable *(if applicable)*	Criteria	Monthly
Benchmark 1 # *	*	*	*	Benchmark 2 # *	*	*	*

GOAL: *
BENCHMARK/S:*

GOAL	Variable	Criteria	Criteria Period	Method	Schedule		Responsibility
Goal# *(if known)* *	*	*	*	*	*		*
BENCHMARK	Variable *(if applicable)*	Criteria	Month	Benchmark	Variable *(if applicable)*	Criteria	Month
Benchmark 1 # *	*	*	*	Benchmark 2 # *	*	*	*

PRE – RS

Invoice Number: _____ **Type of Service:** _____

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

Therapist's Name: _____ **License#/Certification#/Designation:**_____

Child's Name: _____ **DOB:** _____

IEP- Frequency/duration/method (I) or (G): _____/_____/_____**IEP Period: From** _____ **To** _____

Number of Children in Group (if applicable):_____

Name & Address of Service Delivery Site:	Service Date	Start Time	End Time	Attendance Code	Caregiver's Initials	Amount Billed
Attendance Codes:						
Scheduled Session - Specify duration (30 min, 45 min., etc) Example: SS/30**…….SS**						
Session Cancelled……SC						
Coordination……Coord						
Makeup……..……M						
		TOTAL # OF SESSIONS:			**Total This Page $**_____ **Grand Total $**_____	

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

Mainstream Program Signature: _____Title: _____ Date: _____

Parent/Caregiver Signature (home/facility): _____ Date: _____

I, _____ do hereby attest that I am a NYS Licensed/Certified _____
Signature of therapist** **Title(s)

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 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 of*" or supervision 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 # ASHA #

PRE – RS

Invoice Number: _____**A**_____ **Type of Service:** _____**B**_____

CONTRACT NAME: _____**C**_____ **Type of License/Certification:** _____**D**_____

Therapist's Name: _____**E**_____ **License#/Certification#/Designation:**_____**F**_____

Child's Name: _____**G**_____ **DOB:** _____**H**_____

IEP- Frequency/duration/method (I) or (G): _____**/**__**I**__**/**_____**IEP Period: From** _____**J**_____ **To** _____

Number of Children in Group (if applicable):_____**K**_____

Name & Address of Service Delivery Site: **L**	Service Date **M**	Start Time **N**	End Time **O**	Attendance Code **P**	Caregiver's Initials **Q**	Amount Billed **R**
Attendance Codes:						
Scheduled Session - Specify duration (30 min, 45 min., etc) Example: SS/30**…….SS**						
Session Cancelled……SC						
Coordination……Coord						
Makeup……..……M						

TOTAL # OF SESSIONS:

Total This Page $_____**S**_____

Grand Total $_____**T**_____

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

Mainstream Program Signature: _____**U**_____ Title: _____**V**_____ Date: _____

Parent/Caregiver Signature (home/facility): _____**W**_____ Date: _____

I, _____**X**_____ do hereby attest that I am a NYS Licensed/Certified _____**Y**_____
Signature of therapist** **Title(s)

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

****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 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 of*" or supervision MUST sign the following: I, have provided the "*under the direction of,*" SED required supervision for the therapist signing above.

Za	**Zb**	**Zc**	**Zd**
Print Name	Signature of Licensed/Registered Therapist	License#/Certification#/Designation	NPI # / ASHA #

INSTRUCTIONS FOR COMPLETING THE PRE-RS FORM FOR ININERANT RELATED SERVICES

A – Invoice Number	Enter the invoice number this form is being attached to.
B – Type of Service	Enter the type of related service billed for. Only one type of service per PRE-RS form. (Include consultation listed on the IEP and provided by the same therapist)
C – Contract Name	For Individual providers, fill in your first and last name; for Agency Providers, fill in your agency name.
D – Type of License/Certification #	Enter the license/certification of the therapist providing the service billed for.
E – Therapist's Name	Enter the name of therapist who provided the service.
F – License/Certification #	Enter the SED license and or certification number(s) of the therapist who provided the service. Speech and language pathologist who ate also certified as TSHH must list both numbers.
G – Child's Name	Enter the name of the student provided with the service.
H – DOB	Enter the Date of Birth of the student.
I – EIP	Enter the Frequency Duration and Method as indicated on the students IEP.
J – IEP Period this covers	Enter the IEP period this form covers, i.e. Summer 2005-2006, or 10 month program 2005-2006.
K – Number of Children in group (if applicable)	If applicable enter the number of students who are in this group.
L- Name & Address of delivery site	Enter name of delivery site if home, enter "home" and the address of the site.
M – Service Date	Enter the date(s) service was provided to this students. Dates must be entered sequentially and in chronological order.
N – Start Time	Enter the time you started the provision of service for each corresponding date.
O – End Time	Enter the time you finished providing service for each corresponding date.
P – Attendance Code	Enter the attendance code for each date as per the grid on the form.
Q – Caregiver Initials	Enter the caregiver initial.
R – Amount Billed	Enter the dollar amount billed for each date.
S – Total This Page	Enter the total dollar amount billed for each page.
T- Grand Total	Enter the total dollar amount billed.
U – Mainstream Program Provider	If the service was delivered at a mainstream program site have an official of the program sign.

V – Title	The title of the person from the main stream program signing above.
W – Parent/Caregiver signature	If the service was delivered at the students home or in a facility the signature of the parent or caregiver.
X – Signature of the Therapist	The signature of the therapist who provided the service.
Y – Title(s)	The SED title(s) of the therapist signing item W. If the therapist has two or more SED titles, indicate all title's held.
Z – NPI #	Enter the NPI #.
ZA – Signature of the therapist	If the provider of the services is a TSHH and does not have their SLP or is a COTA or PTA the signature of the therapist providing under the direction of or supervision signs this.
ZB – License	The license number of the person signing Z.
ZC – NPI #	Enter the NPI #.
ZD – ASHA #	Enter the ASHA #.

Westchester gov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

PRE-SEIT

Invoice Number: ________________________________ **Type of Service:** ________________________________

CONTRACT NAME: ________________________________ **Type of License/Certification:** ____________________

Teacher's Name: _________________ **Program Name/State Provider #**______________________________________

Child's Name: ____ **DOB:** _____________________

IEP- Frequency/duration/method (I) or (G): _______/_______/_______**IEP Period: From** ___________ **To** __________

Number of Children approved for Group (if applicable):____

Name & Address of Service Delivery Site:	Service Date	Start Time	End Time	Attendance Code	Caregiver's Initials	Amount Billed
Attendance Codes: **Scheduled Session** - Specify duration (30 min, 60 min) Example: SS/30**……………………..SS** **Session Cancelled……………….SC** **Makeup…………………………...…..M**						
		TOTAL # OF SESSIONS:			**Total This Page $**___________ **Grand Total $**___________	

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

Mainstream Program Signature: ____________________________________Title: ______________________ Date: ______________

Parent/Caregiver Signature (home/facility): ____ Date: ______________

I, ___________________________________ do hereby attest that I am a NYS Licensed/Certified Special Education Teacher
SEIT Signature

and did provide the service as noted on this billing form.

PLEASE NOTE: Billable time (i.e., mandated SEIT hours) should not be less than 66% or more than 72% of the SEIT's total Employment time. The reimbursement received may not exceed the time mandated on the IEP.

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS
4410 ITINERANT RELATED SERVICES /SEIT MAKEUP POLICY

1. Reporting Absences

Excessive absences should immediately be reported to the student's school district. The school district may communicate with the family to ascertain the cause of the absences and determine if adjustments to the student's Individual Education Plan (IEP) are indicated. **Please Note:**

- Changes in services that affect reimbursement shall not start without authorization from the school district.
- The school district is responsible for notifying the County of any changes in related services or SEIT by completing the Checklist for Amendments.
- Any change in the child's related service program, e.g., changes in frequency/duration or location (from a home/community service location to the providers office), must be mandated by the school district's Committee on Preschool Special Education (CPSE). Appropriate documentation in support of such changes must be sent to the County.

2. Holidays and Other School Closings due to weather related events

Services and or make up sessions cannot be provided on the following legal holidays: **New Year's Day, Dr. Martin Luther King Jr. Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran's Day, Thanksgiving Day, Christmas Day. Providers must follow the school district or program calendar whenever possible. Programs cannot operate and transportation cannot be provided. Make up sessions can occur under the following conditions:**

- Must be completed within the same IEP period.
- Cannot cross over from school year to extended school year IEP periods.
- Must take place within 30 days after the date of the missed session.
- Follow the school district or program calendar whenever possible.
- Must be clinically appropriate.
- The total number of sessions provided cannot exceed the total number of sessions authorized during the IEP period.

3. **CPSE approval is required for Make –up sessions as follows:**

   - Providers must contact the CPSE Chairperson for written approval if they are requesting that make-up sessions take place during school breaks.
   - Providers must contact the CPSE Chairperson for written approval when make- up sessions cannot be provided up within 30 days.
   - Services approved on the IEP for Community setting, cannot automatically be made up at home. Providers must contact the CPSE Chairperson to determine if their request is appropriate and complies with the IEP.

4. **Extended Absence:**

Agency Providers: In the event that a therapist or SEIT is absent for an extended period of time, the agency is responsible for notifying the school district and the County and arranging for a replacement provider.

Independent Providers: In the event that a therapist is absent for an extended period of time, the Independent Provider is responsible to notify the school district. The school district is responsible for notifying the County and arranging for a replacement provider.

5. **Limitation on Scheduling Therapy Makeup Sessions**

If the school district decides it is appropriate for regularly scheduled "itinerant" related sessions to be extended or the frequency increased on a temporary basis for the purpose of making up a block of missed sessions, the Checklist for Amendments process must be followed.

6. **Documentation Required**

Makeup sessions must be clearly documented as such on the CL-2R Form and the Invoice submitted by the provider. Reasons for the makeup session and the date the session is replacing should also be documented.

7. **4410 Center Based Programs Affected by School Closings Due to Extreme Weather Events**

Programs must be in session for not less than 180 days. If a program decides it is necessary to extend their school calendar for lost days in order to meet the SED 180 day requirement, they must submit a revised calendar to SED and the County. In addition they must inform the SD CPSE to amend IEP's if appropriate to coincide with the revised calendars to ensure payment.

Every effort will be made by the County to ensure that transportation is put in place in order to accommodate these revisions.

