MEDICAID SERVICE CARE PLAN

_______________County Schools

Student's Full Name _________________________________ **Date** ___________________________________

School ____ **Date of Birth** ___________________________

Parent(s)/Guardian(s) _________________________________ **Grade** _________________________________

Address ____ **WVEIS#** ________________________________

City/State/Zip ____ **Telephone** ______________________________

Medicaid Number: __________________________________

Diagnosis Code(s) ____

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Measureable Treatment Goals and/or Objectives (List the goals/objectives from the student's IEP in the areas of Speech, Occupational Therapy, Physical Therapy, Audiology, and Behavior if applicable. For Nursing services attach a copy of the student's Health Care Plan. If a student has a Behavior Intervention Plan attach a copy to this form):

Frequency and Duration of Treatment:

Services	Extent Frequency _________ per	Initiation Date mm/dd/yyyy	Duration mm/yyyy

Targeted Case Management may be provided based upon medical necessity.

Parent/Adult Student Signature: ____ _______________

Date

Provider Signature: ____

Provider Signature: ____

Provider Signature: ____

Provider Signature: ____