Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: ______________________________________ Date of Birth (mm/dd/yy): ______________________________

Diagnostic Code: ____

Provider Information

Provider Name: ___________________________________ Provider Title: ____

Supervisory Union Name: ___________________________ Name of School: ______________________________________

IEP Service:

List the activity being provided as it appears on the IEP.

IEP Activity

X Equals	
Minutes	Group Size

Service Dates: Mark an "X" for each session that the above service was provided OR enter the minutes provided and group size directly in the calendar. For group services, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.

DO NOT USE PENCIL OR WHITE OUT.

Month ___________________ Year _____________

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**				

Month ___________________ Year _____________

Use this set of dates for two-month billing period

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**				

Total 1:1 Hours	
Total Small Group Hours	

By signing below, I verify services were provided as documented in the above calendar. I understand that this is a legal document and services documented on the above calendar will be billed to Vermont Medicaid for federal reimbursement.

Provider Signature: _______________________________________ **Date:** _________________________________

Supervisor Signature: ______________________________________ **Date:** _________________________________

Supervisor Name (Printed): _________________________________