Schenectady County Children with Special Needs Program
CPSE Evaluation Report
Please submit one completed form for EACH CHILD

Schenectady County Public Health Services

NAME OF CHILD: _____ DOB: _____

SED APPROVED EVALUATOR: _____

AUTHORIZING SCHOOL DISTRICT: _____

DATE REVIEWED BY CPSE: _____ ICD-10 Code: _____

DATE OF EVAL	EVALUATION COMPONENTS *(please check appropriate box(es)*	RATE
____ / ____ / ____	☐ PHYSICAL/MEDICAL	
____ / ____ / ____	☐ SOCIAL	
____ / ____ / ____	☐ PSYCHOLOGICAL	
____ / ____ / ____	☐ AUDIOLOGICAL	
____ / ____ / ____	☐ EDUCATION	
____ / ____ / ____	☐ NEUROLOGICAL	
____ / ____ / ____	☐ NEUROPSYCHOLOGICAL	
____ / ____ / ____	☐ OCCUPATIONAL THERAPY	
____ / ____ / ____	☐ OPTOMETRIC (VISUAL)	
____ / ____ / ____	☐ ORTHOPEDIC	
____ / ____ / ____	☐ OTOLARYNGOLOGY	
____ / ____ / ____	☐ PHYSICAL THERAPY	
____ / ____ / ____	☐ PSYCHIATRIC	
____ / ____ / ____	☐ SPEECH/LANGUAGE	
	CLAIM TOTAL	

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: _____