**Service Care Plan**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County Schools**

**Date**:

**Student’s Full Name: DOB:**

**Parent(s)/Guardian(s)/Surrogate Parent: Grade:**

**Address: WVEIS Number:**

**City: State: Zip Code: Medicaid Number:**

**Enter a specific diagnosis code(s) that matches the service(s) being provided (Speech, Nursing, Audiological, Occupational and Physical Therapy will each require a specific ICD diagnosis code):**

**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 | Durationmm/yyyy |
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**Targeted Case Management may be provided based upon medical necessity.**

Parent/Adult Student Signature:

Provider Signature:

Provider Signature:

Provider Signature:

Provider Signature: