HART SCHOOLS HEALTH SERVICE LOG

Student Name: DOB: Medicaid ID#: School:

Provider Name:

Provider Name:

Date Mo/Day/Yr	Time In Out	Billable Minutes	Procedure Code	Progress Notes (Short Description)	Initials Prov/Supv
			☐ Evaluation ☐ Individual	☐ Bowel Care/Cleaning ☐ Feeding via G tube ☐ Feeding- assist ☐ Monitoring health status ☐ Giving medication ☐ Seizure precautions ☐ Transport/positioning ☐ Other:_______________ ☐ Tolerated well ☐Concerns:	
			☐ Evaluation ☐ Individual	☐ Bowel Care/Cleaning ☐ Feeding via G tube ☐ Feeding- assist ☐ Monitoring health status ☐ Giving medication ☐ Seizure precautions ☐ Transport/positioning ☐ Other:_______________ ☐ Tolerated well ☐Concerns:	
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This is to certify that services billed to Medicaid are included in the IEP or Conference Summary and do not exceed units of services specified in the IEP.

Service Provider:_______________________________________ Title:___________________________(Health Aide) Date:________________

Supervising Provider:____________________________________ Title:___________________________(RN / LPN) Date:________________