Suffolk County Early Intervention Confirmation of Delivery of Services

Service Month _____

Child's Name	**DOB**	**Type of Service**	**Frequency & Duration**
Agency Name **All About Kids**	**NPI #** **1669513404**	**Authorization Number (Must use one authorization # per sheet only)**	
Name of Individual Service Provider	**Profession**	**License**	**NPI**

Date of service	Start time	End time	Session Code: P, CA, TA, MU, COVST	Parent/Guardian Signature/Verifying Witness Signature

Service Codes: P-Service Provided, CA-Child Absent, TA-Teacher Absent, MU-Makeup, COVST- Co-Visit Adopted from SCPS*

I certify that on the dates above, the above named child received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process.

Therapist Signature _____ **Date**: _____