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS
LIST OF APPROVED RATES FOR RELATED SERVICES
For the period July 1, 2010 through June 30, 2015

	AGENCY PROVIDERS											
	PROVIDER'S SITE					HOME/COMM.					Site & home/community	
	Individual	Individual	Individual	Group	Group	Individual	Individual	Individual	Group per child	Group per child	Bilingual Group (a1)	Bilingual Group (a1)
	30 MINS	**45 MINS**	**60 MINS**	**30 MINS**	**45-60 Mins**	**30 MINS**	**45 MINS**	**60 MINS**	**30 MINS**	**45-60MINS**	**30 Min**	**45-60 Min**
SPEECH (a)	$42	$64	$85	$26	$38	$48	$69	$85	$26	$38	$28	$40
Teacher of Speech and Hearing Handicapped - reimbursed ~~ONLY~~ when delivered by a SED 4410 Approved Preschool												
SPEECH (a)	$48	$72	$96	$32	$47	$59	$83	$96	$32	$47	$34	$49
Dual Certified - Teacher of Speech and Hearing Handicapped & Speech Language Pathologist												
OT/PT (a)(b)	$48	$72	$96	$32	$47	$59	$83	$96	$32	$47	$34	$49
PSYCH (a)	$48	$72	$96	$32	$47	$59	$83	$96	$32	$47	$34	$49
SOCIAL WORK (a)	$42	$64	$85	$26	$38	$48	$69	$85	$26	$38	$28	$40
SPECIAL ED - **only** - TVI - DEAF	$42	$64	$85	$26	$38	$48	$69	$85	$26	$38	$28	$40
1:1 AIDE			$14					$14				
TCH ASST (c)			$16-35					$16-35				
NURSING LPN			$24-30									
NURSING RN			$35-55					$55				
Asst Tech Service(f)			(f)					(f)				
ASST TECH(g)												

(a) Bilingual professionals for individual session add $5.00 for 30 minute sessions, $7.50 for 45 minute sessions, $10.00 for 1 hour sessions regardless of the number of children. The therapist must have bilingual extension on certification/license.
(a1) Rates are per child where applicable - the therapist must have a bilingual extension on certification/license.
(b) Full rate will be paid for COTA and PTA inclusive of the required clinical supervision. Supervision notes will be audited by WCDOH.
(c) Teaching Assistants - Reimbursed as per directions from WCDH and submission of required documentation. TAs must have NYS Certification.
(d) Maximum Group Size =5 children. - If only one child in attendance therapist is reimbursed at the individual therapy session rate. There is no reimbursement for absences for children in a group.
(e) Coordination - SED permits only 1/2 hour per month where SED regulations require a coordinator of 2 or more related services when a SEIT is not involved. Coordination is built into the SEIT rate.
(f) Assistive Tech Service - At the rate of the discipline delivering the service. The discipline must be noted on the IEP.
(g) Assistive Tech Device - Cost of the device plus 3 hours at the rate of the discipline ordering the device when the IEP mandates a child specific device.

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS
LIST OF APPROVED RATES FOR RELATED SERVICES
FOR THE PERIOD OF JULY 1, 2010 - JUNE 30, 2015

	INDIVIDUAL PROVIDERS (b)											
	PROVIDER'S SITE					HOME/COMM.					Provider Site or Community	
	Individual	Individual	Individual	Group per child(c)	Group per child(c)	Individual	Individual	Individual	Group per child(c)	Group per child(c)	Bilingual Group per Child (a1)	Bilingual (a1)
	30 MINS	**45 MINS**	**60 MINS**	**30 Min**	**45-60**	**30 MINS**	**45 MINS**	**60 MINS**	**30 Min**	**45-60**	**30 Min**	**40-60 Min**
SPEECH (a)	$44	$66	$88	$30	$45	$55	$77	$88	$30	$45	$32	$48
Dual Certified - Teacher of Speech and Hearing Handicapped & Speech Language Pathologist												
OT/PT (a)(b)	$44	$66	$88	$30	$45	$55	$77	$88	$30	$45	$32	$48
PSYCH (a)	$44	$66	$88	$30	$45	$55	$77	$88	$30	$45	$32	$48
SOCIAL WORK(a)	$39	$58	$77	$24	$36	$44	$63	$77	$24	$36	$26	$38
SPECIAL ED:(a) -TVI - DEAF	$39.00	$58.00	$77.00	$24.00	$36.00	$44.00	$63.00	$77.00	$24.00	$36.00	$26.00	$38.00

extension on certification/license.

(a1) Rate is per child where applicable therapist must have bilingual extension on certification/license

(b) Full rate will be paid for 5 children. If only one child in attendance therapist is reimbursed at the individual therapy session rate. There is no reimbursement for absences for children in groups.

(c) Maximum Group Size children. - If only one child in attendance therapist is reimbursed at the individual therapy session rate.

(d) Coordination - SED permits only 1/2 hour per month where SED regulations require a coordinator of 2 or more related services when a SEIT is not involved. Coordination is built into the SEIT rate.

(f) Assistive Tech Service - At the rate of the discipline delivering the service. The discipline must be noted on the IEP

(g) Assistive Tech Device - Cost of the device plus 3 hours at the rate of the discipline ordering the device when the IEP mandates as a child specific device.

CHAPTER 4

TRANSPORTATION

PROVIDER'S RESPONSIBILITY IN THE TRANSPORTATION OF CHILDREN WITH SPECIAL NEEDS

A. REQUIRED DOCUMENTS

Beginning with the summer 2013 school term, The PROVIDER is no longer required to submit to Westchester County Department of Health Children with Special Needs (CSN) a completed Student Information Form (SIF) for each student. Instead, Westchester school districts will submit a completed Bus Transportation Authorization Form (TAF) for each student. As before, the PROVIDER is still required, as per its contract, to send CSN a transportation list – a complete alphabetical listing of the names of all children requiring bus transportation, as well as a transportation calendar.

1) TRANSPORTATION LIST: A separate list of students is to be submitted and labeled appropriately using the attached form. Please be aware that CSN sends the TRANSPORTATION LIST to the transporters with the completed TAFs to aid them in efficiently arranging routes on a timely basis. The transporters will not transport a child without approval from CSN. CSN's approval for each student is contingent upon receipt of a properly signed, dated and completed TAF, STAC-1 and IEP Summary page(s) from the school district Committee on Preschool Special Education (CPSE).

2) TRANSPORTATION CALENDAR: The TRANSPORTATION CALENDAR is the only calendar needed. The calendars submitted shall agree with those approved by the New York State Education Department (SED) for both the summer and school term. Any changes as to the initial or last date of service for either summer or school term shall receive written SED approval prior to change. The PROVIDER must offer transportation service from the first day of student attendance at the program. A separate calendar must be completed for each program campus. Please be aware that CSN sends the TRANSPORTATION CALENDAR to the transporters and this is the only notice the transporters receive of the dates they are required to provide transportation service – **including the first day of school**; if your calendar is not correct, bus service will not be provided on the correct dates.

3) WHERE TO SEND: The PROVIDER is to submit all information to the CSN Transportation Assistant (Nestor Ortiz) by e-mail to **nao4@westchestergov.com** with a copy to the Program Administrator, Specialized Transportation Services (Anthony Magee) to **aamc@westchestergov.com**, or by fax to (914) 813-4159.

4) WHEN TO SEND: TRANSPORTATION LISTS and CALENDARS are due for each term of service as listed below:

TERM	DUE
Summer	June 1
School Year	August 1

B. TRANSPORTATION LIAISON FOR FAMILIES

The PROVIDER is to act as a liaison in transmitting CSN transportation policies and service information to the parent/guardian:

1) TRANSPORTATION HANDBOOK: The PROVIDER is required to give each parent/guardian a copy of the Westchester County Department of Health Preschool and Early Intervention Transportation Handbook for Parents instructing them on the responsibilities of all parties (English and Spanish language versions are included in the manual). It is the PROVIDER'S responsibility to print and distribute these.

2) CHANGES IN TRANSPORTATION INFORMATION: The PROVIDER shall direct families to contact the school district when there is a change in transportation information. Changes in pick-up/drop-off address, contact information, etc. may only be made when the school district submits a new/updated TAF to CSN. The Provider must remind parents that transportation service must be consistent five days a week i.e. same pick-up and if different drop-off, both are consistent 5 days per week. No changes in transportation will be made during the first 10 days of a new school session; summer or fall.

3) PARENT REIMBURSEMENT: The PROVIDER shall give the parent information on CSN reimbursement of parent transportation expenses in lieu of the bus and shall assist families in completing the necessary documents.

4) WHEN A STUDENT MOVES OUT OF DISTRICT: If a child moves their residence to a new school district, **transportation will cease** until CSN is mandated (via proper documentation) to commence service from the new school district of residence.

5) SERVICE WILL STOP IF CONTACT INFO IS INCORRECT: In order to assure safety, transportation will cease if parent/guardian or emergency numbers are not found to be valid working numbers.

6) IF PARENT/GUARDIAN IS NOT AVAILABLE TO RECEIVE THE CHILD: If a parent/guardian or another designated individual on the TAF is not available to receive the child at drop-off, the transportation carrier will finish the route while the emergency contacts are called. If at the end of the route, neither of the alternative contacts can be reached and the parent/guardian is still unavailable, it is the policy to deliver the child into the care of the Westchester County Child Protective Service. UNDER NO CIRCUMSTANCES MAY A CARRIER BRING A CHILD BACK TO THE GARAGE OR DELIVER THE CHILD TO AN INDIVIDUAL NOT DESIGNATED BY THE PARENT/ GUARDIAN ON THE STUDENT INFORMATION FORM unless such information is approved in writing by the PROVIDER during the emergency situation.

7) WHEN A PARENT/GUARDIAN'S BEHAVIOR APPEARS QUESTIONABLE AT DROP-OFF: Questionable behavior can be defined as, but not limited to, repeatedly stumbling, staggering, acting in a seemingly intoxicated or incoherent manner, hitting or dropping a child. When a child is about to be discharged from the vehicle to a parent/guardian (or designee listed on the TAF) and the driver has concern about that person:

   a. The driver must determine from the parent/guardian if another caregiver is available to assist in taking care of the child. This individual and the parent/guardian must both be physically present or the caregiver may not assume responsibility for the child. If an available caregiver is designated by the parent/guardian, the driver must notify Dispatch immediately. Dispatch will verbally notify CSN and then forward a completed incident report, including the available caregiver's name. If no other adult is available to take care of the child, steps b, c and d are followed.

   b. The driver must immediately call Dispatch and report the situation.

   c. Dispatch must immediately call the police whose jurisdiction covers the area of the child's drop-off, and report the driver's suspicion that the parent/designee is unable to provide the appropriate care for the child thus endangering the child's welfare. The police will make a determination as to parent/guardian's ability and resources.

d. Dispatch must also immediately notify CSN verbally and then forward a completed incident report. CSN may also initiate a State Central Registry report based on the circumstances, the driver's account of the incident, and the police report.

C. THE PROVIDER AND THE TRANSPORTERS MUST WORK TOGETHER

Each program campus is served exclusively by one transportation carrier. However programs with multiple campuses may be served by multiple transportation carriers. Cooperation between the PROVIDER and the transportation carrier(s) is essential for safe and efficient transportation service.

1) POLICY/PROCEDURE FOR DELAY OR CLOSING OF SCHOOL DUE TO INCLEMENT WEATHER: Cooperation between the PROVIDER and the transportation carrier is necessary when the weather causes road conditions which may warrant a delay or closing of the school. The emphasis, when making these decisions, shall be on the safety of the children. The process to be used regarding school closings/delays due to weather conditions:

   a. PROVIDER appoints a responsible decision maker and alternate.

   b. Transportation carrier and PROVIDER'S delegated decision makers exchange inclement weather before-hours and after-hours phone numbers/contact information at the beginning of each term of service.

   c. **The Transportation Carrier is responsible for deciding whether or not transportation is provided on inclement weather days**. The decision to provide transportation is independent of the decision to open or close a school. While the PROVIDER may elect to be open, road conditions may prevent transportation from being provided. When the transporter has determined that road conditions will not support safe transportation, it will notify the PROVIDER immediately. When the PROVIDER makes a decision to close or delay, the PROVIDER delegate makes a call to the transportation carrier at least 1-1/2 hours before program opening. Transportation carrier acts as consultant on current road conditions to aid PROVIDER in making its decision.

