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| Student’s Name:       |  |
| Participating School Name:       |  |

**Initial Evaluations**

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|    Audiology |    Occupational Therapy |    Orientation, Mobility & Vision |
|    Physical Therapy |    Psychiatric |    Psychological |
|    Social Work |    Speech & Language |    Hearing Impaired |

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| **I agree that the Initial Evaluations above are both appropriate and medically necessary.** |

|  |  |
| --- | --- |
| Authorized Signature       | \*Date of Signature       |
| Printed Name/Practitioner Title       | License #       |
| NPI#       | MA Provider #       |

If review of medical necessity was conducted face-to-face with the student, separate documentation must be maintained.

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| **\*The date of signature is required prior to or on the date of service. Refer to section 4.8 of the** [**SBAP Handbook**](http://www.dhs.pa.gov/provider/School-BasedACCESS/index.htm) **for the definition of the date of service.** |