Parent/Caregiver –
DO NOT SIGN BLANK LOG NOTES

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

Print legibly/use black ink only
ONE THERAPIST PER LOG

TREATMENT LOG - RELATED SERVICES

Student's Name (Last, First) C DOB:

Agency/Center-Based School/Independent Contractor D

NPI # E

School District F

Location of Service as per IEP: (Use code) O=Office, H=Home, PS=Preschool, D=Daycare, CB=Center, X=Other specify _____G

Print Name of Individual Service Provider/License Number/ASHA #--if applicable H

Type of Service: I

Dates of Service (IEP Dates) J to

Print Name of Individual Supervising Provider/Professional Credentials/License Number/ NPI #/ASHA# --if applicable K

RX or Recommendation Date L

ICD9 Code M

☐ Individual
☐ Group Size Per IEP______
☐integrated R setting

Frequency & Duration as indicated on the IEP - *Individual* Sessions Per week: N Minutes:

Frequency & Duration as indicated on the IEP – *Group* Sessions Per week: O Minutes:

Town of Service P

NCDOH NPI # 1558403824 Q

Frequency & Duration as indicated for this provider -*Individual* Sessions Per Week: S Minutes:

Frequency & Duration as indicated for this provider--*Group* Sessions Per Week: T Minutes:

*** Only NON CB services require a verifying witness signature***

NPI # (Actual Therapist): U

NOTE: All sessions must be signed off by Parent or Authorized Verifying Witness, Provider and UDO/USO Supervisor for TSHH, TSSLD, CFY, COTA, PTA, LPN or Supervisor of LMSW CC

SESSION CODES: P-Service MU – Make Up Session CA – Child Absent TA - Therapist Absent S - CPSE Meeting T - Testing

Date of Session	Start Time	End Time	Session Code
V	W AM PM	X AM PM	Y # in Group ___Z__

Session Notes: Activity related to IEP Goals (Including objectives and measures of success) and response(s) of child BB

CPT Code(s): CC

Student's name: AA

GG

* Signature of Parent or Verifying Witness Date

HH

Provider Signature Professional Credentials Date

II

USO/UDO Supervisor Signature Professional Credentials Date

PROGRESS (CHECK ONE): ☐ Progress ☐ Limited Progress ☐ No Progress

Location Code: DD

Service Type EE

☐ Individual
☐ Group Size Per IEP _FF__

- A Page number
- B Total pages submitted for billing cycle for this student and provider
- C Child's name and date of birth as written on IEP
- D Name of the agency, center-based school or independent contractor who holds the contract for this service as written on the IEP
- E Agency's NPI#
- F Name of the school district as written on the IEP
- G Location where the service is provided as written on the IEP. Use codes provided.
- H The name of the person providing service and his/her license number and ASHA # if applicable (ASHA # for speech language pathologists only). One therapist per log.
- I Type of service (speech, OT, PT, etc.) as written on the IEP
- J Dates of service as written on the IEP
- K Name of person providing supervision [Under the Direction of (UDO) or Under the Supervision of (USO)] for CFY, TSHH, TSSLD, COTA, PTA, LPN, LMSW
- L Date the prescription (Rx) or recommendation was signed. If the service (parent training) does not require a prescription or recommendation, put NA in the box.
- M ICD9 code is required as of 1/1/2012
- N Frequency and duration of the individual service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.

O Frequency and duration of the group service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA.

P The name of the town where the service is provided

Q Nassau County's NPI #. Do not change. This NPI# is for all Nassau County Children receiving related services.

R Check if an individual or group service. If group service, write the # of children in the group as specified on the IEP. In addition, check if child in integrated setting.

S Frequency and duration of the individual service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.

T Frequency and duration of the group service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA.

U NPI # for individual therapist (Speech Language Therapist, OT, PT, LCSW, LMSW, licensed Clinical Psychologist)

V Date of actual session. Must be filled in even if the session is cancelled. In Session Notes, indicate session was cancelled and reason for cancellation.

W,X Fill in start and end times of each session and circle AM or PM

Y,Z Attendance code as listed in the Session Code box on the Treatment Log. Note: a testing code (T) has been added. T should only be used when the entire session is devoted to testing. If the child is receiving group services, indicate the number of children present at the current session in the space provided.

AA Print student's name

BB Session Notes must include description of activities related to IEP Goals, including objectives, measures of success and child's response to activities.

- Use objective language. Avoid using phrases such as "had a good session."
- Be descriptive and focus on the major activities/lessons, include a brief description of student's progress made during each session.
- Describe child's attending behavior, participation and/or responses to lessons/materials presented.
- Do not use "same as above."
- Therapists should follow the calendar specified on the IEP. If no calendar is indicated, please check with the school district for the calendar to be followed. Indicate in the session box, the date span the service is not provided due to the calendar. No signatures are needed if the school is closed.
- If the session is a make-up session, note the date of the original missed session.
- Check one of the boxes indicating child's progress during the session

CC Each session must have appropriate CPT codes that indicate the purpose of the session, whether it was individual or group. Only CPT codes from the approved list from OMIG can be used. If the therapist/agency feels that there is a code that needs to be added to the OMIG list, the desired code and reason for inclusion must be emailed to the Medicaid-in-Education Unit and NYS will make the decision whether or not to add the CPT codes to the list.

DD Fill in a location code for each session. See G.

EE Type of service (speech, OT, PT, etc.) as written on the IEP.

FF Check off whether it is an individual or group service. If the child is receiving group services, write the number of children in the group that were present for the day's session.

GG DOH requires the completion of form PS 1200 Parent/Guardian Consent for Alternate Signature Verification Form listing the names of the Parent and/or Authorized Verifying Witness when services are provided in the home, nursery school, child care site and there may be someone other than the parent signing the Treatment Log. Signature of Parent/Authorized Verifying Witness, *which must be completed at end of session*. Signature must be dated. If session is cancelled, Parent/Authorized Verifying Witness would sign at the next session using the date when signed. Provider must document reason for absence in session note.

HH Signature of provider, professional credentials and date must be completed at end of every session.

II Signature of supervisor is needed when the provider is a TSHH, TSSLD, CFY, COTA, PTA, LPN or LMSW.

Contact and Comments Codes: TC – Telephone Conf CN – Communication Notebook CO – Coordination R – Wkly Recommendations/Interventions for Classroom Teacher/Caregiver O – Other		
Date	Codes	Notes
MM		

Student's Name (Last, First): ________JJ____________ Page _KK__ of __LL_

I certify all information entered on this Treatment Log is correct (Provider Sig.) ________NN____________ Date_____/_____/_____

Treatment Log Reviewed by ________OO____________ Date___ _____/_____/_____

Print Reviewer's Name: ________PP____________ PS 1100 RS Treatment Log revised 08/09/2011

JJ Child's name as written on the IEP

KK Page number

LL Total pages submitted for billing cycle for this student and provider

MM Contacts and Comments section must be completed to document communications with parents and other service providers including classroom teachers if applicable. Each entry which must be dated and coded using the Contact and Comment Codes listed, requires a comment/note at a minimum of one per week.

NN Provider's signature and date,

OO Treatment Log must be reviewed, signed and dated by a person designated by the service provider, school or agency to include but not limited to:

- Supervisor or person directly responsible for the provider
- Quality Assurance Officer
- Compliance Officer
- CEO or COO
- Agency designee

This person is responsible for reviewing the completeness, accuracy and quality of the submitted Treatment Log. *Not applicable to independent contractors who have a separate contract with Nassau County.*

PP Print name of person reviewing Treatment Log.