2) VERIFICATION OF TRANSPORTATION AND ATTENDANCE: The PROVIDER program must verify in writing the actual transportation of children on a daily basis on forms submitted by the county contracted transporter. Upon arrival at the school, the PROVIDER staff will verify each child's attendance on the bus that day by initialing the Daily Transportation Attendance Log presented by the transporter staff. Upon dismissal from school, the transporter staff will record each child's attendance on the bus for the trip home and the PROVIDER staff will verify by initialing the Daily Transportation Attendance Log.

D. PROBLEMS WITH TRANSPORTATION SERVICE

The PROVIDER and program staff should be aware of the standards CSN requires of the transportation contractors (see below). When parents report problems with transportation service and when the PROVIDER notices deficiencies and lack of compliance by the transporters of safe procedures and required standards, the PROVIDER must work with the transporter to resolve the problems and notify CSN when necessary.

1) PARENT COMPLAINTS ABOUT TRANSPORTATION SERVICE: Parents are to be directed to report complaints and problems with transportation service directly to the PROVIDER for resolution. PROVIDERS and program staff are to work with the transporters and families to resolve transportation service issues while maintaining CSN policies and procedures for safety and efficiency. It is expected that the various types of complaints will be handled as indicated below. When it becomes necessary to notify CSN about a transportation service problem, the Provider will submit a written report by e-mail to the CSN Transportation Assistant (Nestor Ortiz) at **nao4@westchestergov.com** with a copy to the Program Administrator, Specialized Transportation Services (Anthony Magee) to **aamc@westchestergov.com**, or by fax to (914) 813 – 4159.

Complaint Type	How Handled
1. Parent complaint regarding service of transporter.	The parent deals directly with school to resolve problem. The school, in turn, will attempt to resolve the problem but will also notify CSN. CSN will intervene when necessary.
2. School complaint regarding service of transporter (instituted by school or passed on by parent).	If a minor problem, the school deals directly with transporter to resolve problem. It must also notify CSN. If a major problem or a minor problem not resolved between the school and transporter, school presents problem in writing to the CSN. Report must be factual, objective, specific and detailed.
3. CSN complaint regarding service of transporter (instituted by CSN or passed on by school).	CSN deals with transporter to resolve problem.
4. Transporter complaint about child/family or school	Same as above, #2

2) TRANSPORTATION SERVICE EMERGENCIES: The PROVIDER's designated transportation coordinator should contact the CSN Transportation Manager when a transportation service emergency exists and you cannot reach the bus company, or the bus company has been non-responsive. We are available on weekdays when programs are in session between 9:00 a.m. and 5:00 p.m. Please call (914) 813-5085 or (914) 813-5089; if we do not answer, please reach us by dialing the emergency cell phone, (914) 424-5850. The cell phone is intended to facilitate communication between CSN and its service providers and this telephone number should not be given to the parent or guardian of a child. Examples of emergency situations include the following:

- If a vehicle has arrived at your program without an appropriate and properly functioning car seat for each child or an appropriate and functioning securement device for a student traveling with a wheelchair.
- If a vehicle has arrived at your program without a monitor or with a driver or monitor who appears to be impaired.
- If a vehicle has failed to arrive within 20 minutes of the dismissal time.
- If a parent is requesting a last-minute change involving an alternate drop-off address or delivery to a person who is not listed on the child's student information form.

3) QUICK SUMMARY OF EXPECTED STANDARDS: The following is a summary of the minimal standards the transporter is required to meet while transporting preschool children with special needs:
   - Appropriate car seats; clean and in good condition, for all children.
   - A list of children on the run, directions to their home and a functioning GPS device.
   - A daily attendance list.
   - An attendant on each vehicle.
   - A working two-way radio or cellular phone.
   - A clean, well-running vehicle.
   - An appropriately heated or cooled vehicle as necessary.

4) COMPLETE SCHEDULE OF REQUIRED TRANSPORTER STANDARDS: To review the complete schedule of the transporter's required standards of service the PROVIDER may read a copy of the transporter's contract. Copies of the contracts between CSN and its transportation providers (and all County contracts) may be accessed through the County's website, www.westchestergov.com. To access the County Contract Database, click on the Business tab, choose Contract Search from the Quick Links Menu, and perform a search by Vendor (transporter) Name. Included below is a series of key excerpts from transportation contract specifications that will help define the responsibilities of all parties.

   Procedures When the Child is not Ready to be Picked up at Home at the Scheduled Time: In the event a child is not ready to be picked up at the scheduled time, the driver will not be required to wait more than 5 minutes for an acknowledgement before continuing on with the route. The driver shall notify the radio dispatcher of the "no-show" prior to leaving and proceeding to the next scheduled pick-up.

   Children shall be expected to wait no longer than 15 minutes beyond the scheduled pick-up time. Likewise, at the end of the program, children shall arrive at their home within 15 minutes of the scheduled drop-off time. In the event Contractor is unable to comply with this requirement, it shall be Contractor's responsibility to notify the child's parent/ guardian of the delay and the expected drop-off time, in addition to notifying the County.

   The Contractor will not provide transportation for a child when the parent/guardian has communicated (at least one hour in advance of the scheduled pick-up time) that the child will not be requiring transportation on a given day. Additionally, the Contractor will not provide transportation when it has been notified by the County of a child's planned, extended absence.

   Pick-up at School at the End of the Program Day: Contractors will insure that vehicles are available at the program facility at least 5 minutes prior to the program's dismissal.

   UNREPORTED ABSENCE OF CHILDREN:
   The Contractor is to discontinue service to a child if the child is not transported for 2 consecutive days and the parent/guardian did not inform the Contractor that the child would be absent. The Contractor is to immediately notify the school by phone and the County in writing within 24 hours after service is discontinued. Service will be reinstated when the parent/guardian calls the Contractor and requests it.

   EARLY DISMISSALS FOR WEATHER OR OTHER EMERGENCY CONDITIONS:
   Cooperation between the school and the Contractor is necessary when a delay or closing of a program is warranted due to an emergency and/or when the weather causes unsafe road conditions. The emphasis, when making these decisions, shall be on the safety of the children.

In the event of an early dismissal, the Contractor will ensure that the children are picked up as quickly as possible and delivered to their homes or other emergency locations as may be necessary, and as directed by the County. The Contractor will inform the school when the vehicles will arrive to pick up the children. Additionally, the Contractor will ensure that every parent/guardian has been notified about the early dismissal and the children's whereabouts as applicable, either directly or in cooperation with the school.

PROCEDURES WHEN PARENT OR PARENTAL DESIGNEE DOES NOT MEET SCHOOL BUS:

1. If no one is home when the bus arrives to drop off the child, the driver will notify Dispatch.

2. Dispatch calls the home. If there is no answer, Dispatch instructs the driver to continue with the route. The driver will return to the child's home once the rest of the children are dropped off.

3. If no one is home when the bus arrives the second time, Dispatch attempts to reach the parents' home and work numbers and the emergency contacts.

4. If Dispatch can reach an emergency contact, arrangements are made so that the emergency contact can take the child.

5. If Dispatch cannot reach a parent or an emergency contact, the school is notified. The school may accept the child when he/she attends an a.m. session and the school has a p.m. session.

6. If the school is unable to accept the child, and Dispatch has not been able to contact a parent or caregiver, and it is before 5:00 p.m., Dispatch contacts Westchester County Department of Health (WCDH). If Dispatch cannot reach WCDH, he/she will call the emergency cell phone at (914) 424-5850.

7. WCDH will verify with Dispatch that all of the above steps have been followed and call Child Protective Services (C.P.S.) Emergency Services at 995-2099 to arrange to place the child.

8. If it is after 5:00 p.m., Dispatch will call and make arrangements to bring the child to C.P.S.

9. The Contractor will provide an incident report the school day following the event.

4410 PRESCHOOL TRANSPORTATION LIST

Service Period: School Year 20 /20 or Summer 20 Page of

Program Name:	Address:	Date Completed:
Contact Name:	Phone #:	E-mail address:

We are aware that CSN must receive a STAC, IEP Summary, and TAF for each student from his/her respective school district in order for transportation service to be authorized; these documents must be received by June 1st for the summer session and August 1st for the fall session, or service will be delayed. The following is an alphabetical list of students that will be attending our program whose families have indicated they will require transportation service:

	Last Name of Child	First Name of Child	Session (AM/PM/FD)	School District
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

TL-Revised 8/13/ajm

You must provide a separate list for each campus.

A separate calendar must be submitted for each campus.

Example of
Westchester County Department of Health
Children with Special Needs
SUMMER 2012 TRANSPORTATION CALENDAR

(Must agree with dates of program submitted to SED and dates of education calendar)

PRESCHOOL PROVIDER_____CAMPUS LOCATION_____

Contact Person: _____Telephone No.:_____

ONE HALF (1/2) DAY PROGRAM: (hours student in attendance)

A.M. –- from_____ to _____

P.M. –- from_____ to_____

ALL DAY PROGRAM: (hours student in attendance)

_____A.M. to _____P.M.

Anticipated maximum number of Westchester preschool students*:

		Preschoolers Bussed From Other Counties
½ day A.M.	_____Per Campus	_____
½ day P.M.	_____Per Campus	_____
Full day	_____Per campus	_____
Total:	_____	Total: _____

***Use actual children not F.T.E.**

DATES OF: T R A N S P O R T A T I O N
(Use only dates children attend—circle dates students attending and star any conference dates.) Transportation and education days must agree with dates submitted to SED.

2012

JULY

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

AUGUST

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

Total number of student attendance days _____.

COMMENTS:

A separate calendar must be submitted for each campus.

Westchester County Department of Health
Children with Special Needs
2012/13 TRANSPORTATION CALENDAR
(must agree with dates of program submitted to SED and dates of education calendar)

SCHOOL_____ **CAMPUS LOCATION**_____

Contact Person:_____ **Telephone No.:**_____

ONE-HALF (1/2) DAY PROGRAM: (hours student in attendance)
A.M. -- from_____ **to**_____
P.M. -- from_____ **to**_____
ALL DAY PROGRAM: (hours student in attendance)
_____**A.M. to**_____**P.M.**

Anticipated maximum number of Westchester preschool students*:

			Preschoolers Bussed From Other Counties
½ day A.M.	_____	**Per Campus**	_____
½ day P.M.	_____	**Per Campus**	_____
Full day	_____	**Per Campus**	_____
Total:	_____	**Total:**	_____

***Use actual children not F.T.E.**

DATES OF: TRANSPORTATION
(Use only dates children attend—circle dates students attending and star any conference dates.) Transportation and education days must agree with dates submitted to SED.

2012

SEPTEMBER

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

OCTOBER

M	T	W	T	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

NOVEMBER

M	T	W	T	F
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

DECEMBER

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

2013

JANUARY

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

FEBRUARY

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	

MARCH

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

APRIL

M	T	W	T	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

MAY

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

JUNE

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

Total student attendance dates_____

COMMENTS:

Westchestergov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

CHILD'S NAME_____

PRESCHOOL and EARLY INTERVENTION PROGRAM

TRANSPORTATION HANDBOOK

FOR PARENTS

The Westchester County Preschool/Early Intervention Transportation Program is managed by Westchester County Department of Health Children with Special Needs. We are pleased to provide you with this handbook as a guide to the transportation service options available. We hope this handbook will help you understand the procedures and answer any questions you may have. Please take a few moments to read this important information.

