

PA SBAP SELF-AUDIT RECORD REVIEW DOCUMENT

Student Name: _____

DOB: _____

Service: _____

Service Date: _____

LEA Reviewer: _____

Date of Review: _____

1. Parent Consent/Notification Form:

Date signed _____

- Students name on form: Yes No
- Signed and dated by parent/guardian: Yes No
- Permission to bill MA given: Yes No
- School listed on form: Yes No

2. IEP:

Duration _____ to _____

- LEA Name Yes No
- IEP in File Yes No
- Group vs individual Yes No
- Health related service listed: Yes No
- Frequency: Yes No
- Duration: Yes No
- Valid for date of service: Yes No

3. Medical Authorization:

Date signed _____

- Authorization for health related service: Yes No
- Date of service covered by authorization: Yes No
- Frequency/duration matches IEP: Yes No
- Signer has active license: Yes No
- Group vs individual Yes No
- Signed and Dated Yes No

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4. Service Provider Log (Health Related Services):

- | | | |
|---|-----|----|
| • Name: | Yes | No |
| • Date of Birth: | Yes | No |
| • Diagnosis: | Yes | No |
| • Dated: | Yes | No |
| • Type of service: | Yes | No |
| • Length of service (time in & time out): | Yes | No |
| • Legible (paper log): | Yes | No |
| • Fully describes service: | Yes | No |
| • Practitioner signature, date and title: | Yes | No |
| • Supervisor signature and date, if needed: | Yes | No |
| • If on behalf of original log in file: | Yes | No |

5. Service Provider Log (Special Transportation, if applicable):

- | | | |
|---|------------|------------|
| • Name: | Yes | No |
| • Date of Birth: | Yes | No |
| • Health Related Service Provided on Same Day | Yes | No |
| • Dated: | Yes | No |
| • Type of service: | One-way | Round-trip |
| • Legible (paper log): | Yes | No |
| • LEA Approval signature: | Yes | No |
| • Daily trip Log on file: | Yes | No |

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6. Attendance Records:

- Student in attendance on date of service: Yes No
- Service Provider in attendance on date of service: Yes No

7. Service Provider List:

- License/Certification number: Yes No
- License/Certification current on date of service: Yes No
- First aid certified on date of service (PCA): Yes No
- CPR certified on date of service (PCA): Yes No

8. Preclusion/Exclusion:

- Policy and procedures in place (See MA Bulletin 99-11-05): Yes No
- List of providers, Superintendents or any staff that participate with SBAP. Yes No
- LEIE list checked monthly: Yes No
- SAM checked monthly: Yes No
- Medichex list checked monthly: Yes No
- Monthly preclusion/exclusion checks documented: Yes No

Corrective Action Needed:

Additional Comments: