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

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| **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:**

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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 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.** |