INSIDE:

September 2015

Transportation Service Options

Westchester County Department of Health (WCDH) provides Transportation Service for children with special needs as mandated by Section 4410 of the Education Laws of 1989, Title II-A of Article 25 of the Public Health Law and/or other applicable acts.

Transportation Service is defined as transportation of each child to and from the child's special needs program (the program or agency providing educational services to the child) using a vehicle that can accommodate the specific needs of the specific child. This includes County-provided school bus service in vehicles equipped with a radio, child-restraint seat and properly trained drivers and monitors; and parent transportation by personal car, public bus, or taxi. As the parent/guardian, you must discuss all available transportation service options with your Early Intervention Service Coordinator or your school district's Committee on Preschool Education (CPSE) Chairperson. Your school district is defined by the geographical area in which your family lives. Each school district has its own CPSE for children 3-5, which determines your child's special education needs.

Mileage Reimbursement and No-Cost Monthly Metro Cards are available to parents who choose to transport their child to/from an Early Intervention Toddler Development Group contained in the Individualized Family Service Plan (IFSP), or to the approved 4410 Special Education Preschool Program contained in the Individualized Education Plan (IEP). Parents who transport their child to/from Early Intervention services occurring at a facility (not a toddler development group) or parent-child group contained in the Individualized Family Service Plan (IFSP) may also receive Mileage Reimbursement, No-Cost Monthly Metro Cards, and in some cases, Taxi Fare Reimbursement.

County-Provided Bus Service is available to children attending an Early Intervention Toddler Development Group contained in the Individualized Family Service Plan (IFSP), or the approved 4410 Special Education Preschool Program contained in the Individualized Education Plan (IEP).

Whichever option is selected at the **IFSP or CPSE meeting**, it must be listed on your child's IFSP or IEP prior to the beginning of transportation services and it must be consistent for each day your child is scheduled to attend the program/service. You may not combine a Metro Card or transportation reimbursement and County-provided bus service.

Any necessary change in the selected transportation option must be communicated to either the Early Intervention Service Coordinator or your school district's CPSE Chairperson; and the appropriate paperwork completed prior to the beginning of the new service option.

Please ask your Early Intervention Service Coordinator or your school district's Committee on Preschool Education Chairperson for a copy of the WCDH brochure with information about Parent Transportation Reimbursement benefits.

If You Choose Bus Service

The Westchester County Department of Health Children with Special Needs-CSN must ensure safe and efficient transportation for all children approved for transportation service. Bus service will begin once the WCDH receives and reviews the following required documents:

- Your child's IFSP or IEP authorizing transportation service
- A properly completed Bus Transportation Authorization Form (TAF)

If the WCDH does not receive the required documents authorizing service, if they are incorrect or arrive late, BUS SERVICE WILL NOT BE AVAILABLE ON THE FIRST DAY OF PROGRAM.

Speak to your child's Early Intervention Service Coordinator to confirm that the correct paperwork is submitted in a timely manner. Or speak to your school district's CPSE to request that your child's meeting be scheduled in a timely manner and that all required documents have been completed and submitted to the WCDH.

Bus Service Facts:

- Your child will receive one round trip (from home to program, from program to home) on a vehicle equipped with child-restraint seats for all children. The vehicles will provide air conditioning as needed from May 1st through October 1st and be properly heated in cold weather months. The vehicles will be wheelchair accessible if necessary.
- Each vehicle will have one bus monitor who will assist your child with getting on, riding, and getting off the bus. The bus monitor is not permitted to help dress or feed your child while on the bus. Nor is he/she permitted to escort your child to or from the school bus.
- Medications are not permitted on the bus. If your child requires medication, it is your responsibility to bring your child's medication to the program.
- Bus routes are generally scheduled for 75 minutes or less. If your child lives a significant distance from the program, the scheduled time of the bus route may be up to 90 minutes. Factors such as traffic congestion/accidents or inclement weather may cause the bus route to take more than the scheduled amount of time. Parents should also keep in mind that buses often depart from the program several minutes after the program's dismissal time once all children have boarded the bus.
- **Scheduled pick-up and drop-off times are approximate**.

Bus Transportation Authorization Form (TAF)

A completed Bus Transportation Authorization Form (TAF) is required before your child can ride the school bus. Your school district or service coordinator will provide you with the TAF to complete. The TAF provides the following information:

- PICK-UP ADDRESS – Your home address. If you choose an address other than your home, the alternate address must also be located within Westchester County. **The pick-up address must be the same every day of the week.**

- DROP-OFF ADDRESS – Your home address or an alternate address within Westchester County. This address may be different from the pick-up address, but it **must be the same every day of the week.**
- EMERGENCY NUMBERS — in case we cannot reach you. This should be someone who knows your child and who has agreed to receive and assume responsibility for your child.
- MEDICAL INFORMATION — This is information you and your child's physician feel is important for us to have in order to provide safe transportation. Complete this section to help us understand your child's needs. Tell us if your child has special medical conditions such as seizures, temperature difficulties, allergies, etc., if your child takes medication regularly and what the medication is.
- Once a student's trip is scheduled according to the information on the TAF, it can only be changed if the family moves to a new address or permanently changes to an alternate pick-up or drop-off address. **Temporary changes to pick up or drop off locations are not permitted; no forms can be accepted for temporary changes.**

Your child's TAF must be up-to-date at all times. **Transportation service will stop if any significant information on the TAF is found to be incorrect.** Changes to bus routes cannot be made by submitting forms or requests directly to the bus driver/company. You must contact your school district or service coordinator as soon as possible to update the TAF if changes to any of the following occur:

- The pick-up or drop-off address
- The program location
- The program session time
- The name of the person(s) authorized to meet your child at the bus
- Telephone numbers for yourself or emergency contacts
- Your child's medical needs

Your school district/service coordinator will complete a new TAF and submit the form to the WCDH. Changes to the pick-up and/or drop-off address or the program location may take up to 10 days to accommodate.

BUS PROCEDURES

You or an Authorized Caregiver must meet the bus:

- All children must be met at the school bus by a **parent/guardian** (a person legally responsible for the care of the child; may be parent, foster-parent, relative, The Department of Social Services) or **caregiver/responsible person** (individuals designated by the parent/guardian to care for the child who are **at least 14 years of age**) **listed on the TAF**.

- For the safety of your child the **bus driver is prohibited from releasing your child to someone not named on the TAF**. ID must be presented.

- If you or someone listed on the TAF are not available to meet the bus and the Bus Company cannot reach you or the emergency contacts, the Bus Company **must call 911 to report that no one is available to receive your child.**

Waiting For the Bus:

- The Bus Company will call you to give you the **approximate** scheduled pick-up and drop-off times for your child.

- Your child must be ready 10 minutes before the pick-up time. If occasionally your child is not ready at the scheduled pick-up time, the driver is not required to wait more than 5 minutes before continuing on the route. **The driver is not required to wait 5 minutes for your child each day**.

- If you are waiting more than 15 minutes from the scheduled pick-up time, and are not contacted by the Bus Company, please call the dispatcher.

- If the bus is late more than two (2) consecutive times, report this to your child's EI or preschool program for assistance.

- Changes in pick-up and drop-off times happen during the school year when children are added or leave the program. The Bus Company will notify you of any schedule changes.

Absence:

- The parent/guardian is required to **notify the Bus Company at least one (1) hour in advance** of the scheduled pick-up time if the child is going to be absent.

- If your child will not need the bus for several days because of a family vacation, etc., **you must call the Bus Company dispatch office (do not tell the bus driver).** You must also notify the program. A minimum of one (1) day advance notification is requested.

No-Shows:

- If you fail to notify the Bus Company that your child will be absent, but do not meet the bus when it arrives at your home, this is considered a No-Show. **If your child is a No-Show for two (2) consecutive days, bus service will stop.** You may call the Bus Company to start service again.

- If it has been five days since the bus company has stopped your child's bus service due to No-Shows, you must contact your child's service coordinator or school district to request bus service. It will take 5-10 days for bus service to start again.

Inclement Weather:

Please listen to local radio or TV or search online for school delays or closing notifications. You may find school district and program closings by following these links to News 12 Westchester and WHUD Westchester: http://westchester.news12.com/ http://pamal.com/stormcenter/whud.php

- If you are not sure about your child's program, contact the program directly.

- The WCDH follows the local school district closings throughout the county. If your school district is closed, the WCDH transportation service will also be canceled.

- If your child's program chooses to open and the WCDH does not provide bus service, you may drive your child to the program; **please be aware that you are responsible for round-trip transportation.**

- Please be aware that if bus service is provided in bad weather you should expect delays.

Complaints:

- If you have a complaint regarding bus service, e.g. routine lateness, attitude, etc., **you should report the problem to your child's program**.

- If the problem cannot be solved, the program will refer it to the WCDH Program Administrator.

When there is an accident:

Our most important mission is the safe transport of your child. If your child is in an accident, the following steps will be taken:

- The Bus Company immediately notifies WCDH and your child's program.

- During program hours, your child's program will contact you. After program hours, the Bus Company will contact you.

- Your child may be taken to the Emergency Room; the police officer(s) at the scene will determine if this is necessary.

- Since New York is a no-fault insurance state, **in the event that your child is involved in a school bus accident and requires medical treatment, the parent/guardian's automobile insurance is primary for all costs, including the emergency room.** This is a New York State Law.

- Should the parent/guardian not have automobile insurance, the bus company is responsible for insurance and possible post-accident costs.

Westchestergov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

NOMBRE DEL ESTUDIANTE _____

PROGRAMA PRESCOLAR Y DE INTERVENCIÓN TEMPRANA

MANUAL DE TRANSPORTE

PARA LOS PADRES

El Departamento de Salud del Condado de Westchester administra el Programa de Transporte Preescolar y de Intervención Temprana del Condado de Westchester. Nos complace proporcionarle este manual como una guía sobre las opciones de servicios de transporte que se encuentran disponibles. Esperamos que el mismo le sirva para entender los procedimientos y aclarar toda duda que pueda tener al respecto. Por favor tome algunos minutos para leer esta importante información.

ÍNDICE

Septiembre de 2015

Opciones de transporte

El Departamento de Salud del Condado de Westchester (WCDH, por sus siglas en inglés) proporcionará servicio de transporte a los niños con necesidades especiales de acuerdo con lo dispuesto en el Artículo 4410 de las Leyes de Educación de 1989, el Título II-A del Artículo 25 de la Ley de Salud Pública y/u otras leyes correspondientes.

El servicio de transporte se define como el llevar a cada menor de ida y vuelta al programa de necesidades especiales (la agencia o programa que proporciona servicios educativos al menor) en un vehículo que satisfaga las necesidades específicas del menor específico. Ello incluye el servicio de autobús provisto por el Condado en vehículos equipados con radio, asientos de seguridad y conductores y personal de vigilancia debidamente capacitados, y el transporte de los padres en carro de uso personal, autobús público o taxi. En su calidad de padre o tutor, usted tiene que hablar acerca de todas las opciones de servicios de transporte disponibles con el Coordinador de Servicios de Intervención Temprana que le corresponda, o con el Presidente del Comité de Educación Preescolar (CPSE, por su sigla en inglés). El distrito escolar que le corresponde está definido por el área geográfica en la que reside su familia. Cada distrito escolar tiene su propio Comité de Educación Prescolar para niños de 3 a 5 años, el cual determinará si su hijo/a tiene la necesidad de recibir servicios de educación especial.

