CAYUGA COUNTY HEALTH DEPARTMENT
PROGRAM FOR CHILDREN WITH SPECIAL NEEDS
3-5 PRESCHOOL SERVICES RECORD

Service Provider: _____ Month: _____

CHILD'S NAME	DAYS ATTENDED	NO. OF SESSIONS	RATE/PER SESSION	FEE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

TOTAL _____

I certify the information I am going to submit will be true, accurate, and complete. I understand that this information may be used for billing and payment and satisfaction of the claim will be from federal and/or state funds. I understand any false claims, statements, or documents, or concealment of material facts, may be prosecuted under applicable Federal or State laws.

Further, I certify all services I am reporting have been provided by or under the direction or supervision of a licensed professional of the healing arts, other licensed health care professional, or other licensed/certified practitioner acting within their scope of practice under state law.

Finally, if after this submission I discover any error in it, I will immediately report such errors for adjustment.

SIGNATURE _____ **DATE** _____

Name: _____

Address: _____

_____