

**MR/DD WAIVER PROGRAM:
Psychological Services Tracking Form**

PARTICIPANT NAME

CSI

SERVICE COORDINATION AGENCY

PROVIDER NAME

SERVICE COORDINATOR NAME

In the spaces below, write in the number of units that psychological services were provided to the participant for each day of the month.

This Report Is For The Month Of: _____, 200____.

Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Psych Diagnostic Int Exam 90801-HI																
Psych Testing w/ Int & Rpt 96101-HI																
Psych Testing-Dev Extended 96111-HI																
Psych Testing-Dev Limited 96110-HI																
IPP Dev-Psychologist T2024-AH																
TC-Beh Analy, Psych,Day T2021-U6-UF																
TC-Beh Analy, Psych,Day T2021-U6-UH																
Psych Behavior Consult T2025-HI																
Code	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Psych Diagnostic Int Exam 90801-HI																
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IPP Dev-Psychologist T2024-AH																
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TC-Beh Analy, Psych,Day T2021-U6-UH																
Psych Behavior Consult T2025-HI																

I certify that the above services were delivered in accordance with the Individual Program Plan (DD-5) for the participant named above and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

PROVIDER SIGNATURE

DATE COMPLETED

CS Community Services, Inc.