Schenectady County
Public Health Services

Delivery of Services:
Aide – 1:1 Related Services
Voucher Verification

REMINDER: one ½ HOUR = 1 UNIT

_____

Service Month and Year

Child's Name:	School District:		
Location:			
Date of Service	**Start Time**	**End Time**	**Number of Units**
TOTAL ½ HOUR UNITS:			

_____ X _____ = _____

(total number of units) (rate) (Reimbursement Total)

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.

1:1 Aide Signature _____ **Date:** _____

Director Signature _____ **Date:** _____