State of Connecticut Medicaid School Based Child Health Quarterly Service Information: Part 2

Note: A copy of this form must be filed in the student's permanent service record. Additional pages should be used when necessary. Electronic records used through billing vendor software may be used as a substitute for this form.

1. Service for Month/Year: ___________/_____________

2. Name of student receiving services: ____
   Last Name First Name MI

3. Student Date of Birth: ____/______/_______

4. Select the service provided to the student:

   ☐ Counseling ☐Nursing ☐Occupational Therapy ☐Physical Therapy

   ☐Speech/Language ☐ Other: ________________________________

5. Select the setting the service was provided in:
   ☐ Individual ☐ Group ☐ Other: ______________________________________

6. List the IEP/504 Goals Addressed for this student:
   a. ____
   b. ____
   c. ____
   d. ____
   e. ____

7. List the activities performed in addressing the above goals (what kind of treatment did the student receive):
   a. ____
   b. ____
   c. ____
   d. ____
   e. ____

8. List the progress for the goals listed above (what was observed during treatment, what was the outcome):
   a. ____
   b. ____
   c. ____
   d. ____
   e. ____

9. List any other relevant information you wish to include pertaining to the goals, activities, and progress reported above:

   ____
   ____
   ____

________________________________ ________________________________ ___/_____/___
Service Provider Signature Printed Name of Service Provider Date

*Services provided by a speech language assistant must be signed by a supervising, licensed SLP.

V3, 5/23/22