Child's Name: Last, First, M.I.	D.O.B.	COUNTY:	DIAGNOSIS CODE: 31 59	DATE OF SERVICE:

LOCATION TYPE (Check One):				ENCOUNTER TYPE (Check One):				ATTENDED: ☐ Yes ☐ No (If "No" check reason why)	
☐	Phone	☐	Store/Mall	☐	Family Interview	☐	Notification	☐	Client Cancelled
☐	Letter/Fax	☐	Church	☐	Screening	☐	Correspondence	☐	Client "No-Show"
☐	Home	☐	Therapist's Office	☐	Eval./Assessment	☐	Transition	☐	R.C. Cancelled
☐	Childcare	☐	Park/Playground	☐	Family Asses.	☐	30 Day Follow-up	☐	Provider Cancelled
☐	Health Dept.	☐	Hospital	☐	IFSP/IFSP Review	☐	Service - Coordination	☐	Unable to locate family
☐	School	☐	Other	☐	I.E.P.			☐	Weather

Starting Time:	Ending Time:	**My signature verifies that this service took place at the time and location indicated.** **Parent / Caregiver Signature.**

Total Documentation Time:	Total Medicaid Billable Time:	Procedure Code: **T1016**	Modifier 1: **TL**	Modifier 2:

Child's Medicaid Number:	☐	Current Number	☐	None at this time	☐	Applying
	☐	New Number	☐	Unknown		

Service Coordinator notes documenting encounter services rendered.

Include the following detail as applicable: type of Medicaid activity (ARRANGE/REFER/MONITOR), who was present, list coaching/mentoring activities, caregiver report, observations, material provided, progress made towards goals, and planned future activities. Cancellations and no-shows Should also be documented.

	Continued on back? ☐ Yes ☐ No	Date note was written/finished: