

MEDICAID SERVICE CARE PLAN

Morgan County Schools

Student's Full Name _____ Date _____

School _____ Date of Birth _____

Parent(s)/Guardian(s) _____ Grade _____

Address _____ WVEIS# _____

City/State/Zip _____ Telephone _____

Medicaid Number: _____

Diagnosis Code(s) _____

Measureable Treatment Goals and/or Objectives (List the goals/objectives from the student's IEP in the areas of Speech, Occupational Therapy, Physical Therapy, Audiology, and Behavior if applicable. For Nursing services attach a copy of the student's Health Care Plan. If a student has a Behavior Intervention Plan attach a copy to this form):

Frequency and Duration of Treatment:

Services	Extent Frequency _____ per	Initiation Date mm/dd/yyyy	Duration mm/yyyy

Targeted Case Management may be provided based upon medical necessity.

Parent/Adult Student Signature: _____

_____ Date

Provider Signature: _____

Provider Signature: _____

Provider Signature: _____

Provider Signature: _____