



Department of
Education

Division of Financial Operations
Bureau of Non-Public School Payables — Preschool Unit
Tel.: (718) 935-2161

SAMPLE

Vendor Invoice #: _____

Month: May Year: 2021

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BILLING FORM FOR PRESCHOOL RELATED SERVICE PROVIDERS

Section 1: Student Information

Student's Name (Last, First): Smith, Jane
 NYC ID#: 123-456-789
 Date of Birth: 8/24/14 Home District: 28
 Related Service: Counsening
 IEP Recommendation: _____
 Frequency: 1 Duration: 30
 Group Size: 1 Language: ENG
 Location of Service: School
 Student Assignment (Check one):
☐ Student was assigned to you/agency by CPSE after being selected from the NYC Municipality List of Approved Preschool Related Service Providers.
☒ Student was assigned to your agency as a result of being awarded the related service contract through the RFP process.
 Contract # (If applicable): 9773252
 Comments: _____

Section 2: Provider Information

Provider's Name (Last, First): Rose, Sally
 Address: 123 West 45th Street
New York, NY 10036
 Telephone #: 646-123-4567 SSN (Required): 123-45-6789

Section 3: Agency Information

Agency Name: New York Therapy Placement Services, Inc.
 Agency Address: 500 Bi-County Blvd #450
Farmingdale, NY 11735
 Agency Contact (Last, First): Nemeth, Daniel
 Federal Tax ID#: 11-3139640
 Telephone #: (718) 264-1640 Email: therapynyc@nytps.org

Section 4: Service Provision

Date	RCV Group Size	Start Time	End Time	Signature of parent/principal/designee verifying that service was provided as indicated	Date	RCV Group Size	Start Time	End Time	Signature of parent/principal/designee verifying that service was provided as indicated
1					17				
2					18				
3					19				
4					20				
5	1	1:00p	1:30p	School Signature	21				
6					22				
7					23	1	1:00p	1:30p	School Signature
8					24				
9	1	1:00p	1:30p	School Signature	25				
10					26				
11					27				
12					28				
13					29				
14					30	1	1:00p	1:30p	School Signature
15					31				
16	1	1:00p	1:30p	School Signature					

Section 5: Certification of Service Provision

I hereby certify that I provided related services on the dates and for the durations indicated above. I understand that any material misrepresentation of fact provided by me on this form may result in criminal action.

LEAVE BLANK FOR OFFICE USE ONLY

Total # of Sessions: BLANK Rate: \$ BLANK

Total Amount Due: \$ BLANK

LEAVE BLANK FOR OFFICE USE ONLY

PROVIDER SIGNS HERE

DATE HERE

SCHOOL SIGNS HERE

DATE HERE

Signature of Provider (original required)

Date

Signature of Agency/School Representative
(if applicable; Original required)

Date