Minnesota Department of **Human Services**  DHS-5085A-ENG 10-15

**IEP/IFSP Services Documentation Log**

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| STUDENT’S NAME       | DATE OF BIRTH       | ICD-10-CM CODE\*       | SCHOOL NAME       |
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\*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[ ]  Physical Therapy (T1018-U1, TM) [ ]  Occupational Therapy (T1018-U2, TM) [ ]  Nursing Services (T1018-U5, TM) [ ]  Speech-language Pathology (T1018-U3, TM)  |

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| **Date of Service**MM/DD/YYYY | **Time Spent Providing Service** | **Number of Children in Group** | **Description of Evaluation Activity**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.Use as many lines as necessary to complete documentation. Do not include indirect time.Do not use pencil, white-out, ditto marks, or arrows.  |
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| SERVICE PROVIDER NAME (type or print) | TITLE | SIGNATURE |