## Schenectady County Children with Special Needs Program

STICTADY CO.	Schenectady County Public Health Services
	<b>Public Health Services</b>

	ASM LORE	•	u.
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

			INDICAT	TE EAC	H DA	Y OF SERVICE IN THE BOX USING	ACCUR/	ATE	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	I	Method: I or G	D	I	Method: I or G D	I
Start Time:			Start Time:			Start Time:		8	Start Time:			Start Time:	
End Time:			End Time:			End Time:		E	End Time:			End Time:	
Parent/Caregiver Signature			Parent/Caregiver Signature			Parent/Caregiver Signature		F	Parent/Caregiver Signature			Parent/Caregiver Signature	
Method: I or G	D	ı	Method: I or G	D	ı	Method: I or G	D I	ı	Method: I or G	D	ı	Method: I or G D	ı
Start Time:			Start Time:			Start Time:		9	Start Time:			Start Time:	
End Time:			End Time:			End Time:			End Time:			End Time:	
Parent/Caregiver Signature			Parent/Caregiver Signature			Parent/Caregiver Signature		F	Parent/Caregiver Signature			Parent/Caregiver Signature	
Method: I or G	D	ı	Method: I or G	D	ı	Method: I or G	D I	ı	Method: I or G	D	ı	Method: I or G D	ı
Start Time:			Start Time:			Start Time:		5	Start Time:			Start Time:	
End Time:			End Time:			End Time:			End Time:			End Time:	
Parent/Caregiver Signature Parent/Caregiver Signature					Parent/Caregiver Signature		F	Parent/Caregiver Signature			Parent/Caregiver Signature		
Method: I or G	D	I	Method: I or G	D	I	Method: I or G	D I	ı	Method: I or G	D	ı	Method: I or G D	ı
Start Time:			Start Time:			Start Time:		5	Start Time:			Start Time:	
End Time:			End Time:			End Time:			End Time:			End Time:	
Parent/Caregiver Signature			Parent/Caregiver Signature			Parent/Caregiver Signature		F	Parent/Caregiver Signature			Parent/Caregiver Signature	
Method: I or G	D	I	Method: I or G	D	I	Method: I or G	D I	ı	Method: I or G	D	ı	Method: I or G D	ı
Start Time:			Start Time:			Start Time:		5	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		F	Parent/Caregiver Signature			Parent/Caregiver Signature		
*I/We certify that on the dates ab	ove, th	e abo	ve named child received the service	s noted	and	that documentation exists and is ma	ntained on	n file	•				
verifying the delivery of said serv	ices in	accoi	rdance with all relevant Federal, State	e and Lo	ocal L	aws and Regulations governing the	Medicaid p	proc	cess.				
SEIS Teacher Signature:				] [		Make up Visits:							
Program Director Signature:				1						-			
									Units Delivered	x	Ra	ate = Total	