SPECIALIZED SERVICE VERIFICATION

by a Private Provider

Date of Submission_____

Implementation Dates _____ to _____

Out of District Placement/Agency: _____

Service Type: _____ **Service Provider: _____**

Student Name: _____, _____ **SASID: _____ D.O.B _____**

Note: Forms currently in use to verify related services reported to LEAs for Medicaid submissions may be used in addition to or in lieu of this form.

Date of Service	Duration /Time	Delivery Model/Comments

Provider Signature: _____ Supervising Provider Signature: _____
(If required)