Case Management Assurance

Student Information

Name: _____ Date of Birth (mm/dd/yy) _____

Diagnostic Code: _____

Provider Information

Provider Name: _____ Name of School: _____

Supervisory Union Name: _____

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on the IEP for Case Management Services:

IEP initiation/Amendment Date	**IEP Hours Per Week** (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.	____ Hours

By signing below, I verify services were provided as documented above. I understand that this is a legal document and services documented above will be billed to Vermont Medicaid for federal reimbursement.

Provider Signature: _____ **Date:** _____