TEXAS EDUCATION AGENCY
SHARS Review Checklist
Self-Monitoring Tool

SECTION I. Demographic Information

School District	Student Name
Special Education Director/Administrator	**Medicaid Number**
Contact Person	**Student SSN (Last 4 digits)**
Contact Telephone Number	**Contact Fax Number**
Time Period of Self Monitoring	
From:	**To:**

SECTION II. SHARS SERVICES

Admission, Review, and Dismissal (ARD)

Date IEP is Signed _____ **School Year** _____

Date Range of IEP _____ **Grade** _____

IEP Signed By_____ **Number of SHARS services in IEP** _____

Service #1

Service Provided _____ **IEP--Description of Medical Necessity:**

Service in IEP Yes ☐ No ☐
Service Ticket Yes ☐ No ☐
Service Ticket Signed Yes ☐ No ☐
Units Match Billing Yes ☐ No ☐
Date Matches Billing Yes ☐ No ☐
Attendance Matches Billing Yes ☐ No ☐
Group or Individual Group ☐ Individual ☐
Provider Name _____

_____
_____
_____
_____

Current License/Certification on File Yes ☐ No ☐
Type of License/Certification _____
Active License/Certification Yes ☐ No ☐
Meets Requirements Yes ☐ No ☐
Supervision Required Yes ☐ No ☐
Name of Supervisor _____
Supervisor's Type of License/Certification _____
Writing Evaluation Report Billed Yes ☐ No ☐

OT/PT Prescription/Speech Therapy Referral

Prescription	Yes ☐	No ☐
Evaluation/Referral	Yes ☐	No ☐
Provider Signature	Yes ☐	No ☐
Provider Name Listed	Yes ☐	No ☐
Valid Evaluation/Referral	Yes ☐	No ☐

Signed By_____

Session Notes

Date of Service _____ Student's Medicaid #_____

Start Time _____ Group or Individual _____

Stop Time _____ Signed By_____

Total Billable Minutes _____

Total Time Concurs w/IEP	Yes ☐	No ☐
Multiple Sessions Initialed	Yes ☐	No ☐

Activity Performed (i.e. direct testing, student observation, direct medical service, etc.):

_____

Comments

Service #2

Service Provided _____

Service in IEP	Yes ☐	No ☐
Service Ticket	Yes ☐	No ☐
Service Ticket Signed	Yes ☐	No ☐
Units Match Billing	Yes ☐	No ☐
Date Matches Billing	Yes ☐	No ☐
Attendance Matches Billing	Yes ☐	No ☐
Group or Individual	Group ☐	Individual ☐

Provider Name _____

Current License/Certification on File Yes ☐ No ☐

Type of License/Certification _____

IEP--Description of Medical Necessity:

_____

_____

_____

_____

Active License/Certification Yes ☐ No ☐
Meets Requirements Yes ☐ No ☐
Supervision Required Yes ☐ No ☐
Name of Supervisor _____
Supervisor's Type of License/Certification _____
Writing Evaluation Report Billed Yes ☐ No ☐

OT/PT Prescription/Speech Therapy Referral

Prescription Yes ☐ No ☐
Evaluation/Referral Yes ☐ No ☐
Provider Signature Yes ☐ No ☐
Provider Name Listed Yes ☐ No ☐
Valid Evaluation/Referral Yes ☐ No ☐
Signed By_____

Session Notes

Date of Service _____ Student's Medicaid #_____

Start Time _____ Group or Individual _____

Stop Time _____ Signed By_____

Total Billable Minutes _____

Total Time Concurs w/IEP Yes ☐ No ☐
Multiple Sessions Initialed Yes ☐ No ☐
Activity Performed (i.e. direct testing, student observation, direct medical service, etc.):

_____

Comments

Service #3

Service Provided _____ **IEP--Description of Medical Necessity:**

Service in IEP Yes ☐ No ☐
Service Ticket Yes ☐ No ☐
Service Ticket Signed Yes ☐ No ☐
Units Match Billing Yes ☐ No ☐
Date Matches Billing Yes ☐ No ☐

