HEALTH DEPARTMENT
Children's Services Unit

MEDICAID

MEDICAL ASSISTANCE CLAIMS FOR RELATED SERVICES

CERTIFICATION
OF
OCCUPATIONAL AND PHYSICAL THERAPY
UNDER THE DIRECTION AND ACCESSIBILITY

School District/Agency _____

I, _____, licensed ☐ Occupational Therapist or ☐ Physical Therapist with current license number _____ certify that I am providing direction to the following Occupational Therapy Assistant or Physical Therapy Assistant for the _____ - _____ school year:

Child's Name: _____ DOB: _____

Name of OTA/PTA	License #

I am providing under the direction and accessibility in the following manner:

- Participate in the development of the child's IEP program, signing and dating the treatment plan
- Monitor the mandated delivery of OT services;
- Be readily available to the OTA/PTA for assistance and consultation, thru phone, email or fax;
- Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA with each student in the provision of services;
- Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA thru regular monthly meetings and make recommendations, as appropriate; and
- Review service sheets used for Medicaid billing.

I will keep the appropriate records documenting that "under the direction of "activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)

_____ _____

Signature of Licensed Occupational/Physical Therapist **Date**

OCCUPATIONAL / PHYSICAL THERAPY "UNDER THE DIRECTION OF" LOG

CHILD NAME _____ SCHOOL YEAR _____

AGENCY_____ OT/PT SERVICES MANDATED _____

ASSIGNED OTA/PTA _____ LICENSE # _____

SUPERVISING OT/PT _____ LICENSE # _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA/PTA)

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	OT/PT SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising OT/PT MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an OTA/PTA.

The **PT** must have on file the manner in which he/she has provided direction to the PTA for each and every child being serviced. (One PT can not supervise more than four (4) PTA, per Article 136, section 3738 a.)

The **OT** must have on file the manner in which he/she has provided "under the direction of" to the OTA for each and every child being serviced. The supervision must be direct supervision.

Instructions for Psychological Counseling and Psychological Counseling requiring "Under the Supervision of"

Psychological Counseling Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services in the community.

A. Services may be provided by:

- NYS licensed and registered **Psychiatrist**
- NYS licensed and registered **Psychologist**
- NYS licensed **Clinical Social Worker – LCSW**
- NYS licensed **Master Social Worker – LMSW** – "Under the Supervision of" a NYS Licensed **Psychiatrist**, **Psychologist** or **LCSW**

Psychological Counseling requiring "Under the Supervision of"

A. The LMSW apprises the **Supervisor** of the diagnosis and treatment for each child. The cases are discussed and supervisor provides oversight and guidance in diagnosing and treating child. The **Supervisor** regularly reviews and evaluates the professional work of the **LMSW.**

B. **The Supervisor** provides at least one hour per week or two hours every other week of in person individual or group clinical supervision provided that at least two hours per month shall be individual clinical supervision.

C. **The Supervisor** must complete a Certification of Supervision for each LMSW being supervised. An "Under the Supervision of" (USO) log must be used to record direct supervision of LMSW. Note that it is child specific and must be prepared for each child. Keep all written documentation of such supervision, including Certification and USO Log. (See Psychological Counseling "Under the Supervision of" section for detailed instructions.)

CERTIFICATION

OF
PSYCHOLOGICAL COUNSELING

UNDER THE SUPERVISION AND ACCESSIBILITY

I, _____, **Psychiatrist**, **Psychologist** or **LCSW**, with current license number _____ certify that I am providing "Under the Supervision of" services to the following Licensed Master Social Worker (LMSW) for the _____ - _____ school year:

Child's Name: _____ DOB: _____

Name of LMSW	License Number

I am providing accessibility to the Licensed Master Social Worker in the following manner:

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Supervision of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

_____ _____

Signature of Supervisor and Title **Date**

Psychological Counseling "Under the Supervision of" LOG

CHILD NAME _____ SCHOOL YEAR _____

PSYCHOLOGICAL COUNSELING MANDATED _____

ASSIGNED LMSW _____ LICENSE # _____

SUPERVISOR _____ TITLE & LICENSE # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SUPERVISOR SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a LMSW "under the supervision of ". The Supervisor MUST have on file the manner in which he/she has provided supervision to the LMSW for each and every child being serviced.

CERTIFICATION
OF
SKILLED NURSING SERVICES

UNDER THE DIRECTION AND ACCESSIBILITY

I, _____, **Licensed Registered Nurse (RN)**, with current license number _____ certify that I am providing "Under the Direction of" services to the following Licensed Practical Nurse (LPN) for the _____ - _____ school year:

Child's Name: _____ DOB: _____

Name of LPN	License Number

I am providing accessibility to the Licensed Practical Nurse in the following manner:

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

_____ _____

Signature of Supervisor and Title **Date**

Skilled Nursing Services "Under the Direction of" LOG

CHILD NAME _____ SCHOOL YEAR _____

SKILLED NURSING SERVICES MANDATED _____

ASSIGNED LPN _____ LICENSE # _____

SUPERVISOR _____ TITLE & LICENSE # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SUPERVISOR SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an LPN "under the direction of ". The Supervisor MUST have on file the manner in which he/she has provided supervision to the LPN for each and every child being serviced.

CERTIFICATION
OF SPEECH

UNDER THE DIRECTION AND ACCESSIBILITY

I, _____, CCC-SLP, Licensed Speech-Language Pathologist, with current license number _____ and ASHA Certification # _____ certify that I am providing "Under the Direction of" services to the following Certified Teachers of the Speech and Hearing Handicapped (Therapist) for the _____ - _____ school year:

Child's Name: _____ DOB: _____

Name of TSHH	Certification Number

I am providing accessibility to the Teachers of the Speech and Hearing Handicapped in the following manner:

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student** etc.)