El reembolso de millas recorridas y tarjetas MetroCard mensuales gratuitas se encuentra disponible para aquellos padres que decidan transportar a sus hijos a un programa de Desarrollo de Intervención Temprana delineado en el Plan Individual de Servicios Familiares (IFSP, por su sigla en inglés) o el programa 4410 aprobado de educación especial prescolar que se describa en el Plan de Individual de Educación (IEP, por su sigla en inglés). Los padres que transporten a sus hijos con el fin de recibir servicios de Intervención Temprana que ocurran en una institución (no en un grupo de desarrollo infantil) o a un grupo de padres y niños contenido en el Plan Individual de Servicios Familiares (IFSP) también podrán recibir el reembolso de las millas recorridas, tarjetas MetroCard mensuales gratis y, en algunos casos, el reembolso del costo del taxi.

El Condado provee servicio de transporte en autobús a aquellos niños que concurran a un Grupo de Desarrollo Infantil del programa de Intervención Temprana incluido en el Plan Individual de Servicios Familiares (IFSP) o el Programa de Educación Especial Prescolar 4410 incluido en el Plan Individual de Educación (IEP)**.**

Cualquiera sea la opción que haya elegido en la reunión con el Comité de Educación Prescolar o la reunión para trazar el Plan Individual de Servicios Familiares, la misma debe figurar en dichos planes y debe ser la misma para cada día que su hijo/a tenga que concurrir al programa. No es posible combinar una MetroCard con reembolso por transporte y servicio de autobús del Condado.

Deberá informársele al Coordinador de Servicios de Intervención Temprana o al Presidente del Comité de Educación Prescolar de su distrito escolar sobre todo cambio realizado en la opción de transporte. Antes de comenzar a recibir servicios de acuerdo con la nueva opción seleccionada se deberá completar el papeleo necesario.

Solicite al Coordinador de Servicios de Intervención Temprana o al Presidente del Comité de Educación Prescolar de su distrito escolar una copia del folleto de información sobre los beneficios de reembolso de gastos de transporte que el Departamento de Salud del Condado de Westchester ofrece a los padres.

Si elige el servicio de transporte en autobús

La Oficina de Menores con Necesidades Especiales del Departamento de Salud del Condado de Westchester debe garantizar transporte seguro y eficaz para todos los niños que hayan sido aprobados para recibir servicios de transporte. El servicio de autobús comenzará una vez que el Departamento de Salud del Condado de Westchester reciba los siguientes documentos:

- El IEP o IFSP del niño en el cual se autorice el servicio de transporte
- El Formulario completo de Autorización para transportar al estudiante en autobús

Si el Departamento de Salud no recibiera los documentos requeridos para autorizar el servicio, están incorrectos o llegan tarde, EL SERVICIO DE AUTOBÚS NO ESTARÁ DISPONIBLE EL PRIMER DÍA DEL PROGRAMA.

Consulte con el Coordinador de Servicios de Intervención Temprana de su hijo para presentar los documentos necesarios en el plazo requerido, o hable con el Comité de Educación Prescolar de su distrito escolar para solicitar que la reunión de su hijo se fije puntualmente y que todos los documentos requeridos se hayan completado y enviado al Departamento de Salud del Condado de Westchester.

Información sobre los autobuses:

- Su niño recibirá un viaje de ida y vuelta (de casa al programa, del programa a su casa) en un vehículo equipado con asientos de seguridad para todos los niños. Los vehículos tendrán aire acondicionado según sea necesario desde el 1 de mayo hasta el 1 de octubre y contarán con calefacción apropiada durante los meses de frío. De ser necesario, los vehículos tendrán acceso para sillas de ruedas.

- En cada vehículo habrá un monitor que ayudará a los niños a subirse al autobús, a viajar y a bajarse del autobús. El monitor no tiene permitido ayudar a vestir o dar de comer a los niños, ni tiene permitido acompañar a los niños hasta el autobús, ni desde el mismo.

- No se permite transportar medicamentos en el autobús. Si su hijo debe tomar medicamentos, usted tendrá la responsabilidad de llevar los mismos al programa.

- El recorrido del autobús por lo general no dura más de 75 minutos. Si su hijo vive a una distancia considerable del programa, la duración del viaje podrá ser de hasta 90 minutos. Factores tales como la congestión del tráfico, accidentes o mal tiempo podrán causar que el viaje lleve más que el tiempo designado. Los padres deberán tener en cuenta que los autobuses a menudo parten del programa varios minutos después del horario de salida del mismo y una vez que todos los niños se hayan subido al autobús.

- **Los horarios de ida y vuelta son aproximados.**

Formulario de autorización para transportar al estudiante en autobús:

Se requiere que complete un Formulario de Autorización para transportar al estudiante en autobús (TAF, por sus siglas en inglés) antes de que su niño pueda viajar en autobús escolar. El distrito escolar o el coordinador de servicios le proporcionarán el formulario que debe completar. Dicho formulario provee la siguiente información:

- DIRECCIÓN DE SALIDA – La dirección de su casa. Si elige una dirección diferente, la misma también debe de estar ubicada dentro del Condado de Westchester. **La dirección de salida debe ser la misma para todos los días de la semana.**

- DIRECCIÓN DE LLEGADA – La dirección de su casa o una dirección alternativa que se encuentre dentro del Condado de Westchester. Esta dirección podrá ser diferente de la dirección de salida, pero **debe ser la misma para todos los días de la semana.**

- NÚMEROS EN CASO DE EMERGENCIA – si no podemos comunicarnos con usted. Esta persona debe ser alguien que conozca a su niño y que además esté de acuerdo en recibir a su hijo y hacerse responsable de él.

- INFORMACIÓN MÉDICA – Esta es la información que usted y el doctor de su hijo consideren que es importante que tengamos para poder proveer transporte seguro. Complete esta sección para ayudarnos a entender las necesidades de su niño. Díganos si su hijo tiene condiciones médicas especiales tal como convulsiones, dificultades relacionadas con la temperatura, alergias, etc., y también si toma medicamentos regularmente y cuáles son dichos medicamentos.

- Una vez que el viaje del estudiante se programe según la información que figure en el formulario, solamente se puede cambiar si la familia se muda a una nueva dirección o cambia permanentemente el lugar de donde se recogerá o se dejará al estudiante. **No se permitirá realizar cambios temporarios con respecto al lugar de donde se recoge o se deja al estudiante. No se aceptarán formularios para hacer cambios temporarios.**

El Formulario de Autorización para transportar al estudiante deberá estar al día en todo momento. **El servicio de transporte se suspenderá de inmediato si se determina que la información que figura en el Formulario de Autorización es incorrecta.** No se podrá realizar cambios a las rutas de autobuses por medio de la presentación de solicitudes directamente al conductor o a la compañía de autobuses. Usted deberá comunicarse con el distrito escolar o el coordinador de servicios tan pronto como sea posible para actualizar el formulario de autorización de haber cambios en cualquiera de los siguientes:

- Dirección de salida o dirección de llegada
- Ubicación del programa
- Horario de las sesiones del programa
- Nombre de la persona autorizada a encontrarse con su hijo en la parada del autobús
- Su número de teléfono o los contactos en caso de emergencia
- Las necesidades médicas de su hijo

El distrito escolar o el coordinador de servicios deberán completar un nuevo formulario de autorización (TAF, por sus siglas en inglés) y presentarlo ante el Departamento de Salud del Condado de Westchester. El realizar los cambios necesarios con respecto a la dirección de salida y/o llegada y a la dirección del programa podrá llevar un máximo de 10 días.

PROCEDIMIENTO PARA TOMAR EL AUTOBÚS

Usted o la persona autorizada debe esperar al bus:

- **Uno de los padres o el tutor** (Persona legalmente responsable del niño. Puede ser uno de los padres, padre/madre adoptivo, familiar, el Departamento de Servicios Sociales), **la persona que lo cuide o la persona responsable por el menor** (individuos designados por los padres o el tutor para cuidar al menor y que **tengan por lo menos 14 años de edad**) **cuyos nombres se encuentren en el Formulario de Autorización para Transportar al estudiante.**

- Por la seguridad de sus hijos, **el conductor del autobús tiene prohibido dejar a sus hijos con alguien cuyo nombre no figure en el Formulario de Autorización.** La persona deberá presentar su documento de identificación.

- Si usted o una de las personas cuyo nombre figura en el Formulario de Autorización no están disponibles para esperar el autobús y la Compañía de Autobuses no se puede poner en contacto con usted o algunos de los contactos de emergencia, la Compañía de Autobuses **deberá llamar al 911 para denunciar que no hay nadie disponible para recibir a su hijo/a.**

Al esperar el autobús:

- La Compañía de Autobuses lo llamará para decirle los horarios **aproximados** en que pasará a recoger y a dejar a su hijo/a.

- Su hijo/a debe estar listo por lo menos diez minutos antes de la hora en que el autobús pasará a buscarlo. Si de vez en cuando su hijo no está listo a la hora indicada, no se requiere que el conductor espere más de cinco minutos antes de continuar con la ruta. **NO se requiere que el conductor espere cinco minutos a su hijo todos los días.**

- Si se encuentra esperando más de quince minutos luego de transcurrida la hora indicada, y la Compañía de Autobuses no lo ha llamado, por favor llame al despachante.

- Si el autobús llegó tarde más de dos veces consecutivas, infórmele al programa prescolar o de intervención temprana para que lo asistan.

- A veces es necesario realizar cambios en los horarios durante el año lectivo a medida que se agregan o eliminan niños del programa. La Compañía de Autobuses le notificará sobre los mismos.

Ausencias:

- Se requerirá que uno de los padres o el tutor **le notifique a la Compañía de Autobuses por lo menos una (1) hora antes** de la hora fijada si el niño va a estar ausente.

- Si su hijo/a no va a necesitar el servicio de autobús debido a vacaciones familiares, etc. Solicitamos que nos notifique por lo menos con un día de anticipación. **Usted debe llamar a la oficina de la Compañía de Autobuses. No le informe al conductor.** Usted también deberá notificar al programa.

- Si usted no le notifica a la Compañía de Autobuses que su hijo estará ausente y no sale a esperar el autobús cuando llegue a su casa, se considerará que no se ha presentado. **Si no notifica que su hijo estará ausente y no sale a esperar el autobús dos (2) veces consecutivas, el servicio de autobús cesará.** Usted podrá llamar a la Compañía de Autobuses para reiniciar el servicio.

- Si han transcurrido cinco días desde que la Compañía de Autobuses le suspendió el servicio por la razón expuesta anteriormente, usted deberá ponerse en contacto con el coordinador de servicios o con el distrito escolar para solicitar nuevamente el servicio de transporte. Llevará entre cinco y diez días reiniciar el servicio.

En caso de mal tiempo:

Escuche las estaciones de radio /locales, vea los canales de televisión locales o busque por Internet las notificaciones sobre el cierre de las escuelas. Por medio de los siguientes enlaces a News 12 Westchester y WHUD Westchester encontrará información relacionada con el cierre de distritos escolares y programas debido al mal tiempo: http:///westchester.news12.com/ http://pamal.com/stormcenter/whud.php

- Si no está seguro si el programa de su hijo operará normalmente, llame al programa directamente.

