

**MR/DD WAIVER PROGRAM  
Therapist-PT/OT/ST/DIETICIAN 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 therapist 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
Physical Therapist 97530-GP-HI																
Occupational Therapist 97530-GO-HI																
Speech Therapist 92507-GN-HI																
Registered Dietician 97802-AE-HI																
IPP Dev-Physical Therapist T2024-GP																
IPP Dev-Occupational Ther. T2024-GO																
IPP Dev-Speech Therapist T2024-GN																
IPP Dev-Registered Dietician T2024-AE																
Code	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Physical Therapist 97530-GP-HI																
Occupational Therapist 97530-GO-HI																
Speech Therapist 92507-GN-HI																
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IPP Dev-Occupational Ther. T2024-GO																
IPP Dev-Speech Therapist T2024-GN																
IPP Dev-Registered Dietician T2024-AE																

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

*CSJ Community Services, Inc.*