Schenectady County
Children with Special Needs Program

Schenectady County
Public Health Services

CPSE Related Services
Parent/Caregiver Signature Log

Child's Name:	**Agency/Provider Name:**
DOB: **Month/Year:** **ICD - 10 Code(s):**	**Make-Up Visits**
	Discipline:
	INDICATE EACH DAY OF SERVICE IN THE BOX USING ACCURATE CALENDAR FORMAT:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
I or G Start Time: ___________ End Time: ___________ Parent/Caregiver Signature	I or G Start Time: ___________ End Time: ___________ Parent/Caregiver Signature	I or G Start Time: ___________ End Time: ___________ Parent/Caregiver Signature	I or G Start Time: ___________ End Time: ___________ Parent/Caregiver Signature	I or G Start Time: ___________ End Time: ___________ Parent/Caregiver Signature
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*I/We 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.

Therapist Signature with credentials:

Schenectady County
Public Health Services

Program Director Signature: