Department of Education

Division of Financial Operations
Non Public School Payables
65 Court Street, room 1001
Brooklyn, NY 11201

Reset Form

Related Service Billing Form

Month: _____ Year: _____

Section 1: Students Information

Students Name: _____ Date of Birth: _____

NYC ID #: _____ Service District: _____ Related Service: _____

Recommendation on IEP:

Hourly Rate: _____ Frequency: _____ Duration: _____ Group Size: _____ Language: _____

Location of Services Provided
Home, School or Place of Buisness _____

Section 2: Provider Information

Providers Name: _____ Social Security #: _____

Address: _____

Telephone # : _____ E- Mail Address: _____

Section 3: Agency Information

Agency Name: New York Therapy Placement Services, Inc. Federal Tax ID #: 11-3139640

Address: 500 Bi-County Blvd. #450, Farmingdale, NY 11735

Telephone # : 718-264-1640 E- Mail Address: therapynyc@nytps.org

Section 4: Service Provision

Date	Frequency	Start Time	End Time	Group Size

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

Section 5: Certification

I hereby certify that I have provided related services on the dates 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

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