_____

_____

Attendance Matches Billing Yes ☐ No ☐ _____

Group or Individual Group ☐ Individual ☐

Provider Name _____ _____

Current License/Certification on File Yes ☐ No ☐

Type of License/Certification _____

Active License/Certification Yes ☐ No ☐

Meets Requirements Yes ☐ No ☐

Supervision Required Yes ☐ No ☐

Name of Supervisor _____

Supervisor's Type of License/Certification _____

Writing Evaluation Report Billed Yes ☐ No ☐

OT/PT Prescription/Speech Therapy Referral

Prescription Yes ☐ No ☐

Evaluation/Referral Yes ☐ No ☐

Provider Signature Yes ☐ No ☐

Provider Name Listed Yes ☐ No ☐

Valid Evaluation/Referral Yes ☐ No ☐

Signed By_____

Session Notes

Date of Service _____ Student's Medicaid #_____

Start Time _____ Group or Individual _____

Stop Time _____ Signed By_____

Total Billable Minutes _____

Total Time Concurs w/IEP Yes ☐ No ☐

Multiple Sessions Initialed Yes ☐ No ☐

Activity Performed (i.e. direct testing, student observation, direct medical service, etc.):

_____

Comments

Service #4

Service Provided _____

Service in IEP Yes ☐ No ☐
Service Ticket Yes ☐ No ☐
Service Ticket Signed Yes ☐ No ☐
Units Match Billing Yes ☐ No ☐
Date Matches Billing Yes ☐ No ☐
Attendance Matches Billing Yes ☐ No ☐
Group or Individual Group ☐ Individual ☐

Provider Name _____

Current License/Certification on File Yes ☐ No ☐
Type of License/Certification _____
Active License/Certification Yes ☐ No ☐
Meets Requirements Yes ☐ No ☐
Supervision Required Yes ☐ No ☐
Name of Supervisor _____
Supervisor's Type of License/Certification _____
Writing Evaluation Report Billed Yes ☐ No ☐

IEP--Description of Medical Necessity:

_____

_____

_____

_____

OT/PT Prescription/Speech Therapy Referral

Prescription Yes ☐ No ☐
Evaluation/Referral Yes ☐ No ☐
Provider Signature Yes ☐ No ☐
Provider Name Listed Yes ☐ No ☐
Valid Evaluation/Referral Yes ☐ No ☐
Signed By_____

Session Notes

Date of Service _____

Start Time _____

Stop Time _____

Total Billable Minutes _____

Total Time Concurs w/IEP Yes ☐ No ☐
Multiple Sessions Initialed Yes ☐ No ☐

Student's Medicaid #_____

Group or Individual _____

Signed By_____

Activity Performed (i.e. direct testing, student observation, direct medical service, etc.):

_____

Comments

Specialized Transportation Service

Related Service _____

Bus Log	Yes ☐	No ☐
Attendance Log	Yes ☐	No ☐
Service in IEP	Yes ☐	No ☐
SHARS Provided on Same Day	Yes ☐	No ☐

Description of Medical Necessity in IEP:

_____

_____

_____

SECTION III. SHARS COST REPORT

To be added at a later date.

TEXAS EDUCATION AGENCY
SHARS Review Checklist
Self-Monitoring Tool
INSTRUCTIONS

SECTION I. Demographic Information

Enter the corresponding information for each item in the table from left to right.

School District: *Enter the name of the school district*

Student Name: *Enter the student's name*

Special Education Director/Administrator: Enter the name of the Special Education Director or Administrator

Medicaid Number: *Enter the student's Medicaid number*

Contact Person: *Enter the name of the contact person*

Student SSN (Last 4 digits): *Enter the last four digits of the student's social security number*

Contact Telephone Number: *Enter the contact person's telephone number*

Contact Fax Number: *Enter the contact person's fax number*

Time Period of Self Monitoring: *Enter date range of the time period for which the Self Monitoring covers.*

SECTION II. SHARS Services

Enter the corresponding information in each blank from left to right.

Admission, Review, and Dismissal (ARD)

Date IEP is signed: *Enter the date the IEP was signed.*

School Year: *Enter the calendar school year.*

Date Range of IEP: *Enter the date range the IEP is effective.*

Grade: *Enter the grade of the student.*

IEP Signed By: *Enter the name of the person that signed the IEP.*

Number of SHARS Services in IEP: *Enter the number of SHARS services authorized in the IEP.*

Service # 1 through #4

Enter or respond to the corresponding information for **each** School Health Related Service (SHARS) provided to the student. (For additional services, copy and paste the "Services Provided" section through the Comments box onto a new page.)

Service Provided: *Enter the type of service provided from the list below.*

Eligible SHARS services are listed below.

