SHARS Self-Monitoring Tool
Texas Education Agency

Review Period Dates: _____ to _____

Reviewer Name: _____ Date of Review: _____

Section I. Demographic/ARD Meeting Information

School District/Campus	Handicapping Condition(s)/Grade *(at the time of review period)*
Full Individual Evaluation (FIE) in Effect During Review Period — Date	Medicaid Number
ARD/IEP in Effect During Review Period — Date(s)	ARD/IEP Date Range(s)

ARD/IEP Committee Members:		SHARS Services in ARD/IEP:	
Parent	Yes ☐ No ☐ N/A ☐	Audiology Services * *(audiologist, assistant)*	Yes ☐ No ☐
Student	Yes ☐ No ☐ N/A ☐	Counseling * *(LPC, LCSW, LMFT)*	Yes ☐ No ☐
LEA Representative *(admin)*	Yes ☐ No ☐	Psychological Services * *(LSSP, psychologist, psychiatrist)*	Yes ☐ No ☐
General Education	Yes ☐ No ☐	Nursing # *(RN, LVN, LPN, NP, CNS, ANP, delegated)*	Yes ☐ No ☐
Special Education	Yes ☐ No ☐	Occupational Therapy (OT) * *(OT, COTA)*	Yes ☐ No ☐
Assessment Representative	Yes ☐ No ☐ N/A ☐	Physical Therapy (PT) * *(PT, LPTA)*	Yes ☐ No ☐
AI Teacher:	Yes ☐ No ☐ N/A ☐	Personal Care Services # *(trained, at least 18 years old)*	Yes ☐ No ☐
VI Teacher:	Yes ☐ No ☐ N/A ☐	Physician # *(physician)*	Yes ☐ No ☐
Other:	Yes ☐ No ☐	Specialized Transportation # *(school bus driver)*	Yes ☐ No ☐
Other:	Yes ☐ No ☐	Speech Therapy (ST) * *(SLP, intern, assistant, grandfathered SLP)*	Yes ☐ No ☐

**Requires session notes.* *#Requires service logs.*

Medicaid Number

1. Is the Medicaid number on each page of the ARD/IEP(s)? Yes ☐ No ☐ _____
2. Is the Medicaid number on each page of the FIE(s)? Yes ☐ No ☐ _____

Parental Consent

Parent Consent: Yes ☐ No ☐	Date Signed:	Medicaid # on Form: Yes ☐ No ☐
Annual Written Notice: Yes ☐ No ☐ N/A ☐	Date:	Medicaid # on Form: Yes ☐ No ☐

1. Do the consent and notice forms meet TEA standards? Yes ☐ No ☐
2. Are the consent and notice forms filled out completely? Yes ☐ No ☐
3. Is the consent date prior to the start of services to be billed? Yes ☐ No ☐
4. Is the annual notice current (within a year)? Yes ☐ No ☐

Notes:

Considerations for Services Requiring Service Logs

Specialized Transportation Service

ARD/IEP:

ARD requires physically adapted vehicle not routinely available	Yes ☐	No ☐
Above vehicle need based on identified handicapping condition in FIE	Yes ☐	No ☐
Frequency indicated	Yes ☐	No ☐
Modality (indicate individual transportation as appropriate)	Yes ☐	No ☐

Service Log Review:

Date of service	Yes ☐	No ☐	Modality (indicate if individual)	Yes ☐	No ☐
District/provider name listed	Yes ☐	No ☐	Route name/number	Yes ☐	No ☐
First and last name of student	Yes ☐	No ☐	One-way trips per day identified	Yes ☐	No ☐
Student ID number	Yes ☐	No ☐	Driver verified own attendance for each trip	Yes ☐	No ☐
Student Medicaid number	Yes ☐	No ☐	Driver signed (legibly) and dated form	Yes ☐	No ☐

Student in attendance on dates of service	Yes ☐	No ☐
Another SHARS service provided on dates of service	Yes ☐	No ☐
Service matches ARD/IEP (frequency and modality)	Yes ☐	No ☐

Service Provider:

Driver trained and hired (or contracted) with the district/charter Yes ☐ No ☐

Comments:

Nursing/Medication Administration/Physician Services

ARD/IEP:

