

<b>SAMPLE Documentation of Orientation and Mobility Services</b>				<b>Diagnosis Codes</b>		
Student:	DOB:	Medicaid#:	<input type="checkbox"/> 369.00	<input type="checkbox"/> 368.8	<input type="checkbox"/> 343.9	
District:	Place of Service: Home (12) <input type="checkbox"/> School (03) <input type="checkbox"/> Other (99) <input type="checkbox"/>		<input type="checkbox"/> 343.0	<input type="checkbox"/> 317	<input type="checkbox"/> 368.9	
Provider:	School Name:		<input type="checkbox"/> 854.00	<input type="checkbox"/> 299.0	<input type="checkbox"/>	

	Objectives	Activities/Consultation	Results	Progress	Plan	NARRATIVE(Description of activity and results)
<p>Date: ___/___/___</p> <p>Procedure Code:                      ___ T1024 Assessment / One assessment / Eight units per Lifetime.</p> <p>___ T 1024/TS Reassessment/One reassessment/ Up to 5 units with3 every 12 months.</p> <p>___ T1024/TM Services/15 minutes/30 per week.</p> <p>Length of Time</p> <p>___ hrs. ___ min.</p> <p>Units _____</p> <p>Initials _____</p>	<u>Obj. #</u>	<input type="checkbox"/> Sensory/Auditory Skills <input type="checkbox"/> Concepts/Spatial Development <input type="checkbox"/> Adaptive Aids/Technology <input type="checkbox"/> Low Vision Training/ Aids <input type="checkbox"/> Mobility Training (Canes/Trailing/Protective) <input type="checkbox"/> Community Travel (Residential/Rural/Commercial) <input type="checkbox"/> Communication/ADL <input type="checkbox"/> Other	___ % correct ___ of ___ correct ___ Not assessed Other: _____ _____ _____ _____	___ Mastered ___ Progress ___ No change ___ Regression Other: _____ _____ _____	___ Continue objective ___ Objective met ___ Initiate new objective ___ Teacher training ___ Parent training ___ Consult ___ Discontinue _____ _____	
<p>Date: ___/___/___</p> <p>Procedure Code:                      ___ T1024 Assessment / One assessment / Eight units per Lifetime.</p> <p>___ T 1024/TS Reassessment/One reassessment/ Up to 5 units with3 every 12 months.</p> <p>___ T1024/TM Services/15 minutes/30 per week.</p> <p>Length of Time</p> <p>___ hrs. ___ min.</p> <p>Units _____</p> <p>Initials _____</p>	<u>Obj. #</u>	<input type="checkbox"/> Sensory/Auditory Skills <input type="checkbox"/> Concepts/Spatial Development <input type="checkbox"/> Adaptive Aids/Technology <input type="checkbox"/> Low Vision Training/ Aids <input type="checkbox"/> Mobility Training (Canes/Trailing/Protective) <input type="checkbox"/> Community Travel (Residential/Rural/Commercial) <input type="checkbox"/> Communication/ADL <input type="checkbox"/> Other	___ % correct ___ of ___ correct ___ Not assessed Other: _____ _____ _____ _____	___ Mastered ___ Progress ___ No change ___ Regression Other: _____ _____ _____	___ Continue objective ___ Objective met ___ Initiate new objective ___ Teacher training ___ Parent training ___ Consult ___ Discontinue _____ _____	

**Note: Each clinical service note must include sufficient information to support billing Medicaid for services per the most current Medicaid Manual.**