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| *North Carolina Infant-Toddler Program* |  |

*Provider Monthly Summary Note*

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| Name of ITP Provider Agency: | | | | | |  | | | | ITP Provider’s Name: | | | | |  | | | | | |
| Provider Vendor Number: | | | | |  | | | Provider Discipline: | |  | | | | | | | | | | |
| For Month of: | | |  | | | | | Service Order Date [if applicable]: | | | | |  | | | Scheduled Frequency: | | |  | |
| Child’s Name: | | |  | | | | | | | Child’s Medicaid ID Number: | | | | | | |  | | | |
| Child’s DOB: | | |  | | | | | | | Name of Service Coordinator: | | | | | | |  | | | |
| IFSP Outcomes Utilized: [Indicate IFSP Goal/Outcome number and brief description beside each.] | | | | | | | | | | | | | | | | | | | | |
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| **Legend for Place of Service [POS]: Home or other community setting = 12 Office = 11 Health Dept. = 71 Rural Health Dept. = 72 [See DMA website for additional codes.]** *NOTE: Each summary must include a description of provider’s interventions, and the effectiveness of the interventions, including achievements or measurable progress toward IFSP Goals/Outcomes listed. Please list any difficulties encountered in the provision of service delivery, if any.* | | | | | | | | | | | | | | | | | | | | |
| Svc Date: | |  | | Svc Date: | | |  | | Svc Date: | |  | | | Svc Date: | | |  | Svc Date: | |  |
| Proc. Code: | |  | | Proc. Code: | | |  | | Proc. Code: | |  | | | Proc. Code: | | |  | Proc. Code: | |  |
| # Units: | |  | | # Units: | | |  | | # Units: | |  | | | # Units: | | |  | # Units: | |  |
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| POS | |  | | POS | | |  | | POS | |  | | | POS | | |  | POS | |  |
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| Signature & Title: | | | | | | | | | | | | | | | | | Date of Signature: | | | |