

LEA: \_\_\_\_\_  
(School District)

Plan of Care  
Addendum  
Authorization for Rehabilitation Services

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Medicaid Number

\_\_\_\_\_  
School

\_\_\_\_\_  
Diagnosis

\_\_\_\_\_  
ICD-9 Code

Change to Original Plan of Care (include reason for change)

\*\*\*\*\**(Goals must have a time frame for achievement (by \_\_\_/\_\_\_/\_\_\_) and must be measurable with \_\_\_% accuracy)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Discipline: \_\_\_ SLP \_\_\_ PT \_\_\_ OT      Frequency: Individual: \_\_\_ X/ \_\_\_ and/or Group: \_\_\_ X/ \_\_\_

Date Plan of Care Addendum will be implemented: \_\_\_/\_\_\_/\_\_\_ (include month/day/year)

\_\_\_\_\_  
Signature & Title of Therapist

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date