Minnesota Department of Human Services

**IEP/IFSP Services Documentation Log**

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| STUDENT’S NAME | DATE OF BIRTH | ICD-10-CM CODE\* | SCHOOL NAME |

\*ICD-10-CM Code – Informational only – not required on this form. ICD-10-CM must be reported on claim.

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| **TYPE OF SERVICE PROVIDED (SERVICE CODE) –** check one  O Physical Therapy (T1018-U1) O Mental Health (T1018-U4) O Occupational Therapy (T1018-U2)  O Nursing Services (T1018-U5) O Speech-language Pathology (T1018-U3) |

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| **Date of Service**  MM/DD/YYYY | **Start/End Time Providing Service** | **Total**  **Minutes Spent Providing Service** | **Number of Children in Group** | **Description of Services**  Enter a description of the actual services provided relating to goals/objectives on the IEP/IFSP, including: activities, results, response, progress, and plan for next session. Please use black pen. Use as many lines as necessary to complete documentation. Do not use pencil, white-out, ditto marks, or arrows. |
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| SERVICE PROVIDER NAME (Type or print) | TITLE | SIGNATURE |