New York City Department of Education
JOEL I. KLEIN , Chancellor
DFO-Bureau of Contract Aid Tel:(718)-935-2161
Billing Form for Preschool Related Service Providers

Vendor Invoice #_____ **Page**____**of**____
(optional)
Month_____**Year**____

Section 1: Student Information

Student's Name:_____
Last First

NYC ID # _____

Date of Birth:____/____/____Home District:_____

Related Service:_____

Recommendation on IEP:
Frequency:_____ Duration:_____ Group Size____ Lang._____

( ) Check here if student was assigned to you/agency by CPSE after being selected from the NYC Municipality List of Approved Preschool Related Service Providers

OR

( ) Check here if student was assigned to your agency as a result of being awarded the related service contract through the RFP process.

Contract # _____

Location Where Services are Provided:_____

_____Comments:_____

Section 2: Provider Information

Provider's
Name _____

Address:_____

_____

S.S.#(required)_____

Telephone:_____

Section 3: AGENCY INFORMATION

Name: Therapy Pros O.T. & Educational Services, PLLC

Address: 962 Manor Road
Staten Island NY 10314

Telephone: 718-982-5944

Agency Rep (print name)_____

Fed. Tax ID: 77-0679785

Section 4 :Service Provision

DATE	RCV Group Size	Start Time	End Time	Signature of parent/Principal or designee verifying that service has actually been provided at the times indicated	DATE	RCV Group Size	Start Time	End Time	Signature of parent/Principal or designee verifying that service has actually been provided at the times indicated
1					17				
2					18				
3					19				
4					20				
5					21				
6					22				
7					23				
8					24				
9					25				
10					26				
11					27				
12					28				
13					29				
14					30				
15					31				
16									

Section 5: Certification for the Provision of Services:

I hereby certify that I have served in the Related Service Program on the dates and for the duration indicated herein. I understand that any material misrepresentation of fact provided by me on this form may result in criminal action.

Total # of Sessions:_____ Rate:_____

Total Amount Due:_____

_____ _____
Signature of Provider (original) Date Signature of Agency/School Representative (original) Date

***The DOE will only accept Billing Forms that have instructions for completion on the reverse side**