**Minnesota Department of Human Services**

**Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) Evaluation Documentation Log**

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| STUDENT’S NAME | DATE OF BIRTH | ICD-10-CM CODE | SCHOOL NAME |
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\*ICD-10-CM Code – Informational only – not required on this form. ICD-10-CM must be reported on claim. Verify procedure codes, modifiers and units chart to ensure proper and correct billing.

**TYPE OF SERVICE PROVIDED (SERVICE CODE)**

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| --- |
| O Physical Therapy (T1018-U1) O Mental Health (T1018-U4) O Occupational Therapy (T1018-U2)  O Nursing Services (T1018-U5) O Speech-language Pathology (T1018-U3) |

**Description of evaluation or assessment activity:** For each entry, enter a description of the evaluation or assessment activities that were performed and the instruments, tools or protocols used in making the determination of medical need. Medical Assistance (MA), Minnesota’s Medicaid, will reimburse the federal share of the cost of covered health-related evaluations and assessments under the Individuals with Disabilities Education Act (IDEA) when conducted for the sole purpose of identifying the health-related needs for a child’s IEP or IFSP to determine the need for continued coverage. Meaning, if the school is evaluation a child for the sole purpose of identifying the health related needs of that child for the child’s IEP or IFSP, MA will cover the time spent performing that evaluation or assessment even if the service does not get added to the IEP or IFSP or result in an IEP or IFSP.

**Time Spent:** Report only time spent to determine health related needs which includes administering face-to-face assessments of health related needs, interpreting test results and writing reports.

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| --- | --- | --- | --- | --- |
| **DATE OF EVALUATION**  MM/DD/YYYY | **Description of evaluation or assessment activity** | **Start time (use am/pm)** | **End time (use am/pm)** | **Time spent** |
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**Total time \_\_\_\_\_\_\_\_\_­­­**

It is a federal crime to provide false information on service billings for Medical Assistance payments. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the child’s care plan.

SERVICE PROVIDER NAME (Type or print) TITLE SIGNATURE

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