- El Departamento de Salud del Condado de Westchester se guía por las determinaciones de cada distrito escolar del condado. Si su distrito escolar cancela las clases por el día, el servicio de transporte del Departamento de Salud también se cancelará.

- Si el programa al que concurre su hijo decidiera abrir y el Departamento de Salud no proporcionara servicio de autobuses, usted podrá llevar a su hijo al programa. **Usted estará a cargo de transportar a su hijo/a de ida y de vuelta.**

- Recuerde que si se proporciona el servicio de transporte cuando haya mal tiempo, habrá retrasos.

Quejas:

- Si tiene alguna queja con respecto al servicio de transporte, por ejemplo que el autobús siempre llega tarde, la mala disposición de los empleados, etc., **debe informar al programa sobre el problema.**

- Si el problema no se puede resolver, el programa lo enviará al Administrador de Programa del Departamento de Salud del Condado de Westchester.

En caso de accidente:

La misión más importante que tenemos es transportar a su hijo/a de forma segura. Si su hijo/a se ve involucrado en un accidente, se seguirán los siguientes pasos:

- La Compañía de Autobuses inmediatamente le notificará al Departamento de Salud del Condado de Westchester y al programa de su hijo. Durante el horario del programa, el programa al que concurre su hijo se pondrá en contacto con usted. Luego del horario habitual, la Compañía de Autobuses se pondrá en contacto con usted.

- Es posible que sea necesario llevar a su hijo a la sala de emergencias. Los oficiales de policía que se presenten en la escena determinarán si ello es necesario.

- Ya que en Nueva York los seguros automovilísticos son sin culpabilidad, **en el caso que su hijo se vea involucrado en un accidente en el autobús escolar y requiera tratamiento médico, el seguro automovilístico de los padres o tutor será el primario para cubrir los costos, incluyendo la sala de emergencias.** Así lo establece la ley del Estado de Nueva York. Si los padres o tutor no tuvieren seguro automovilístico, la compañía de autobuses será responsable del seguro y posiblemente por los costos posteriores al accidente.

Westchester gov.com

Robert P. Astorino
County Executive

Sherlita Amler, M.D.
Commissioner of Health

January 1, 2012

Dear CPSE Chairperson:

RE: 4410 Parent Transportation Alternatives

Section 4410 of the Education Law of New York State requires Committees on Preschool Special Education (CPSE) to "request and encourage" parents to transport their children to their preschool programs at public expense; see the most recent memorandum: http://www.p12.nysed.gov/specialed/publications/preschooltrans-811.pdf.

Accordingly, the County offers parents a choice of transportation alternatives, as listed below. These options are available during the time children attend approved special education preschool programs and are provided in lieu of County-provided school bus services.

- **MILEAGE REIMBURSEMENT**: Parents will be reimbursed for the cost of driving their child to approved special education preschool program. Tolls will be reimbursed when necessary. Parking will be reimbursed for the period of time the child is in program when the program does not have a parking area in or around their facility.
- **METRO CARD**: Parents will receive at no cost a monthly Metro Card to be used for transporting the child to and from the preschool program.
- **TAXI FARE REIMBURSEMENT**: Parents will be reimbursed for the cost to transport their child to and from the preschool program by taxi each day.

In order to implement the above, we are asking CPSEs to discuss these alternatives to school bus transportation with all parents, to distribute copies of the enclosed **TRANSPORTATION PLAN** form, and to assist the parents to complete the form by choosing one of the above transportation alternatives. This will document that the parents were requested and encouraged to transport their children to the special needs preschool and will facilitate arrangements for the delivery of a Metro Card or reimbursements. CPSEs will then be responsible for submitting completed TRANSPORTATION PLAN forms to the County with the child's STAC-1 and IEP. The transportation option selected by the parent must be indicated on the STAC -1. Once we have received the completed TRANSPORTATION PLAN forms, we will forward additional information and documents to qualifying families.

Of course, parents have the option to decline to transport their children to special education preschool, and in such cases, County-provided bus service will continue to be available for children attending an approved special class or special class in an integrated setting. **However, parents will not he permitted to combine transportation reimbursement and County-provided bus service. Whatever option is selected, it must be consistent for each day the child is scheduled to attend the program.**

As may be necessary due to family circumstances, a change in the selected transportation service option can be effected. In order to select a different transportation service, parents must contact the CPSE to obtain another TRANSPORTATION PLAN form. CPSEs will then be responsible for submitting the completed form to the County prior to the beginning of the newly selected transportation service. If you have any questions about these procedures, you can contact Anthony Magee, Program Administrator – Specialized Transportation Services, at (914) 813-5089. Thank you for your cooperation and for your continued assistance in implementing these procedures.

Sincerely,

Marina Yoegel

Marina Yoegel, Assistant Commissioner
Children with Special Needs

Westchester gov.com

CHILDREN WITH SPECIAL NEEDS

TRANSPORTATION PLAN - Preschool

Child's Name: _____ School District: _____

Address: _____

Preschool Program Name: _____

Address: _____

4410 Approved Preschool Program Transportation Facts

Transportation for children attending preschool programs is governed by the 4410 Preschool Law. The Law encourages parents to transport their children to their preschool programs at public expense. Accordingly, the following options are available to Westchester parents who transport their children to an approved special education preschool program:

Mileage Reimbursement: Parents will be reimbursed for driving their child to and from the child's preschool program. Reimbursement will be paid at the current county approved rate per mile, for one round trip per day between the city or town in which the child lives and the city or town in which the child's preschool program is located as calculated by an online web mapping service (MapQuest or similar). Reimbursement for parking and tolls may also be provided when necessary and authorized by the County.
Metro Card: Parents will receive at no cost a monthly Metro Card to be used for transporting the child to and from the preschool program.
Taxi Fare Reimbursement: Parents will be reimbursed for the cost to transport their child to and from the preschool program by taxi each day.

W**hatever option is selected, it must be consistent for each day of travel to the program;** bus transportation may not be combined with receipt of a Metro Card, mileage or taxi fare reimbursement. Special school bus transportation is available for children whose parents decline to transport them to preschool.

I will transport my child to special needs preschool and select the following option:

[ ] Mileage Reimbursement [ ] Metro Card [ ] Taxi Fare Reimbursement

Parent's Printed Name: _____ Phone: _____

Parent's Signature: _____ Date: _____

Please note that once you have selected an option, you may only change your selection by contacting your school district's Committee on Preschool Education and completing another form.

January 2012

Westchester County Department of Health

Bus Attendance Log for the Month of _____ , 20___

Trip Code: P/U = Pickup from Home; D/O =Drop Off to Home
Daily Attendance Code: P=Present; A=Absent; N=No Show;n/a=not scheduled ;O=Child in another bus

Page ___ of ____

☐ Check if bus is one way

Bus Co: _____________ Bus # _______________ School: ___________________________________ School Location:______________

Last, First Name	Trip	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
	P/U																															
	D/O																															
	P/U																															
	D/O																															
	P/U																															
	D/O																															
	P/U																															
	D/O																															
	P/U																															
	D/O																															
	P/U																															
	D/O																															
	P/U																															
	D/O																															
Driver Signature:																																

(The numbered columns are headed: DAY OF MONTH TRANSPORTED)

Contractor Verification: I do hereby certify that the foregoing is a true and accurate representation of services provided for the Children with Special Needs Program for the month indicated.

Administrator Signature ____ Print ____ Title ____ Date ____

School Verification: I have reviewed this list of children and have verified that the children listed above were transported by the above listed contractor on the days indicated.

Administrator Signature ____ Print ____ Title ____ Date ____

Created 8-18-08 Rev.

NYSED Memorandum
Special Transportation for Students with Disabilities

http://www.p12.nysed.gov/specialed/publications/topics

Click on *Transportation*

CHAPTER 5

ASSISTIVE TECHNOLOGY

PROTOCOL
FOR
OBTAINING ASSISTIVE TECHNOLOGY DEVICES THROUGH WESTCHESTER COUNTY DEPARTMENT OF HEALTH FOR 4410 PRESCHOOL CHILDREN

Assistive technology devices may be provided to children enrolled in a 4410 Preschool Program. An assistive technology device is defined as "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities." The Committee on Preschool Special Education (CPSE) must recommend and include the device on the child's Individualized Education Plan (IEP). For more information regarding determination, use and types of devices, please refer to New York State Education Department Field Memorandum dated September 1995, Subject: Assistive Technology Devices and Services http://www.trecenter.org/appendixc.htm .

Assistive technology devices can be obtained two ways. Devices can be provided through the TRAID Loan Program. These devices are to be returned to the Loan Program upon expiration of the agreed upon terms. Devices can be obtained through the Westchester County Department of Health. The device would be available for the duration of the IEP as well as the length of the child's enrollment in a 4410 Preschool Program. When a child transitions out of Preschool, the device becomes the property of the County. At this time, the School District may purchase the device from the County if it wishes.

The Protocol that follows pertains to the process to be followed if the assistive technology device is going to be obtained through the Westchester County Department of Health.

OBTAINING AN ASSISTIVE TECHNOLOGY DEVICE

I. COMMITTEE ON PRESCHOOL SPECIAL EDUCATION

A. For children who receive Related Services/SEIT or Center-Based children who require a child-specific device, the CPSE makes the recommendation and indicates the type of device and the number of AT service visits needed, if necessary, in the child's IEP.

B. The CPSE Chairperson should contact the TRAID Loan Closet to see if the device is available for loan until such time that the child receives their own.

C. A STAC-1 is completed in Related Services fashion. In Section 11, Line 1 write in "Purchase AT Device (specify type of device). In Section 12, RS Line 1, fill in the type of device. Be sure to list the type and not the brand name. In Section 12, RS Line 2, fill in AT Service Visits, if needed. The STAC-1 along with a copy of the child's IEP should be sent to the AT Coordinator at the Department of Health.

D. The CPSE sends the 4410 WCDH-contracted Evaluator/Provider the AT Packet to be completed.

E. In order for WCDH to obtain an assistive technology device for a child, the Evaluator or Provider must complete and submit an AT Packet ("Packet") to the AT Coordinator consisting of the following:

- Form PRE-AT-1. Since assistive technology equipment will be acquired through a bidding process, it is especially important that the device specifications and features noted on this form are sufficiently precise to enable potential vendors to offer appropriate equipment during the bidding process.

- Form PRE-AT-2. This form must present clearly how the device will be used, its relationship to the child's functional capabilities, and the functional outcomes expected to be attained by the child as a result of using the device.

- Itemized Price Quote. This should specify the estimated cost of the device, cost of any and all accessories; adaptations and/or modifications needed; extended warranties; insurance; and a suggested vendor. Whenever feasible, please include the name of vendor representative from which you obtained the information.

The AT-1 and AT-Forms are to be completely filled out. The Packet must be complete and received along with the STAC and IEP in order for it to be processed. Any incomplete packets or missing information will result in a delay.

II. CSN

A. Will log in the receipt of the AT Packet.

B. Will review the AT Packet to ensure it is complete. If additional information is needed the AT Coordinator will contact the Evaluator/Provider who completed the Packet.

C. The AT Coordinator will process all AT devices to be sent out to bid, as follows:
- Transfer the information noted in the Packet, including the device specifications, accessories/attachments, cost per item, suggested vendor for the device and delivery address, to a computerized Westchester County PURCHASE REQUISITION.
- Transmit the Purchase Requisition Form electronically.

