Heart of Georgia RESA
Medicaid Program Checklist

Date Sent In _____

Student Name: _____
(Last) (First) (MI)

Date of Birth: ___/___/___ Sex: ☐ - Female
☐ - Male

Student Information Type: ☐ - New ☐ - Returning ☐ - Update

Therapist Name: _____

Therapy: ☐ - Nursing ☐ - OT ☐ - PT ☐ - Speech

County: _____ School Name: _____

School Type: ☐ - Pre-K ☐ - Elementary ☐ - Middle ☐ - High

_____ Signed and Current Copy of IEP
_____ Permission to Evaluate
_____ Permission to bill Medicaid
_____ Permission to bill for the frequencies of services
_____ Authorization to release and obtain information
_____ Student Eligibility Form
_____ Copy of Medicaid Card or Social Security Card/ Number _____/_____/_____
_____ Physician's Orders
_____ Permission to dispense medicine/***Nursing only***
_____ Current Goals and Objectives
_____ Progress Reports for Services provided

******Updated Information******
(Please send in supporting documentation)

☐ Dismissed
☐ New IEP
☐ Moved out of System
☐ Moved within System
☐ Student Name Change
☐ Therapist Change
☐ Frequency of Service Change
☐ New Services Added