Aurora Public Schools District 28J
2017-18 School Year

Aurora Public Schools, 28J

School Medicaid Department

Provider Codes
RN- S01
Health Tech- S18
Sped Ed Teacher-I01

Nursing Treatment Plan Services Form

***Student's Name:** ***Student's ID#:**

***School:** ***Date of Birth:**

Nursing services must be included in the IEP/IFSP. ***ICD-10 Code:**

RN/Health Tech's Name (*Print*)	RN/Health Tech's Signature	Initials	Provider Code (Circle)
______________________	______________________	________	S01 S18 I01
______________________	______________________	________	S01 S18 I01
______________________	______________________	________	S01 S18 I01
______________________	______________________	________	S01 S18 I01

Indicate ALL nursing services, including delegated services by the School Nurse, to be provided to the student in accordance with the IEP/IFSP or HCP attached to IEP/IFSP.* ***Required fields are noted with an asterisk (*)*

Check all types of services that apply (NURSE)	Indicate length of time	Indicate # of times	Indicate total time per day
1_____ G-tube feeding /tracheotomy care	Length of time _____ min.	Times/day_____	Total Amount of time_____min.
2_____Suctioning, inhaler, or nebulizer treatment:	Length of time_____min.	Times/day_____	Total Amount of time_____min.
3_____Administering insulin/ diabetic care:	Length of time_____min.	Times/day_____	Total Amount of time_____min.
4_____Seizure care:	Length of time_____min.	Times/day_____	Total Amount of time_____min.
5_____Diapering/catheter care	Length of time_____min.	Times/day_____	Total Amount of time_____min.
6_____Other: (Specify) ______________________	Length of time_____min.	Times/day_____	Total Amount of time_____min.

**Enter corresponding service # from above*	*Type of Service ________		*Type of Service ________		*Type of Service ________		
***Date**	***Actual Min(s)**	***Initials**	***Actual Min(s)**	***Initials**	***Actual Min(s)**	***Initials**	**Observation/Comments**
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I certify that the information provided on this form is true and accurate and that the services were provided in accordance with federal and state laws applicable to Medicaid. Delegation of nursing tasks is in accordance with the Colorado Nurse Practice Act.

______________________ ______________________ ______/___/______

RN's Name *(Print) ***RN's Signature** ***Date**