ANYTHING HIGHLIGHTED IN YELLOW IS FILLED IN BY THE PROVIDER

ANYTHING HIGHLIGHTED IN PINK PLEASE LEAVE BLANK

SAMPLE

NYC Department of Education

Impartial Hearing Order Implementation Unit
Division of Specialized Instruction and Student Support

VENDOR MONTHLY SERVICE INVOICE FORM

SETSS

CASE INFORMATION

Case Number: LEAVE BLANK
Service Period: Month MARCH Year 2025
Today's Date: APRIL 5, 2025
Service Type: SETSS
Service Location: HOME
Invoice Number: N/A

STUDENT INFORMATION

Name: ROBERT PLACKARD
Student ID/OSIS #: 000-111-222
Home Address: 25 TEACHER KANE SCHOOLVILLE NY 55545

AGENCY/INDEPENDENT PROVIDER INFORMATION

Name: NEW YORK THERAPY PLACEMENT SERVICES, INC.
TIN #/SSN #: LEAVE BLANK
Address: 500 BI-COUNTY BLVD SUITE 450, FARMINGDALE, NY 11735
Email Address: THERAPYNYC@NYTPS.COM
Telephone Number: (718) 264 - 1640
Service Provider Name (**FOR AGENCIES ONLY**): JANE SMITHNER

DATE OF SERVICE	START TIME	END TIME	NO. OF SESSSION	DATE OF SERVICE	START TIME	END TIME	NO. OF SESSION	DATE OF SERVICE	START TIME	END TIME	NO. OF SESSION
3-1-25	3:00pm	4:00pm	1	3-12-25	2:30pm	3:15pm	.75	3-27-25	student	absent	
3-2-25	12:00pm	1:30pm	1.5	3-13-25	3:00pm	5:00pm	2	3-28-25	2:00pm	4:15pm	2.25
				3-14-25	teacher	absent					
3-4-25	3:00pm	4:15pm	1.25					3-31-25	3:20pm	6:20pm	3
3-5-25	3:00pm	4:30pm	1.5	3-17-25	2:30pm	4:30pm	2				
3-6-25	2:45pm	3:45pm	1	3-18-25	3:00pm	4:45pm	1.75				
3-7-25	3:15pm	4:30pm	1.25	3-16-25	3:05pm	5:05pm	2				
3-10-25	3:00pm	4:45pm	1.75	3-25-25	3:00pm	4:30pm	1.5				
3-11-25	student	absent		3-26-25	2:45pm	5:15pm	2.5				

Mandated Session Length: _____ **Total Number of Sessions:** _____ **Rate Per Session: $**_____ **Total Amount Due: $**_____
(e.g. 30/45/60 minutes)

LEAVE ABOVE BOXES BLANK - LENGTH,SESSIONS, RATE, AND DUE

I hereby certify that I have provided services on the dates for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the NYC Department of Education (DOE) and is relied upon by the DOE to make payment and any material misrepresentation may subject me to criminal, civil, and/or administrative action.

Provider Full Name (please print): JANE SMITHNER
Provider Signature: Jane Smithner Date: 4/3/25

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

FOR SERVICES PROVIDED AT HOME/AGENCY:

Parent Full Name (please print): JOHN PLACKARD
Parent Signature: John Plackard
Date: 9-3-25

FOR SERVICES PROVIDED AT SCHOOL:

Principal Full Name (please print): _____
Principal Signature: _____
Date: _____

Submit original invoices to: **New York City Department of Education**
Impartial Hearing Order Implementation Unit
65 Court Street – Room 1503
Brooklyn, New York 11201

PLEASE NOTE: FAILURE TO COMPLETE ALL FIELDS MAY RESULT IN THE DELAY OF PAYMENT. **Revised: 9/19/2019**