



Billing Form for Preschool Related Service Providers

Vendor Invoice # _____ Page _____ of _____

Month _____ Year _____

Section 1: Student Information

Student's Name: _____
Last First

NYC ID # _____

Date of Birth: ____/____/____ Home District: _____

Related Service: _____

Recommendation on IEP:

Frequency: _____ Duration: _____ Group Size _____ Lang. _____

() Check here if student was assigned to you/agency by CPSE after being selected from the NYC Municipality List of Approved Preschool Related

Service Providers

OR

() Check here if student was assigned to your agency as a result of being awarded the related service contract through the RFP process.

Contract # _____

Location Where Services are Provided: _____

Comments: _____

Section 2: Provider Information

Provider's Name _____

Address: _____

S.S.#(required) _____

Telephone: _____

Section 3: Agency Information

Name: Mid Island Therapy Associates, LLC d/b/a All About Kids

Address: 255 Executive Drive, Suite LL 102
Plainview, NY 11803

Telephone: 516-576-0962 email : _____

Agency Rep (print name) Himanshu Markan

Fed. Tax ID: 113052361

Section 4 :Service Provision

| DATE | RCV Group Size | Start Time | End Time | Signature of parent/Principal or designee verifying that service has actually been provided at the times indicated | DATE | RCV Group Size | Start Time | End Time | Signature of parent/Principal or designee verifying that service has actually been provided at the times indicated |
|------|----------------|------------|----------|--|------|----------------|------------|----------|--|
| 1 | | | | | 17 | | | | |
| 2 | | | | | 18 | | | | |
| 3 | | | | | 19 | | | | |
| 4 | | | | | 20 | | | | |
| 5 | | | | | 21 | | | | |
| 6 | | | | | 22 | | | | |
| 7 | | | | | 23 | | | | |
| 8 | | | | | 24 | | | | |
| 9 | | | | | 25 | | | | |
| 10 | | | | | 26 | | | | |
| 11 | | | | | 27 | | | | |
| 12 | | | | | 28 | | | | |
| 13 | | | | | 29 | | | | |
| 14 | | | | | 30 | | | | |
| 15 | | | | | 31 | | | | |
| 16 | | | | | | | | | |

Section 5: Certification for the Provision of Services:

I hereby certify that I have served in the Related Service Program on the dates and for the duration indicated herein. I understand that any material misrepresentation of fact provided by me on this form may result in criminal action

Total # of Sessions: _____ Rate: _____

Total Amount Due: _____

Signature of Provider (original) _____ Date _____

Signature of Agency/School Representative (original) _____ Date _____

+Instructions for Completing the Billing Form for Preschool Related Service Providers

Indicate Vendor Invoice # (optional), Page # (i.e. 1 of 1, 1 of 56), month and year service provided.

Section 1: Student Information

- ◆ Name of student (last name, first name)
- ◆ NYC identification number of student
- ◆ Date of birth of the student (mm/dd/yy)
- ◆ Home District of student
- ◆ Type of related service provided
- ◆ Indicate the frequency, duration, group size and language (if appropriate) as indicated on the student's Individualized Education Program (IEP)
- ◆ () Check the appropriate field for student assignment.

If student was assigned to you/agency by CPSE after being selected from the NYC Municipality List of approved Preschool Related Service Providers.

OR Student was assigned to your agency as a result of being awarded the related service contract through the RFP process. **Provide the Contract #.**

- ◆ Location where service was provided
 - ◆ In the comment section, indicate exceptions to the location identified above providing the date and where the service was provided.
-

Section 2: Provider Information

- ◆ Name of provider (last name, first name)
 - ◆ Address of provider
 - ◆ **Provider's social security number – Required on all invoices**
 - ◆ Provider's telephone number
-

Section 3: Agency Information (This section must be filled out for any services that are provided by an agency.)

- ◆ Name of Agency
 - ◆ Agency's address
 - ◆ Agency's telephone number
 - ◆ Agency Representative (print name)
 - ◆ Federal Tax Identification Number
-

Section 4: Service Provision

You may not bill for services in excess of the frequency/duration of services specified on the IEP.

Next to the date service was provided during the month indicate the following:

- ◆ Receiving group size- This is the actual group size for which service has been provided (e.g., 2:1 students to therapist)
 - ◆ Start time of the specific session
 - ◆ End time of the specific session
 - ◆ Make-up sessions may be provided only in accordance with the instructions provided in the Agreement
 - ◆ Signature of Parent/Principal or Designee verifying that service has actually been provided at the times indicated
 - ◆ Total number of billing sessions provided for all students served. (Regular and makeup sessions)
 - ◆ Contracted rate (To be paid at the correct rate for a psychologist or registered nurse, a copy of the provider's license must be submitted with the initial billing for the fiscal year)
 - ◆ Total amount due
-

Section 5: Certification for Provision of Services

- ◆ Original signature (no photocopies) of provider attesting that information is correct and accurate and all services have been provided. The person that actually provided the service must sign this form.
 - ◆ Date the billing form was signed by the provider
 - ◆ Original co-signature (no photocopies) of the Agency Representative attesting that information is correct and accurate must sign this form
 - ◆ Date the billing form was signed by Representative
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Notes:

- ◆ The approved **two-sided** New York City Department of Education Billing Form must be used when billing for services. Invoices without the instructions for completion on the reverse side will not be accepted
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Submission of Billing Forms: Please submit completed billing forms to:
Bureau of NPSP
Preschool Unit
65 Court Street Room 1503
Brooklyn, New York 11201

Telephone: (718) 935-2161 Fax: (718) 935-3801
Please be advised that invoices submitted with incomplete or illegible information will be returned. Effective FY 10, the deadline for invoice submission is the 31st of October.