**Rehabilitative Assistance must be recommended by a licensed practitioner of the healing arts and specified in the student’s IEP.**

**Student Full Legal Name:** **Month of Service:**

**Student DOB:** **Setting:** **School/Residence (Circle One)**

**District of Liability:** **School/Residence:**

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| *Date* | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
| *# of Units\** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *RA Initials* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Service Code | Description | **Unit Designation** |
| G | Group Treatment/Therapy/Services – **include group size (all students receiving a simultaneous, health related service)** | 1 unit = 15 (8-22) minutes |
| I | Individual Treatment/Therapy/Services | 1 unit = 15 (8-22) minutes |

**For group therapy: Record units, “G”, and group size, e.g., 12G2 (12 units, group therapy, 2 students in group).**

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| *Unless so noted, school was in session and student was in attendance on all days recorded above. I/We have edited this form to correctly reflect services delivered on the above dates.*  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Signed†:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Initials:** **Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  [*Rehabilitative Assistant(s)*] |
| *I certify that activities being billed under rehabilitative assistance for the above student on the dates specified, for which I am knowledgeable of the service provision, and provide weekly consultation to the aide(s), are not classroom instruction or academic tutoring, but are therapeutic in nature and are necessary for the maximum reduction of the student’s physical/mental disabilities.*  **Lic. Practitioner Signature†**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ **License/Certification/DOE Endorsement‡:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_  **Lic. Practitioner Printed Name: ­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**†*Original, handwritten signature(s) required* ‡*E.g., School Counselor, RN, etc.***

**Rehabilitative Assistance must be recommended by a licensed practitioner of the healing arts and specified in the student’s IEP.**

**Student Name:** **Month of Service:**

**Student DOB:** **Setting:** **School/Residence (Circle One)**

**District of Liability:** **School/Residence:**

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**†*Original, handwritten signature(s) required* ‡*E.g., School Counselor, RN, etc.***