

## Independent Providers of Related Service Billing Form: RSA -7A

Month: \_\_\_\_\_ Year: \_\_\_\_\_

<b>Section 1: Students Information</b>					
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 Business _____					

<b>Section 2: Provider Information</b>	
Providers Name: _____	Social Security #: _____
Address: _____	
Telephone #: _____	E- Mail Address: _____

<b>Section 3: Agency Information</b>	
Agency Name: _____	Federal Tax ID #: _____
Address: _____	
Telephone #: _____	E- Mail Address: _____

Section 4: Service Provision				
Date	Frequency	Start Time	End Time	Group Size
Total # of Sessions: _____		Rate: _____	Total Amount Due: _____	

<b>Section 5: Certification</b>	
<p>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.</p>	<p>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.</p>
_____ Signature of Provider	_____ Signature of Parent/Guardian/Principal
_____ Date	_____ Date

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