HEALTH DEPARTMENT
essex county
Children's Services Unit

CENTER BASED ATTENDANCE AND THERAPY REPORT
CPSE SERVICES ONLY

AGENCY ______ CHILD'S NAME (Last, First) ______ Date of Birth ______ Month/Year ______

ICD - 9 Code ______

USE ONLY THE LETTERS PROVIDED IN THIS KEY

G = RELATED SERVICE DELIVERED IN GROUP
I = RELATED SERVICE DELIVERED 1:1
P = PRESENT AT CB PROGRAM/THERAPIES
A = AUTHORIZED ABSENCE FROM CB PROGRAM/THERAPIES
U = UNAUTHORIZED ABSENCE FROM CB PROGRAM/THERAPIES
S = STAFF/CONFERENCE DAY
W = WEATHER CLOSING

SERVICES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	# days of attendance
PROGRAM ATTENDANCE																																
SPEECH THERAPY																																
OCCUPATIONAL THERAPY																																
PHYSICAL THERAPY																																
SOCIAL WORK/PSYCHOLOGICAL																																
1:1 AIDE																																
OTHER RELATED SERVICE - SPECIFY																																

Signatures (with credentials) needed for all Center Based services:

Special Educ. Teacher ______ Occupational Therapist ______ Physical Therapist ______ Psych/CSW ______ 1:1 aide ______

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.

SPEECH:

☐ ______ SLP

☐ ______ TSHH/CFY

☐ ______ date of first co-vist with SLP (if required)

______ PROGRAM DIRECTOR

$ ______
CLAIM TOTAL

9.10