Service Record – Initial/Triennial Treatment Plan

Medicaid Number	Last Name	First Name
Diagnosis Code	**County**	**School**

	Beginning Date	Ending Date	Proc. Code	Units
			H2000	1

INITIAL/TRIENNIAL/REEVALUATION (H2000)

1. Student Assistance Team Meeting or Date of Referral To Special Education (if initial) _____
2. Reviewed previous reports /documentation _____
3. Received parental consent to evaluate **or** completed a re-evaluation determination plan _____
4. Prepared notice of eligibility and parental rights to send home _____
5. Eligibility Committee Report date _____
6. IEP date (use as Beginning Date and Ending Date) _____

IEP TEAM LEADER'S SIGNATURE _____ **DATE** _____

Note: Documentation for Step 6 is the IEP form (all parts). The date for Step 6 is the date on the form.