SPECIAL EDUCATION/MEDICAID SERVICES REIMBURSEMENT RECORD

Month/Year _____ School Name _____

Name _____ ID# _____ D.O.B. _____ Grade _____ Room # _____

SERVICE	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	Sub-total
APPLICATIONS (warm)																																
BLOOD GLUCOSE (monitoring)																																
CAST (care)																																
CATHETER, URINARY, INDWELLING (reinsertion of)																																
CATHETERIZATION (urinary)																																
DRESSINGS (sterile)																																
GASTROSTOMY FEEDING (bolus method or with medication)																																
GASTROSTOMY FEEDING, initiation of by drip method (monitoring of the drip feeding can be assigned after initiation by the licensed nurse)																																
INSULIN PUMP (problem assessment/intervention)																																
INTAKE AND OUTPUT MEASUREMENTS OF GASTRIC AND PERENTERAL FLUIDS																																
MEDICATIONS (administration of subcutaneous, intramuscular, intravenous, or rectal medications)																																
MEDICATIONS (administering oral, topical and inhalant nonself-directed students according to State Education Department guidelines)																																
NEBULIZER (with oxygen or medication)																																

SERVICE	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	Sub total
OBSERVATIONS AND DATA COLLECTION																																
OSTOMY CARE (care of stoma and changing the appliance)																																
OXYGEN ADMINISTRATION (prn/intermittent) or initiation of continuous oxygen)																																
RESPIRATORY/VENTILATOR CARE																																
RESPIRATORY CARE (postural drainage and cupping, etc.)																																
SHUNT FUNCTION (monitoring of)																																
SUCTIONING (oropharyngeal)																																
SUCTIONING (tracheostomy)																																
TRACHEOSTOMY CARE																																
TUBE FEEDINGS (nasogastric)																																
ULCER DECUBITUS (care)																																
OTHER																																
TOTAL OF ABOVE SERVICES: (Place in box at far right) →																																

I hereby certify that the list of services provided on this form is a true and accurate representation of the facts and that all services were performed in compliance with the laws and agreements governing the School Supportive Health Services Program. I am aware that deliberate filing of false information may result in criminal penalties.

R.N. Signature _____ Date completed _____

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