



Expanded Hearing Order Implementation Unit
Division of Special Education and Student Support

YES DOE MONTHLY SERVICE INVOICE FORM

CASE INFORMATION

Case Number: _____ Service Period: Month _____ Year _____ Today's Date: _____
Service Type: _____ Service Location: _____ Provider's Name: _____

STUDENT INFORMATION

Name: _____ Student ID/OSIS #: _____
Home Address: _____

AGENCY-INDEPENDENT PROVIDER INFORMATION

Name: _____ ID# (OSIS) #: _____
Address: _____
Mailing Address: _____ Telephone Number: () _____
Service Provider Name (FROM ATTENTION ONLY): _____

DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION

Total Number of Hours: _____ Rate Per Hour: \$ _____ Total Amount Due: \$ _____

I hereby certify that I have provided services on the dates for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the NYC Department of Education (DOE) and is relied upon by the DOE to make payment and any material misrepresentation may subject me to criminal, civil, and/or administrative action.

Provider Full Name (please print): _____
Provider Signature: _____ Date: _____

By my signature, I acknowledge that I have reviewed this billing form and that, to the best of my knowledge, these services were provided as indicated.

FOR SERVICES PROVIDED AT HOME:

Parent Full Name (please print): _____
Parent Signature: _____
Date: _____

FOR SERVICES PROVIDED AT SCHOOL:

Principal Full Name (please print): _____
Principal Signature: _____
Date: _____