_____ _____

Signature of Licensed/ASHA Speech/Language Pathologist **Date**

SPEECH "Under the Direction of" LOG

CHILD NAME _____ SCHOOL YEAR _____

SPEECH SERVICES MANDATED _____

ASSIGNED TSHH _____ CERTIFICATION # _____

SUPERVISING SLP _____ LICENSE # _____ASHA#_____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Services / Evaluation Recommended	SLP SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QTR REVIEW				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QTR REVIEW				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QTR REVIEW				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QTR REVIEW				
Meeting				
Meeting				
Meeting				

NOTE: The supervising SLP MUST provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH "under the direction of ". The SLP must have on file the manner in which he/she has provided supervision to the TSHH for each and every child being serviced

INSERT PROVIDER NAME
ADDRESS
ADDRESS
PHONE #

Speech Referral / Recommendation for Evaluation / Services

A Speech and Language referral for an ☐ **evaluation** and / or ☐ **services** is recommended in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: _____Date of Birth: _____

School District: _____IEP Dates: _____
mm/dd/yyyy – mm/dd/yyyy

Frequency & Duration of Services: _____ (Circle one) Individual / Group

DIAGNOSIS / ICD10 Code: _____

Purpose of Treatment or Evaluation (CPT Code): _____

_____ _____
(Please Print SLP Name) **Signature**
(must be a NYS Licensed Speech Pathologist/ASHA Certified)

LICENSE NUMBER: _____ **DATE SIGNED: _____**

ASHA CERTIFICATION # _____ EXPIRES_____ NPI #: _____

Note: Medicaid requires that speech evaluations and services be recommended by a **Licensed Speech Pathologist**, Physician, Physician's Assistant or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

INSERT PROVIDER/AGENCY LETTERHEAD

SCHOOL YEAR _____

Dear Parents/Guardians,

In order for _____INSERT AGENCY/Provider_____ to provide related services to your child, including nursing, occupational, physical and/or speech therapy, NY State laws require us to collect a current prescription for the school year of _____for each related service that your district has approved for your child. As per NYS Preschool Supportive Health Services Program, all scripts must contain the information stated below. We apologize to those parents who have already secured prescriptions prior to this regulation, but the prescription without the information is not valid.

It is required that you obtain a prescription that includes the following information:

- √ Your child's name clearly written
- √ *School year* _____
- √ Service to be provided (OT, PT, or ST) ***submit a separate Rx to acknowledge each service***
- √ ICD10 code / Diagnosis
- √ Original signature of the doctor required – **Stamped signature will NOT be accepted**
- √ License number or NPI#
- √ **YOU DO NOT NEED – "per IEP" or frequency and duration on prescription**

For your convenience, we have enclosed a form that your doctor may wish to use to authorize your child's school based related services.

Mail your prescription to:

Agency Address

PRESCRIPTION FOR PRESCHOOL BASED RELATED SERVICES

(A SEPARATE PRESCRIPTION IS REQUIRED FOR EACH SERVICE)

Student's Name: _____DOB: _____

District: _____School: _____

The child named above has been recommended for the following service by his/her school district:

Service/Therapy (Please check one)	Frequency & Duration Example: 2 days/week x 60 minutes	IEP Dates mm/dd/yyyy – mm/dd/yyyy
☐ OT ☐ PT ☐ ST ☐ *NU		

* In addition to the prescription a specific Dr.'s order with detailed instructions is required.

ICD10 Code/Diagnosis/Purpose of Treatment	

Physician/Physician's Assistant/Nurse Practitioner Information (please print or use stamp):

Name:	
Address:	
Phone Number:	
License Number / NPI #:	

_____

Physician/Physician's Assistant/Nurse Practitioner (**Must be original signature**)

Date

ESSEX COUNTY
DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
132 Water St. PO Box 217, Elizabethtown NY, 12932-0217

MEDICAL REFERRAL (Prescription)

Based on a review of the child's records, I am referring this child for the following evaluation(s):

Student's Name: _____ DOB: _____

District: _____ School: _____

Type Of Evaluation (Please check all that apply)			
☐ Audiological	☐ Neurological	☐ Orthopedic	☐ Psychiatric
☐ Occupational Therapy	☐ Physical Therapy	☐ Other _____	

ICD10 code/Diagnosis/Purpose of Evaluation	

Physician/Physician's Assistant/Nurse Practitioner Information (please print or use stamp):

Name:	
Address:	
Phone Number:	
License Number / NPI #:	

_____ _____
Signature of Physician/Physician's Assistant/Nurse Practitioner Date
(**Must be original signature**)

HEALTH DEPARTMENT
Children's Services Unit

DIRECTOR OF PUBLIC HEALTH- Linda Beers, MPH
CHILDREN'S SERVICES COORDINATOR-Lucianna Celotti, BA

Dear Parent/ Guardian of _____:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

This consent allows the Municipality to bill for covered health-related services and to release information to the Municipality's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____,
(Print child's name)
have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the Municipality to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)
IEP
Written Order / Referral
Evaluation Reports
Session Notes
Immunization and current Physical (Within one year)
Special Transportation Log
Other Personally Identifiable information
Any other specific records pertaining to the child's services or program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Name and Signature:

_____

Signature

_____

Print Name

_____

Date

Does your child have Medicaid: YES or NO (circle one)

If Yes please indicate CIN:_____