**Schenectady County**
**Children with Special Needs Program**

**Schenectady County**
**Public Health Services**

**CPSE Related Services**
**Parent/Caregiver Signature Log**

| Child's Name: | | Agency/Provider Name: | |
|---|---|---|---|
| **DOB:**<br><br>**Month/Year:**<br><br>**ICD - 10 Code(s):** | **Make-Up Visits** | **Discipline:** | |
| | | | INDICATE EACH DAY OF SERVICE IN THE BOX USING ACCURATE CALENDAR FORMAT: |

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|
| I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature |
| I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature |
| I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature |
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| I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature | I or G<br>Start Time: _____<br>End Time: _____<br>Parent/Caregiver Signature |

*I/We 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 with credentials:**

7.23

**Program Director Signature:**