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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.** |