



## “Under the Direction of” Documentation for Speech

*School Year:*

Student Name:

Diagnosis:

Date of Birth:

Provider Name:

Per Medicaid policy, a face-to-face contact with the student is required at the beginning of treatment.

Date of Initial Contact:

<b>Review of IEP / Evaluations</b> (at a minimum at the beginning of the school year or the beginning of treatment for new students)	
Date:	Date:
<b>Direct Observation</b> (at a minimum 1x per quarter)	
Date:	Date:
Date:	Date:
<b>Review of Medicaid Documentation</b> (at a minimum of 1x per quarter)	
Date:	Date:
Date:	Date:
<b>Conference with TSLI:</b> (at a minimum of 1x per quarter)	
Date:	Notes:
<b>Other Relevant Data:</b>	
Date:	Notes:

CCC Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit a copy of this log to Kim Foster at Sanilac ISD