Individual health plan *(nursing need & activity)*	Yes ☐	No ☐
Frequency indicated	Yes ☐	No ☐

Service Log Review:

Date of service	Yes ☐	No ☐			
First and last name of student	Yes ☐	No ☐	Student Medicaid number	Yes ☐	No ☐
Start and end time	Yes ☐	No ☐	Total billable minutes	Yes ☐	No ☐
Activity performed	Yes ☐	No ☐	Signature (legible)/initials for each event	Yes ☐	No ☐

Student in attendance on dates of service	Yes ☐	No ☐
Service matches ARD/IEP (frequency/activity/modality)	Yes ☐	No ☐

Service Provider:

Provider has appropriate certification (*RN, LVN, LPN, NP, CNS, ANP, delegated supervised by RN)* Yes ☐ No ☐

Comments:

Personal Care Services (PCS)

ARD/IEP:

Medical need established in FIE	Yes ☐ No ☐
Service based on identified handicapping condition in ARD/IEP	Yes ☐ No ☐
Medical need established in ARD	Yes ☐ No ☐
Not based on age-appropriate skills	Yes ☐ No ☐
Not based on support for educational task	Yes ☐ No ☐
Not based on time student is independent	Yes ☐ No ☐
Frequency and duration clearly indicated	Yes ☐ No ☐
Modality (indicate individual, group, or bus)	Yes ☐ No ☐
Goals/activities included with frequency and duration	Yes ☐ No ☐

(Example: If lunch is included in goals and PCS, this time is included in the total frequency and duration.)

Service Log Review:

Date of service	Yes ☐ No ☐	Modality indicated	Yes ☐ No ☐
First and last name of student	Yes ☐ No ☐	Student Medicaid number	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	Signature (legible)/initials for each event	Yes ☐ No ☐

Student in attendance on dates of service	Yes ☐ No ☐
Service matches ARD/IEP (frequency and duration/activity/modality)	Yes ☐ No ☐

Service Provider:

Staff is at least 18 years old and trained for assigned task	Yes ☐ No ☐

Comments:

Assessments/Evaluations

ARD/IEP:

Need for assessment is indicated in ARD/IEP Yes ☐ No ☐ Date: _____

Testing Log Review:

Date of service	Yes ☐ No ☐		
First and last name of student	Yes ☐ No ☐	Student Medicaid number	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	Signature (legible)/initials for each event	Yes ☐ No ☐

Student in attendance on dates of service	Yes ☐ No ☐
Service matches ARD/IEP	Yes ☐ No ☐

Service Provider:

Provider has appropriate certification	Yes ☐ No ☐

Comments:

Services with Session Notes *(OT, PT, SI, counseling, psychological service, audiological therapy)*

Name of Service: _____

ARD/IEP:

Medical need established in FIE/eligibility form	Yes ☐ No ☐
Service based on identified handicapping condition in ARD/IEP	Yes ☐ No ☐
Medical need established in ARD	Yes ☐ No ☐
Frequency and duration clearly indicated	Yes ☐ No ☐
Modality (indicate individual or group)	Yes ☐ No ☐
Goals/objectives included in IEP	Yes ☐ No ☐

Service Log Review:

Date of service	Yes ☐ No ☐	Modality indicated	Yes ☐ No ☐
First and last name of student	Yes ☐ No ☐	Student Medicaid number	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	Signature (legible)/initials for each event	Yes ☐ No ☐
Reference to IEP objective(s)	Yes ☐ No ☐		

Student in attendance on dates of service	Yes ☐ No ☐
Service matches ARD/IEP (frequency and duration/objective/modality)	Yes ☐ No ☐

Service Provider:

Current license/certification on file	Yes ☐ No ☐
Active license/certification	Yes ☐ No ☐
Meets service requirements	Yes ☐ No ☐
Supervision required	Yes ☐ No ☐
If so, supervisor:	
has license/certification on file	Yes ☐ No ☐
has active license/certification	Yes ☐ No ☐
meets service requirements	Yes ☐ No ☐

Prescription (*OT, PT only*):

Prescription with name/address of physician	Yes ☐ No ☐
Valid date *(within 3 years)*	Yes ☐ No ☐

Comments: