

PA SBAP SELF-AUDIT RECORD REVIEW DOCUMENT

Student Name: _____

DOB: _____

Service: _____

Service Date: _____

LEA Reviewer: _____

Date of Review: _____

1. Parental Consent/Notification Form:

Date Signed _____

- | | | |
|--|-----|----|
| • Student's name on form: | Yes | No |
| • Signed and dated by parent/guardian: | Yes | No |
| • Permission to bill MA given: | Yes | No |
| • LEA listed on form: | Yes | No |

2. IEP:

Duration _____ to _____

- | | | |
|----------------------------------|-----|----|
| • LEA Name: | Yes | No |
| • IEP in File: | Yes | No |
| • Group vs. Individual: | Yes | No |
| • Health-related service listed: | Yes | No |
| • Frequency: | Yes | No |
| • Duration: | Yes | No |
| • Valid for Date of Service: | Yes | No |

3. Medical Authorization:

Date Signed _____

- | | | |
|---|-----|----|
| • Authorization for health-related service: | Yes | No |
| • Date of Service covered by authorization: | Yes | No |
| • Frequency/duration matches IEP: | Yes | No |
| • Signer has active license: | Yes | No |
| • Group vs. Individual: | Yes | No |
| • Signed and Dated: | Yes | No |

This self-audit tool is provided to aid in reviewing LEA documentation retention practices.

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4. Service Provider Log (Health Related Services):

- Student Name: Yes No
- Date of Birth: Yes No
- Diagnosis: Yes No
- Dated: Yes No
- Type of service: Yes No
- Length of service (time in & time out): Yes No
- Service minutes logged do not exceed service minutes authorized: Yes No
- Legible (paper log): Yes No
- Fully describes service: Yes No
- Services are *not* educational in nature (PCA): Yes No
- Provider signature, date, and title: Yes No
- Supervisor signature and date, if needed: Yes No
- If “on behalf of,” original log in file: Yes No

5. Service Provider Log (Specialized Transportation, if applicable):

- LEA Name: Yes No
- Student Name: Yes No
- Date of Birth: Yes No
- Dated (Month and Year): Yes No
- Driver/Bus Company Name (who is logging?): Yes No
- Type of service: One-way Round-trip
- Legible (paper log): Yes No
- LEA Attestation signature: Yes No
- Daily trip Log on file: Yes No

6. Attendance Records:

- Student in attendance on Date of Service: Yes No
- Service Provider in attendance on Date of Service: Yes No

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7. Service Provider List:

- | | | |
|---|-----|----|
| • License/Certification number: | Yes | No |
| • License/Certification current on Date of Service: | Yes | No |
| • First aid certified on Date of Service (PCA): | Yes | No |
| • CPR certified on Date of Service (PCA): | Yes | No |

8. Preclusion/Exclusion:

- | | | |
|---|-----|----|
| • Policy and procedures in place (See MA Bulletin 99-11-05): | Yes | No |
| • List of providers, Superintendents or any staff that participate with SBAP: | Yes | No |
| • LEIE list checked monthly: | Yes | No |
| • SAM checked monthly: | Yes | No |
| • Medichex list checked monthly: | Yes | No |
| • Monthly preclusion/exclusion checks documented: | Yes | No |

Corrective Action Needed:

Additional Comments: