DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01198 (07/2008)

STATE OF WISCONSIN

WISCONSIN MEDICAID

OPTIONAL SCHOOL-BASED SERVICES ACTIVITY LOG
NURSING / THERAPY MEDICAL SERVICES

Name — Student (Last, First, MI)	Name — School	Method Used (Circle One) ☐ **Time** ☐ **Task**

Date of Service (MM/DD/YY)	**General Service Category**	**Unit of Service** (Time or Units)	**Group or Individual**	**Describe Specific Services Performed**	**Student's Response/ Progress**	**Initials or Signature*** (Of Person Who Performed Service)

*Initials Key	Signatures — Corresponding Staff	Date Signed (MM/DD/YY)

Therapy services only:

A. Does the recipient have insurance?
☐ Yes ☐ No
(If yes, go to B. If no, stop.)

B. Is there an insurance exclusionary clause for all school-based services?
☐ Yes ☐ No
(If yes, insurance liability does not apply. If no or do not know, go to C.)

C. Check the option selected:
☐ Option 1: School assuming insurance liability. (Subtract the first occurring unit of occupational therapy [OT] [group or individual] and/or physical therapy [PT] [group or individual] during the calendar month from the monthly claim for services. Bill the remaining services to Wisconsin Medicaid. Do not indicate an "other insurance" disclaimer code in Element 9 of the CMS 1500 claim form.)
☐ Option 2: School seeking insurance payment for OT (group or individual) and/or PT (group or individual). Schools must have parental permission for this option.
☐ Option 3: School not seeking Medicaid payment for OT (group or individual) and/or PT (group or individual).