III. PURCHASING DEPARTMENT

A. Upon receipt of a computerized PURCHASE REQUISITION from the Department of Health, the Purchasing Department will initiate a bidding process for selection of the lowest responsible bidder for the AT device. Bid prices may include shipping and handling as well as extended warranties.

The device will be purchased from the lowest responsible bidder who has met all of the specifications described on the PRE-AT-1 form. The device that is purchased may not necessarily be the same brand that is named in the specifications; however, the individual specifications prescribed for the device may not be substituted.

B. Once the vendor is selected, the Purchasing Department will send a PURCHASE ORDER to the vendor with a copy to the Department of Health

IV. CSN

Upon receipt of the PURCHASE ORDER, CSN will send out a NOTIFICATION OF ASSISTIVE TECHNOLOGY EQUIPMENT VENDOR letter to the Evaluator/Provider.

V. AT VENDOR

Upon receipt of the PURCHASE ORDER, the vendor will contact the Evaluator/Provider to arrange for delivery and post delivery fitting visit(s), if needed.

VI. EVALUATOR/PROVIDER

A. When the delivery and any post-delivery adjustments/attachments that may be needed have been completed to the satisfaction of the Evaluator/Provider (agency/therapist), they/s/he

will **notify CSN Operations to this effect by phone (914-813-5089) within two (2) business days of acceptance/completion of the device**.

B. For the AT devices purchased by the provider, submit a Westchester County Department of Health Provider Invoice Form along with a copy of the vendor's invoice and packing slip to CSN Operations.

VII. CSN

A. For items obtained through a bid:
- Note the date of the Evaluator/Provider's acceptance call and the date of acceptance/completion of the device.
- Complete the RECEIVING REPORT and forward it to the Westchester County Finance Department. (This gives the Finance Department permission to pay the AT Vendor's claim for the device.)

B. For provider purchased items:
- Log in the receipt of the Provider Invoice.
- Review invoice for completeness.
- Process the invoice for payment.

VIII. AT VENDOR

When the Evaluator/Provider has accepted delivery of the AT device, the assistive technology vendor may bill the county for the device. To bill, the vendor must submit an invoice which includes the Purchase Order Number for the device. Invoices should be forwarded to:

Westchester County Department of Finance
148 Martine Avenue, 7th Floor
White Plains, NY 10601

IX. EVALUATOR/PROVIDER

In cases where upon delivery an item is found to be deficient, (i.e., does not meet the specifications noted in the Purchase Order; workmanship is not up to standard; material is of inadequate quality, etc.) the Evaluator/Provider (agency/therapist) will work with the vendor to correct the deficiencies or replace the item.

The device obtained will reflect the specifications as submitted. Any features not included in the original specifications noted on the PRE-AT-1 form are not a reason for rejection of the device.

If the vendor and Evaluator/Provider are unable to resolve problems related to AT devices, then the Evaluator/Provider should: (a) notify the AT Coordinator, (b) ask the AT Coordinator to

intervene and either insist that appropriate corrections be made or arrange for exchange or return of the device.

X. SCHOOL DISTRICT

If the school district wishes to purchase the AT Device from the County as the child transitions out of Preschool, please contact AT Coordinator Unit at 914-813-5089 to make arrangements.

XI. PARENT OF PRESCHOOL CHILD

Assistive Technology Devices purchased by the Westchester County Department of Health may be used by the child for the duration of his/her enrollment in a 4410 Preschool Program. When the child transitions out of Preschool, the AT Device is to be returned to the County. It is at this time that CSN Coordinator will direct the parent to bring/ship the device to the TRAID Loan Program in Valhalla.

Westchester gov.com

Children with Special Needs
Department of Health

4410 PRESCHOOL ASSISTIVE TECHNOLOGY INFORMATION FORM

Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Phone Number: _____

Address: _____

Responsible Therapist recommending the device name/e-mail/phone numbers: _____

_____

Agency Affiliation and Address/Phone: _____

School District name: _____ Chairperson name: _____

Date of Evaluation: _____ **Child's Diagnosis/ICD-9 Code:** _____

Provider: _____ Discipline: _____

Agency/Program _____ Medicaid: [ ] Yes [ ] No

Device(s) being requested: _____

_____

CPT/HCPCS: _____

Where device is to be delivered: _____

Suggested Vendor for the device: _____

Number of Assistive Technology Service Visits Needed (must be indicated on the IEP):_____

SPECIFICATIONS of the device: (Include dimensions, weight, material, or catalog picture with this information so that potential vendors can offer an appropriate device. The device purchased need not be the brand name you request, so be sure you are specific enough to get as close a match as possible.) **Attach an itemized invoice from the suggested vendor with the cost of the device including any necessary modifications and/or attachments/accessories.**

_____

_____

Is the device available for loan through TRAID? [ ] Yes [ ] No

If yes, will the family be borrowing the device from the Loan Program while this order is being processed? [ ] Yes [ ] No

[ ] Prescription attached [ ] Vendor price quote attached [ ] Specifications attached

Responsible Therapist's Signature: _____ Date: _____

Physician/Evaluator's Signature: _____ Date: _____

Westchester gov.com

Children with Special Needs
Department of Health

4410 PRESCHOOL ASSISTIVE TECHNOLOGY JUSTIFICATION

Child's Name: _____

Date of Birth: _____ IEP Period: _____
From/To

DIAGNOSIS – Describe the relationship of this device to the child's functional capability.

DESIRED OUTCOMES - Identify the functional outcomes expected to be attained by the child as a result of the use of this device during this IEP period. Describe how the device will be used to accomplish these outcomes.

PLAN FOR USE OF DEVICE - How will the device be used? Frequency and duration? By whom? In what setting (i.e. home, center)? If used by more than 1 therapist, specify goals for each discipline. Specify if parent will be using the device and any precautions or safety factors they should be made aware of.

DURATION - What is the anticipated period of time (months/years) device will be used by the child?

Responsible Therapist's Signature: _____ Date: _____

_____

For WCDH/CSN Use Only

RECOMMENDATION: [ ] Device Approved [ ] Device Disapproved Reviewed By:

_____

Date: _____

Westchestergov.com

Children with Special Needs
Department of Health

INVOICE FOR 4410 PRESCHOOL ASSISTIVE TECHNOLOGY REIMBURSEMENT

For Health Department use: INVOICE # _____ INVOICE DATE: _____

CHILD'S NAME _____ DOB _____

PARENT'S NAME _____ TEL # _____

ADDRESS_____

SERVICE PROVIDER'S NAME _____ TEL # _____

SERVICE PROVIDER'S AGENCY _____

ASSISTIVE TECHNOLOGY DEVICE(S) PURCHASED

NAME/DESCRIPTION OF DEVICE: _____

_____

QUANTITY: _____ ESTIMATED LENGTH OF USE: _____

DATE PURCHASED: _____ METHOD OF PAYMENT: _____

PRICE OF ASSISTIVE TECHNOLOGY DEVICE(S): _____

COST OF SHIPPING, TAXES, OR OTHER FEES: _____

TOTAL ASSISTIVE TECHNOLOGY EXPENSE/REIMBURSEMENT REQUESTED: $ _____

CERTIFICATION STATEMENT:

I certify that the parent referenced above provided the listed Assistive Technology Device(s) as described to this child.

Name of Related Service Provider	Signature of Related Service Provider	Date

I certify that I provided the listed Assistive Technology Device(s) as described to this child.

Name of Parent	Signature of Parent	Date

You must attach a receipt/proof of purchase for each device in order to be reimbursed.

MEDICAID

PROTOCOL

FOR PRESCHOOL SERVICES

Note: It is the responsibility of each provider to be current with all the Medicaid requirements and recommendations in accordance with the New York State Education Department.

Please refer to the following website for instructions/updates for Medicaid requirements and documentation:

http://www.oms.nysed.gov/medicaid/

Required Documentation

- Referral for Evaluation(s)
- Evaluation Report for Service(s) that are listed on the IEP
- One-Time Consent from Parent to Bill Medicaid (school districts should secure these when meeting with the parents) – Please note the CM-1 is no longer a valid consent
- IEP (if special transportation is required the school district should specify this in the IEP)
- Prescription/Written Order/Referral for Service (signed and dated)
    - Effective January 1, 2014 the Ordering/Prescribing/Referring/Attending provider must be Medicaid Enrolled (eMedNY)
- Session Notes:
    - Student Name
    - Service Type
    - Individual
    - # in Group
    - Setting (Location)
    - Date & Time
    - Notes/Comments
    - CPT Code
    - License & NPI Number
    - Name, Title & Signature of provider
    - Signature of Supervisor (if required)
- “Under the Direction of” Form & Notes (is applicable)
- “Under the Supervision of” Form & Notes (if applicable)

IEP (Special Transportation)

- According to NYSED guidelines:
    - Special Transportation is reimbursable when it is medically necessary and included in the student's IEP
    - Student must be traveling to or from a Medicaid reimbursable service (other than special transportation)
    - Vehicle must be specially modified
- Two exceptions listed in the Alert:
    - "A student resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP and the student is traveling to or from a Medicaid reimbursable service; and
    - A student is transported from school or home directly to and/or from a provider in the community for the exclusive purpose of accessing an SSHSP service, (e.g., BOCES or other contracted provider), and transportation is noted in the IEP. If the student is transported to a provider located in the community and is then transported directly back to school or directly home, both one-way trips are Medicaid reimbursable."
- Medicaid Alert #13-10: http://www.oms.nysed.gov/medicaid/medicaid_alerts/alerts_2013/13_10_clarification_of_federal_guidelines_for_transport_8_28_13.pdf
- FAQ's regarding Medicaid Alert #13-10: http://www.oms.nysed.gov/medicaid/q_and_a/Q_and_A_220-226_11_25_13.pdf

Medicaid Training

NYSED provides Medicaid Training for relevant employees within the Preschool/School Supportive Health Services Program.

When available, newly hired, relevant staff should receive the most current Medicaid Training provided by NYSED.

For detailed instructions on the requirements, to review previous training material and to sign up for any available training, please follow the link below.

http://www.oms.nysed.gov/medicaid/training_materials/home.html

Useful Websites

- NY State: www.health.state.ny.us/health_care/medicaid
- eMedNY: https://www.emedny.org/toolscenter.aspx
- CPT Codes: http://health.westchestergov.com/images/stories/pdfs/medicaid-protocol.pdf
- ICD9 Codes: www.cms.gov/ICD9ProviderDiagnosticCodes/
- NYSED Medicaid-in-Education: www.oms.nysed.gov/medicaid/
- Frequently Asked Questions: http://www.oms.nysed.gov/medicaid/q_and_a/

One-Time Medicaid Consent Form

The One-Time Medicaid Consent Form should be secured by the appropriate school district. This consent form has strict requirements regarding Written Notification prior to the parent/guardian signing the consent form and strict requirements regarding the Annual Notification which must be sent out each year after the consent form is signed. Following is the current consent form that is required for Medicaid claiming.

(Insert district information) **CIN # _____**

Medicaid Consent

Dear Parent/ Guardian of _____:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's Individualized Education Program (IEP). This consent allows the School District/ Westchester County to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose. **I, _____as the parent/guardian of _____,**
(Print child's name)
have received a written notification from the School District that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/ Westchester County may access Medicaid to pay for special education and related services provided to my child.

