Payroll # ______

Pay cycle ______

All About Kids

Evaluations & Therapy

255 Executive Drive Ste. LL102 Plainview, NY 11803

Attn: Finance Department

Tel: 516-576-0962

Fax: 516-349-0961

Toll Free: 1877333kids

NYC Early Intervention Services Monthly Summary Form

DUE DATE - 3RD OF NEXT MONTH

Independent Contractors: Please fax or scan and email this form, your personal invoice and notes.

Employees: Please mail or hand in ALL ORIGINAL PAPERWORK.

Therapist: ______________________ Business Name (if applicable) ______________________

Address: ______________________

City______________ State___ zip ______

Mobile#____________ Home#____________

Email ______________________

Billing Month _______201__

SERVICE TYPE: SP SPED/ABA OT PT SW PSYCH OTHER_______ (CIRCLE ONE)

Child's Name ______________________

(CIRCLE ONE) BROOKLYN-EI BRONX-EI MANHTN-EI QUEENS-EI

(__________) (__________) X (__________) = __________

Authorized length of session Number of Sessions Session Rate Amount Due

Child's Name ______________________

(CIRCLE ONE) BROOKLYN-EI BRONX-EI MANHTN-EI QUEENS-EI

(__________) (__________) X (__________) = __________

Authorized length of session Number of Sessions Session Rate Amount Due

Child's Name ______________________

(CIRCLE ONE) BROOKLYN-EI BRONX-EI MANHTN-EI QUEENS-EI

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(CIRCLE ONE) BROOKLYN-EI BRONX-EI MANHTN-EI QUEENS-EI

(__________) (__________) X (__________) = __________

Authorized length of session Number of Sessions Session Rate Amount Due

TOTAL AMOUNT $______________

Page ____ of ____