

**Putnam County Department of Health
Preschool Special Education Program**

C2 - FORM
(Related Services Claim Form)

Month & Year of Service: _____

IEP Period: From _____ to _____ Type of Service: _____

AGENCY NAME: _____ Type of License/Certification: _____

Therapist Name: _____ License#/Certification#: _____

Child Name: _____ DOB: _____

IEP Service Schedule: _____ Group or Individual Group Size: _____
(frequency/duration/method) (Circle)

Name & Address of Service Delivery Site:												
Service Dates	Start Time	End Time	Attend. Code*	Caregiver Initials	Amount Billed		Service Dates	Start Time	End Time	Attend Code*	Caregiver Initials	Amount Billed
1.							18.					
2.							19.					
3.							20.					
4.							21..					
5.							22.					
6.							23.					
7.							24.					
8.							25.					
9.							26.					
10.							27.					
11.							28.					
12.							29.					
13.							30.					
14.							31.					
15.							# _____ X _____ = _____ (sessions) (rate) Grand Total Claimed					
16.												
17.												
Attendance Codes		SS = Scheduled Intervention Specify duration (30 min, 45 min, etc.) Example: SS/30		FC = Session Cancelled by Family Coord = Coordination		TC = Session Cancelled by Therapist M = Makeup						

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

Parent/Caregiver Signature: _____ Date: _____

(*Written authorization from parent/guardian is required for Childcare Provider, etc. to review and sign)

I _____ do hereby attest that I am a NYS Licensed/Certified: _____

Signature of Therapist**

**Title

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

NPI#: _____

Speech-Language Pathologists providing service MUST include their TSSLD certification Information. TSHH must indicate Special Education Teacher designation. Both TSSLD and TSHH must have documentation on file with their agency.

_____(therapist/agency initials) A copy of the daily notes or the monthly/quarterly or (other time frame designated on IEP) progress notes have been submitted to the appropriate school district.

If the service was provided by a TSHH, COTA or PTA, LPN, LMSW, the therapist providing "under the direction /or supervision of" MUST sign the following: I have provided the "under the direction of," SED required supervision for the therapist signing above.

Print Name

Signature of Licensed/Registered Therapist

License#/Certification#/Designation

NPI#