HEALTH DEPARTMENT
Children's Services Unit

INSTRUCTIONS FOR COMPLETING
ESSEX COUNTY CENTER BASED ATTENDANCE AND THERAPY REPORT

Submit one per child per month listing all services for a single program. All forms submitted must contain all ***original signatures*** and ***no copies are required.***

1. **AGENCY:** Please complete with full name.

2. **CHILD'S NAME:** Complete with the child's full name (last name, first).

3. **DOB:** Complete with the child's date of birth (month, date, year).

4. **MONTH /YEAR:** The month and year the services are delivered.

5. **ICD- 10 CODE:** Place the diagnostic code for conditions or reasons for which care is provided.

6. **PROGRAM ATTENDANCE:** Place a "P" for days the child is physically present at program, "A" for days the child is scheduled for but is legally absent from program, "U" for days the child is absent from program for reasons other than legal excuses, "S" for staff/conference day, or "W" for weather related closings.

7. **SERVICES:** Place either "I" for individual service or "G" for group service, on the line corresponding to the type of service provided, under the day of the month the service was provided. Use the "other" lines to specify services not listed on the form. DO NOT list services scheduled but not provided.

8. **NUMBER DAYS OF ATTENDANCE:** Place the number of days the child was physically present at the program.

9. **CLAIM TOTAL:** The total amount is the number of weeks times the weekly rate. Place this amount on the Voucher Verification Form.

10. **SIGNATURES:**

    - **THERAPIST :** The treating therapist must sign the 'Signature' line, and complete with their full name. All providers must sign their credentials immediately after their signature. ANY therapists that require supervision (eg. COTA, PTA) per NYSED, the supervisor must sign below the therapist's signature. The form must be submitted with original signatures, photocopies are not acceptable.

    - **PROGRAM DIRECTOR:** The program director must certify the form on the program director's signature line, using your full name. The form must be submitted with original signature, photocopies are not acceptable.

    - **OT, PT & SPEECH:** The CB ATR now has a special section for the provider. If services were provided by "under the direction of" then **BOTH** the Providers must sign the form in the area provided, and include the date of the first co-visit. **This date should be completed on all subsequent Center Based Attendance and Therapy Reports.** Remember, all signatures must include credentials.