PA SBAP SELF-AUDIT RECORD REVIEW DOCUMENT

Student Name: _____ **DOB:** _____

Service: _____ **Service Date:** _____

LEA Reviewer: _____ **Date of Review:** _____

1. **Parent Consent/Notification Form:** **Date Signed** _____
   - Student's name on form: ☐Yes ☐No
   - Signed and dated by parent/guardian: ☐Yes ☐No
   - Permission to bill MA given: ☐Yes ☐No
   - School listed on form: ☐Yes ☐No
2. **IEP:** **Duration** _____ **to** _____
   - LEA Name: ☐Yes ☐No
   - IEP in File: ☐Yes ☐No
   - Group vs. Individual: ☐Yes ☐No
   - Health related service listed: ☐Yes ☐No
   - Frequency: ☐Yes ☐No
   - Duration: ☐Yes ☐No
   - Valid for Date of Service: ☐Yes ☐No
3. **Medical Authorization:** **Date Signed** _____
   - Authorization for health related service: ☐Yes ☐No
   - Date of Service covered by authorization: ☐Yes ☐No
   - Frequency/duration matches IEP: ☐Yes ☐No
   - Signer has active license: ☐Yes ☐No
   - Group vs. Individual: ☐Yes ☐No
   - Signed and Dated: ☐Yes ☐No

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4. **Service Provider Log (Health Related Services):**
   - Name: ☐Yes ☐No
   - Date of Birth: ☐Yes ☐No
   - Diagnosis: ☐Yes ☐No
   - Dated: ☐Yes ☐No
   - Type of service: ☐Yes ☐No
   - Length of service (time in & time out): ☐Yes ☐No
   - Legible (paper log): ☐Yes ☐No
   - Fully describes service: ☐Yes ☐No
   - Practitioner signature, date and title: ☐Yes ☐No
   - Supervisor signature and date, if needed: ☐Yes ☐No
   - If "on behalf of," original log in file: ☐Yes ☐No
5. **Service Provider Log (Special Transportation, if applicable):**
   - Name: ☐Yes ☐No
   - Date of Birth: ☐Yes ☐No
   - Health Related Service Provided on Same Day ☐Yes ☐No
   - Dated: ☐Yes ☐No
   - Type of service: ☐One-way ☐Round-trip
   - Legible (paper log): ☐Yes ☐No
   - LEA Approval signature: ☐Yes ☐No
   - Daily trip Log on file: ☐Yes ☐No
6. **Attendance Records:**
   - Student in attendance on Date of Service: ☐ Yes ☐No
   - Service Provider in attendance on Date of Service: ☐ Yes ☐No

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7. **Service Provider List:**
   - License/Certification number: ☐ Yes ☐ No
   - License/Certification current on Date of Service: ☐ Yes ☐ No
   - First aid certified on Date of Service (PCA): ☐ Yes ☐ No
   - CPR certified on Date of Service (PCA): ☐ Yes ☐ No
8. **Preclusion/Exclusion:**
   - Policy and procedures in place (See MA Bulletin 99-11-05): ☐ Yes ☐ No
   - List of providers, Superintendents or any staff that participate with SBAP: ☐ Yes ☐ No
   - LEIE list checked monthly: ☐ Yes ☐ No
   - SAM checked monthly: ☐ Yes ☐ No
   - Medicheck list checked monthly: ☐ Yes ☐ No
   - Monthly preclusion/exclusion checks documented: ☐ Yes ☐ No

Corrective Action Needed:

Additional Comments: