NYC Department of Education

Christopher McKay, *Director*
Bureau of Non-Public School Payables

RSA-7a Billing Form for Independent Providers of Related Services (RSA)

Vendor Invoice # _____ Month: _____ Year: _____

Section 1: Student Information

Student's Name: _____
Last First
NYC ID #: _ _ _ _ _ _ _ _ _
Date of Birth: _____/_____/_____
Service District: _____
Related Service: _____
Recommendation on IEP:

_____ _____ _____ _____
Frequency Duration Group Size Language

Location where services are provided (Home, School or Place of Business): _____

Comments:

Section 2: Provider Information

Provider's Name: _____
Address: _____
_____
Telephone #: ( ) _ _ _ - _ _ _ _
Social Security #: _ _ _ - _ _ - _ _ _ _
(Required)

Section 3: Agency Information

Agency Name: Therapy Pros, LLP
Address: 962 Manor Road
Staten Island NY 10314
Telephone #: (718) 9 8 2 - 5 9 4 4
Federal Tax ID #: 4 3 1 - 9 7 - 0 6 3 9
(Required)

Section 4: Service Provision

DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE	DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE
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									

Total # of Sessions: _____ Rate: _____ Total Amount Due: _____

Section 5:Provider Certification for provision of Services

I hereby certify that I have provided related services on the dates and for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the Board of Education and that any material misrepresentation may subject me to criminal, civil and/or administrative action.

_____
Signature of Provider Date

Parent/Principal/Guardian Certification

By my signature I acknowledge that I have reviewed this Related Service billing form and that, to the best of my knowledge, these sessions were provided as indicated.

_____
Signature of Parent/Guardian/Principal Date