I understand that: providing consent will not impact my child's/ my Medicaid coverage; upon request, I may review copies of records disclosed pursuant to this authorization; services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid; I have the right to withdraw consent at any time; and the School District must give me annual written notification of my rights regarding this consent.

I also give my consent for the School District/ Westchester County/ Providers to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
Prescription	Service Provider Attendance
Referral	"Under the Direction of" Certification
Treatment Logs	"Under the Supervision of" Certification
Individualized Education Program - IEP	"Under the Direction of" Logs
Attendance Records	"Under the Supervision of" Logs
Bus Logs	Calendar
Other unnamed documents needed to support a claim to Medicaid	

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Daily Session Notes

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):
Scheduled Session: **SS,** Therapist Canceled: **TC**,
Family Canceled: **FC,** Holiday: **H,**
Inclement Weather: **IC,** Makeup Session: **M**

LOCATION OF SERVICE AS PER CHILD'S IEP
PLEASE PRINT THE FULL ADDRESS SERVICES TOOK PLACE:

ICD-10 Code:

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 | Date | License #

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 | Date | License #

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 | Date | License #

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**	**NPI#**

Westchester gov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

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:

ICD-10 Code:

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	DATE	License #

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	DATE	License #

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	DATE	License #

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:

PRESCRIPTION ~REFERRAL FOR PRESCHOOL EVALUATIONS ~ SERVICES

Student Name: _____ **DOB:** _____

District: _____

The child named above is recommended for the following:
(You must provide the **most specific ICD10 Code*** for each Evaluation/Service checked)

***Effective October 1, 2015 all written orders/referrals must contain an ICD10 Code**

EVALUATION(S)		**SERVICE(S)**	
		Frequency & Duration as per the IEP, for the School Year: _____ to _____	
__ Audiological	ICD10 Code _____	__ Audiological	ICD10 Code _____
__ Occupational Therapy	ICD10 Code _____	__ Occupational Therapy	ICD10 Code _____
__ Physical Therapy	ICD10 Code _____	__ Physical Therapy	ICD10 Code _____
__ Speech*	ICD10 Code _____	__ Speech*	ICD10 Code _____
__ Skilled Nursing**	ICD10 Code _____	__ Skilled Nursing**	ICD10 Code _____
__ Psychological***	ICD10 Code _____	__ Psychological Counseling***	ICD10 Code _____
*** Reason/Need: _____		*** Reason/Need: _____	

* Referrals for Speech Evaluation or Services may be signed by a Speech Language Pathologist who has seen the child

** Referrals for Skilled Nursing Services require specific physician's order with specific instructions

*** Referrals for a Psychological Evaluation or Psychological Counseling Services may be signed by an appropriate school official such as school administrator or the chairperson of the CPSE or a licensed practitioner acting within his/her scope of practice; Psychological Evaluation and/or Psychological Counseling can have ICD10 Code OR Reason Need: all others need ICD10

_____ Date: _____
Original Signature of Physician, Physician Assistant, Nurse Practitioner or other professional explained below.

Print Name: _____ Title: _____
Address/Printed or Stamp:
_____ NPI #_____
_____ License # _____
_____ Medicaid # _____
Phone: _____ Fax: _____

~A copy of this form or its equivalent must be sent to the County~

Facsimile or photocopy of this is acceptable

~Changes in frequency, duration or type of service need new prescription/referral~

Westchestergov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

Speech Referral / Recommendation for Evaluation / Services

Effective October 1, 2015 all written orders/referrals must contain an ICD10 Code

A Speech and Language referral for an **[ ] evaluation** and / or **[ ] services** is recommended in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the frequency and duration listed within the Individualized Education Program designed by the Committee. Any changes made to the frequency and / or duration in the IEP requires a new referral.

Student Name: _____ Date of Birth: _____

School District: _____ School Year: _____
mm/dd/yyyy – mm/dd/yyyy

Provider Agency: _____

ICD-10 Code: _____

Purpose of Treatment or Evaluation: _____

_____ _____
Please Print SLP Name **Signature – Must be NYS licensed SLP/ASHA certified**

License Number: _____ **NPI Number: _____**

Date Signed: _____

Contact Information for SLP:

_____
Full Address/Phone Number

Note: Medicaid requires that speech evaluations and services be recommended by a **Licensed Speech Pathologist**, Physician, Physician's Assistant or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

Westchestergov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

Psychological Counseling Referral for Evaluation / Services

Effective October 1, 2015 all written orders/referrals must contain an ICD10 Code

A psychological counseling referral for an **[ ] evaluation** and / or **[ ] services** is recommended in accordance with the request by the Committee on Pre-School Special Education.
Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Services recommended for: _____
mm/dd/yyyy – mm/dd/yyyy

Student Name: _____ DOB: _____

ICD-10 Code: _____

Purpose of Evaluation: _____

_____ _____
Print Name Signature

_____ _____
Title Date

License or NPI Number: _____

Contact Information (Address/phone):
_____

Note: Medicaid requires that psychological counseling services be recommended by an appropriate school official, such as a school administrator or chairperson of the CSE/CPSE or other licensed practitioner acting within his or her scope of practice, on or before the start of services.

Westchester gov.com
George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

MEDICAL REFERRAL for EVALUATION (Prescription)

Effective October 1, 2015 all written orders/referrals must contain an ICD10 Code

Based on a review of the child's records, I am referring this child for the following evaluation(s):

Student's Name: _____ DOB: _____

District: _____ School: _____

Type of Evaluation (please check all that apply)			
[ ] Audiological	[ ] Neurological	[ ] Orthopedic	[ ] Psychiatric
[ ] Occupational Therapy	[ ] Physical Therapy	[ ] Other _____	

ICD-10 Code:	
Purpose of Evaluation:	
Frequency and Duration:	

Physician/Physician's Assistant/Nurse Practitioner Information (please print or use stamp):

Name (print):	
Address Line 1:	
Address Line 2:	
Phone Number:	
License or NPI Number:	

_____ _____

Physician/Physician's Assistant/Nurse Practitioner **(must be original signature)** Date

CERTIFICATION OF UNDER THE SUPERVISION AND ACCESSIBILITY FOR PSYCHOLOGICAL COUNSELING SERVICES

School Year: _____

Name (LMSW): _____ License #: _____ NPI #: _____

_____ _____
Signature of Licensed Master Social Worker **Date**

I am providing accessibility to the Licensed Master Social Worker in the following manner:

_____
_____
_____
_____
_____

I will keep the appropriate records documenting that the **"Under the Supervision of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

Print Name of Supervisor: _____ NYS License #:_____ NPI #:_____

_____ _____
Signature of Supervisor/Title **Date**

Contact Information:

_____
_____

Child: _____ Date of Birth: _____

Psychological Counseling "Under the Supervision of" LOG

Child Name: _____ Agency: _____

School Year: _____ Psychological Counseling Services Mandated: _____

Assigned LMSW: _____ License #: _____ NPI #: _____

Supervisor Name/Title: _____ License #: _____ NPI #: _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and LMSW).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SUPERVISOR SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH "under the direction of ". The Supervisor MUST have on file the manner in which he/she has provided supervision to the LMSW for each and every child being serviced.

The Supervisor must provide at least two hours per month of in person individual or group clinical supervision

“Under the Direction of” Forms and Logs

CERTIFICATION OF
UNDER THE DIRECTION AND ACCESSIBILITY
FOR SPEECH THERAPY SERVICES

School Year: _____

Name (TSHH/TSSLD): _____ Certification Number: _____
(Please circle one)

_____ _____
Signature of Certified TSHH or TSSLD **Date**

I am providing accessibility to the Teachers of the Speech and Hearing Handicapped in the following manner:

_____
_____
_____
_____
_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student,** etc.). I verify that I am providing "Under the Direction of" services to the above named TSHH/TSSLD.

Print Name of SLP: _____ NYS License #:_____ NPI #:_____

_____ _____
Signature of Licensed / ASHA Speech/Language Pathologist **Date**

Contact Information:

_____
_____

Child: _____ Date of Birth: _____

SPEECH "Under the Direction of" LOG

Child Name: _____ Agency: _____

School Year: _____ Speech Services Mandated: _____

Assigned TSHH/TSSLD: _____ Certification #: _____

Supervising SLP: _____ License #: _____ NPI #: _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and TSHH/TSSLD).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SLP SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising SLP **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH/TSSLD "under the direction of ". The SLP must have on file the manner in which he/she has provided supervision to the TSHH/TSSLD for each and every child being serviced.

CERTIFICATION OF UNDER THE DIRECTION AND ACCESSIBILITY FOR OCCUPATIONAL AND PHYSICAL THERAPY

School Year: _____

Name (OTA/PTA): _____ License #: _____ NPI #: _____
(Please circle one)

_____ _____
Signature of Certified OTA/PTA **Date**

I am providing under the direction of and accessibility in the following manner:

- Participate in the development of the child's IEP program, signing and dating the treatment plan
- Monitor the mandated delivery of OT services;
- Be readily available to the OTA/PTA for assistance and consultation, through phone, email or fax;
- Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA with each student in the provision of services;
- Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA through regular monthly meetings and make recommendations, as appropriate; and
- Review service sheets used for Medicaid billing.

I will keep the appropriate records documenting that supervision activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)

Print Name of OT/PT: _____ NYS License #:_____ NPI #:_____

_____ _____
Signature of Licensed Occupational/Physical Therapist **Date**

Contact Information:

_____

_____

Child: _____ Date of Birth: _____

OCCUPATIONAL / PHYSICAL THERAPY "Under the Direction of" LOG

CHILD NAME _____ SCHOOL YEAR _____

AGENCY_____ OT / PT SERVICES MANDATED _____

ASSIGNED OTA / PTA _____ LICENSE # _____ NPI # _____

SUPERVISING OT / PT _____ LICENSE # _____ NPI # _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA / PTA).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	OT / PT SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising OT / PT MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an OTA / PTA.

The PT must have on file the manner in which he/she has provided supervision to the PTA for each and every child being serviced. (One PT cannot supervise more than four (4) PTA, per Article 136, section 3738 a.)

The OT must have on file the manner in which he/she has provided supervision to the OTA for each and every child being serviced. The supervision must be direct supervision.

CERTIFICATION OF UNDER THE DIRECTION AND ACCESSIBILITY FOR SKILLED NURSING SERVICES

School Year: _____

Name (LPN): _____ License #: _____ NPI #: _____

_____ _____
Signature of Licensed Practical Nurse **Date**

I am providing accessibility to the Licensed Practical Nurse in the following manner:

_____
_____
_____
_____
_____

I will keep the appropriate records documenting that the **"Under the Supervision of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

Print Name of Supervisor: _____ NYS License #:_____ NPI #:_____

_____ _____
Signature of Supervisor/Title **Date**

Contact Information:

_____
_____

Child: _____ Date of Birth: _____

Skilled Nursing Services "Under the Direction of" LOG

Child Name: _____ Agency: _____

School Year: _____ Skilled Nursing Services Mandated: _____

Assigned LPN: _____ License #: _____ NPI #: _____

Supervisor Name/Title: _____ License #: _____ NPI #: _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and LPN).

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SUPERVISOR SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an LPN "under the direction of ". The Supervisor MUST have on file the manner in which he/she has provided supervision to the LPN for each and every child being serviced.