

PLEASE PRINT

Medicaid Direct Service Claiming Health Aide Log

SCHOOL DISTRICT: _____
 PROVIDER NAME: _____
 PROVIDER ID: _____

STUDENT NAME: _____
 STUDENT DOB: _____
 AHCCCS ID: _____

Circle Appropriate Month: → July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June

PROCEDURE	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	Mon.	Tue.	Wed.	Thu.	Fri.	Mon.	Tue.	Wed.	Thu.	Fri.
Assist with daily living										
Toileting										
Feeding										
Dressing										
Grooming										
Wheelchair										
Other										
Occupational Therapy										
Holding										
Grabbing										
Picking Up										
Hand-over-hand										
Other										
Physical therapy										
ROM										
Strength										
Endurance										
Flexibility										
Other:										
Speech										
Repetition										
Formation										
Verbal Cues										
Other										
Behavior										
Rage control										
Play Integration										
Socialization										
Impulse Control										
Redirection										
Other										
Student Absent										
Provider Absent										
Total Minutes										

I certify that the services indicated above were performed by me and are included in the IEP.
 SIGNATURE: _____ DATE: _____