LEA Medicaid Billing – Weekly Progress Notes – Behavior Services

Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_ICD-10 Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School district: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Building: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Teacher Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials: \_\_\_\_

**Progress notes/weekly summary to include**: General observation of the child’s condition; child’s activity and participation in treatment; activities of staff; future plans for working with the child. Attach additional progress monitoring data as appropriate.

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| **Week 1 - From date: \_\_\_\_\_\_\_\_ To date: \_\_\_\_\_\_\_\_\_**  **Printed Name of person completing summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature/title of person completing summary­­­­­­­­­­­­­­­­­­­­­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Week 2 - From date: \_\_\_\_\_\_\_\_ To date: \_\_\_\_\_\_\_\_\_**  **Printed Name of person completing summary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature/title of person completing summary­­­­­­­­­­­­­­­­­­­­­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Week 3 - From date: \_\_\_\_\_\_\_\_ To date: \_\_\_\_\_\_\_\_\_**  **Printed Name of person completing summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature/title of person completing summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Week 4 - From date: \_\_\_\_\_\_\_\_ To date: \_\_\_\_\_\_\_\_\_\_**    **Printed Name of person completing summary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature/title of person completing summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

I attest that the documented services/interventions provided by the LEA staff members are consistent with this student’s Behavior Intervention Plan (BIP) or specific goal(s) as described in the student’s Individualized Education Plan (IEP). This does not imply my supervision of the LEA staff members, nor have I necessarily observed these services. My signature verifies that documented services/interventions on this form are aligned with the student’s BIP or IEP. **Printed Name of MHP Mental health professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MHP Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Circle Title** BOEE: School Psychologist/School Social Worker IDPH:LISW/LMFT/LMHC/LMSW/Psychologist **Date**\_\_\_\_\_\_\_\_\_\_\_ (2-22-2022)