- Audiology Services
- Counseling
- Nursing Services
- Physician Services
- Occupational Therapy (OT)
- Physical Therapy (PT)
- Psychological Services, including assessments (procedure code 96101)
- Speech Therapy Services (ST)
- Personal Care Services
- Specialized Transportation in a school setting

IEP -- Description of Medical Necessity Documentation: *Enter the description documented in the IEP as the medical necessity of the SHARS service.*

Service in IEP: *Check "Yes or No" if the service is documented in the IEP.*

Service Ticket: *Check "Yes or No" if a service ticket is on file.*

Service Ticket Signed: *Check "Yes or No" if the service ticket includes an original signature.*

Units Match Billing: *Check "Yes or No" if the units of service provided match the billing submitted.*

Date Matches Billing: *Check "Yes or No" if the date of service matches the billing submitted.*

Attendance Matches Billing: *Check "Yes or No" if the student's attendance record matches the billing submitted for the day of service provided.*

Group or Individual: *Check "Group or Individual" for the type of setting under which the service was provided.*

Provider Name: *Enter the name of the service provider as it appears on the license/certification.*

Current License/Certification on File: *Check "Yes or No" if current license/certification of service provider is on file.*

Type of License/Certification: *Enter the type of license/certification of the service provider.*

Active License/Certification: *Check "Yes or No" if the effective and expiration dates of the provider's current license/certification covers the date of service provided.*

Meets Requirements: *Check "Yes or No" if provider's license/certification meets SHARS requirements to be a service provider.*

Supervision Required: *Check "Yes or No" if the person that provided services requires supervision by a licensed/ certified service provider. Enter N/A if not applicable.*

Name of Supervisor: *Enter the name of the supervisor if the person that provided services requires supervision by a licensed/ certified service provider. Enter N/A if not applicable.*

Supervisor's Type of License/Certification: *Enter the type of license/certification of the supervisor. Enter N/A if not applicable.*

Writing Evaluation Report Billed: *Check "Yes or No" if any time for writing the evaluation report was billed. Enter N/A if not applicable.*

OT (Occupational Therapy)/PT (Physical Therapy) Prescription/Speech Therapy Referral

Prescription: *Check "Yes or No" if the prescription/referral for the service provided is on file. Skip if not applicable.*

Evaluation/Referral: *Check "Yes or No" if the evaluation/referral for the service provided is on file. Skip if not applicable.*

Provider Signature: *Check "Yes or No" if the provider's signature is on the prescription/referral.*

Provider Name Listed: *Check "Yes or No" if the provider's name is clearly listed on the prescription/referral.*

Valid Evaluation/Referral: *Check "Yes or No" if the date of the prescription/referral covers the date of service provided.*

Ending Date: *Enter "Yes or No" if the ending date of eligibility of the service provided is listed on the prescription/referral.*

Signed By: *Enter the name and title of the person that signed the prescription, evaluation, or referral form.*

Session Notes

Date of service: *Enter the date of service included in the session notes.*

Student's Medicaid #: *Enter the student's Medicaid number.*

Start Time: *Enter the start time of the service provided.*

Group or Individual: *Enter "Group or Individual" if the service provided was in an individual or group setting.*

Stop Time: *Enter the stop time of the service provided.*

Signed By: *Enter the name and title of the person that signed the session notes.*

Total Billable Minutes: *Enter the total billable minutes for the service provided.*

Total Time Concurs w/IEP: *Check "Yes or No" if the total time of session concurs with time authorized in IEP/ARD.*

Activity Performed: *Enter "Yes or No" if a description of the activity performed is included in the session notes.*

Student Observation: *Enter "Yes or No" if a student observation is documented in the session notes..*

Multiple Sessions Initialed: *Check "Yes or No" If each entry of multiple sessions documented is initialed by provider.*

Activity Performed: *Enter description of activity performed (i.e. direct testing, student observation, direct medical service, etc.).*

Comments

Enter additional information as needed in space provided.

Specialized Transportation Service

If Specialized Transportation Services were provided, enter a description of the related service and respond to all corresponding information for service provided.

Related Service: *Enter a description of the related service requiring specialized transportation service.*

Bus Log: *Check "Yes or No" if the student's name is listed on the bus log.*

Attendance Log: *Click "Yes or No" if attendance log matches date of trip billed.*

Service in IEP: *Click "Yes or No" if specialized transportation service is prescribed in the IEP for related service.*

Session Notes: *Click "Yes or No" if session notes indicate related service was provided on the same day of bus trip.*

SHARS Provided on Same Day: *Enter "Yes or No" if another SHARS service was provided on the day that Specialized Transportation Service was provided.*

Description of Medical Necessity in IEP: *Enter the description documented in the IEP authorizing the medical necessity of the Specialized Transportation Service and the specialized bus adaptation required by the student.*

SECTION III. SHARS COST REPORT

To be added at a later date