



Child's Name:	
DOB:	
Month / Year:	

Agency:	
Visit Type:	D = # of Direct 1/2 hours each day I = # of Indirect 1/2 hours each day

A = Absent on scheduled day
Please indicate an "A" within the daily box

INDICATE EACH DAY OF SERVICE IN THE BOX USING ACCURATE CALENDAR FORMAT

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I
Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____	
End Time: _____		End Time: _____		End Time: _____		End Time: _____		End Time: _____	
Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature	
Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I
Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____	
End Time: _____		End Time: _____		End Time: _____		End Time: _____		End Time: _____	
Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature	
Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I
Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____	
End Time: _____		End Time: _____		End Time: _____		End Time: _____		End Time: _____	
Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature	
Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I
Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____	
End Time: _____		End Time: _____		End Time: _____		End Time: _____		End Time: _____	
Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature	
Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I	Method: I or G	D I
Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____		Start Time: _____	
End Time: _____		End Time: _____		End Time: _____		End Time: _____		End Time: _____	
Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		Parent/Caregiver Signature		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.

SEIS Teacher Signature:
Program Director Signature:

Make up Visits:

_____ x _____ = Total
Units Delivered x Rate = Total