



**Schenectady County
Public Health Services**

**Schenectady County Children with Special Needs Program
CPSE Evaluation Report**

Please submit one completed form for EACH CHILD

NAME OF CHILD: _____

DOB: _____

SED APPROVED EVALUATOR: _____

AUTHORIZING SCHOOL DISTRICT: _____

DATE REVIEWED BY CPSE: _____

ICD-10 Code: _____

DATE OF EVAL	EVALUATION COMPONENTS <i>(please check appropriate box(es))</i>	RATE
___ / ___ / ___	<input type="checkbox"/> PHYSICAL/MEDICAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> SOCIAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> PSYCHOLOGICAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> AUDIOLOGICAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> EDUCATION	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> NEUROLOGICAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> NEUROPSYCHOLOGICAL	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> OCCUPATIONAL THERAPY	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> OPTOMETRIC (VISUAL)	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> ORTHOPEDIC	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> OTOLARYNGOLOGY	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> PHYSICAL THERAPY	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> PSYCHIATRIC	<input type="text"/>
___ / ___ / ___	<input type="checkbox"/> SPEECH/LANGUAGE	<input type="text"/>
	CLAIM TOTAL	<input type="text"/>

Comments: _____

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.

Authorized Agency Signature: _____

Date: _____