**Early Intervention Weekly Confirmation of Services- Service Delivery Log LIEIP**

**Instructions:** This form must be completed by the teacher/therapist to ensure delivery of Early Intervention Services. All fields are required to be filled out; providers may add more fields if needed. The parent/caregiver documents that the service was received by the child on the date and time recorded must be completed ***after each session*** (i.e. In-Person and/or Telehealth). (10 NYCRR 69-4.26(c)). All fields are required. Each field must be completed and must match the appropriate fields on accompanying session notes. Typed signatures are not acceptable. Please ask caregiver to sign in **wet ink**. Session notes & Service Logs must be maintained by interventionists and collected by service provider agencies to support billing. Session notes and service logs must be furnished and kept in the child’s file for program monitoring, fiscal audits, and due process proceedings.

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| --- | --- | --- |
| **Child’s Name:** | **DOB:** | **Child’s EI#:** |
| **Service Type (One SA # Per Sheet): \_\_ST\_\_OT\_\_PT\_\_ABA\_\_SI** **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Service Authorization (one per page)#:**  |
| **Teacher/Therapist’s Name:** | **Discipline: \_ST\_\_OT\_\_PT\_\_ABA\_\_SI\_\_Other:\_\_\_\_** | **NPI#:** |
| **Provider Agency Name: Important Steps, Inc. County:**  | **Frequency: IFSP Mandate: \_\_30\_\_60** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of****Service** | **Start Time** | **End Time** | **CPT Code** | **Signature of Parent/Caregiver Verifying that the Service was Delivered on the Date and time Indicated** | **In-Person (I)****or****Tele (T)** | **Date Signed** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |
|  **/ /2024** |  am/pm |  am/pm | 1) \_\_\_\_\_\_x\_\_\_2) \_\_\_\_\_\_x\_\_\_ |  | I / T |  **/ /2024** |

 \*\****\*Please attach a Session Note for each line. Please circle Method (In-Person or Tele). Check if Dates of Service, SA#, Time & CPT Codes Match\*\*\****