|  |  |
| --- | --- |
| Student’s Name:       | Date of the current IEP Meeting:       |
| Participating School Name:       | MM/DD/YY |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Related Services** | **Duration** | **Frequency** | **Projected Start Date** | **Projected End Date** | **Group** | **Individual** |
| Audiology |       |       |       |       | N/A |    |
| Nursing |       |       |       |       | N/A |    |
| Occupational Therapy |       |       |       |       |    |    |
| Occupational Therapy |       |       |       |       |    |    |
| Orientation, Mobility & Vision |       |       |       |       | N/A |    |
| Personal Care Services |       |       |       |       | N/A |    |
| Physical Therapy |       |       |       |       |    |    |
| Physical Therapy |       |       |       |       |    |    |
| Psychiatric |       |       |       |       |    |    |
| Psychiatric |       |       |       |       |    |    |
| Psychological |       |       |       |       |    |    |
| Psychological |       |       |       |       |    |    |
| Social Work |       |       |       |       |    |    |
| Social Work |       |       |       |       |    |    |
| Speech & Language |       |       |       |       |    |    |
| Speech & Language |       |       |       |       |    |    |
| Hearing Impaired |       |       |       |       |    |    |
| Hearing Impaired |       |       |       |       |    |    |
| Special Transportation |       |       |       |       | N/A |    |

**Re-Evaluations to be provided throughout the duration of this IEP:**

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

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| --- |
| I reviewed the Individualized Education Program (IEP) for this student and agree that the health-related services and re-evaluations recommended above by the IEP team 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.** |