**Daily PCS Service Documentation Form**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student’s Last Name** | |  | | | **MI** | |  | **First Name** | |  | | **DOB** | |  | | **Date** |  |
| **Student ID** |  | | **Gender** |  | |  | | | **School** |  | **PCS Aide Hours Worked** | |  | | | | |
| **Health Condition and ICD-10** | | |  | | | | | | | | | | | | **Date of Most Recent PCS Plan:** | | |

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| **Instructions:** Document actual clock time spent with individual student performing MD-prescribed service(s) in PCS plan. See most recent PCS Plan for usual symptoms, seizure pattern (if any), treatment plan, medications, protocols and emergency contacts. Treatment services are billed to Medicaid in 15-minute increments. One unit of service may be billed if a minimum of 7 or more continuous minutes of direct service time is provided to a student. A unit cannot be made up of shorter time periods provided throughout the day and added together. The “units” column below refers to the number of billable units of service. | | | | | | | | | | | | | |
| **TIME** | **:00-**  **:07** | **:08-**  **:14** | **:15-**  **:24** | **:23-**  **:29** | **:30-**  **:37** | **:38-**  **:44** | **:45-**  **:53** | **:53-**  **:60** | **Total Minutes** | **Units** | **Observations / Concerns / Difficulties \*** | **Procedures / Interventions / Medications Given \*\*** | **Initials** |
| 7:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Total |  | | | | | | | |  |  |  | | |

\* Attach separate Progress Notes page if more space is needed to describe any changes, events or concerns.

**Notes:**

**Justification for not providing any required services (if applicable this day):**

|  |  |  |  |
| --- | --- | --- | --- |
| By signing below, I certify that I have been trained by the school nurse to observe, monitor and provide health-related interventions for this student and that I have provided the interventions listed above. | | | |
| **Printed Name** | **Initials** | **Signature** | **Date** |
|  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Observations / Concerns\*** | |  | **Procedures / Interventions\*\*** | | **Frequency/Time** |
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