SCHOOL MEDICAID PROGRAM CHECKLIST

Student

Date	School
Student ID	DOB
Student Name	Grade

Services Included

Physical Therapy	☐	Counseling	☐
Occupational Therapy	☐	Physician	☐
Speech Therapy	☐	Personal Care (Health Aide)	☐
Nursing	☐	Psychological	☐
Specialized Transportation	☐		

Special Education Student

Evaluation

Date

Written Report	☐ Yes	☐ No
Required Signatures	☐ Yes	☐ No
Service Area/ Date/ Provider of Evaluation Specified	☐ Yes	☐ No

IEP/ARD

Date

Lists Need in PLAFFP	☐ Yes	☐ No
Specific Goals	☐ Yes	☐ No
Covered Services including Frequency, Scope, Duration	☐ Yes	☐ No
Appropriate Signatures	☐ Yes	☐ No

Non-Special Education Student

Authorizing Documents ☐ Yes ☐ No

Other Documentation Requirements

Other Required Documentation

Physician Prescription	☐ Yes	☐ No	
Service Pre-Approval	☐ Yes	☐ No	
Plan of Care/Treatment Plan	☐ Yes	☐ No	
Treatment Authorization	☐ Yes	☐ No	
Signed Parental Consent / Date	☐ Yes	☐ No	Consent Date:

Provider #1

Name	Service				
Current License	☐ Yes	☐ No	First Aid Certification	☐ Yes	☐ No
CPR Certification	☐ Yes	☐ No	Public Safety Card	☐ Yes	☐ No
CDL	☐ Yes	☐ No	Other	☐ Yes	☐ No

Provider #2

Name	Service				
Current License	☐ Yes	☐ No	First Aid Certification	☐ Yes	☐ No
CPR Certification	☐ Yes	☐ No	Public Safety Card	☐ Yes	☐ No
CDL	☐ Yes	☐ No	Other	☐ Yes	☐ No

Provider #3

Name	Service				
Current License	☐ Yes	☐ No	First Aid Certification	☐ Yes	☐ No
CPR Certification	☐ Yes	☐ No	Public Safety Card	☐ Yes	☐ No
CDL	☐ Yes	☐ No	Other	☐ Yes	☐ No