



Department of
Education

Carmen Fariña, Chancellor

Impartial Hearing Order Implementation Unit
Division of Specialized Instruction and Student Support

VENDOR MONTHLY SERVICE INVOICE FORM

CASE INFORMATION

Case Number: _____

Service Period: Month _____ Year _____

Today's Date: _____

Service Type: _____

Service Location: _____

Invoice Number: _____

STUDENT INFORMATION

Name: _____

Student ID/OSIS #: _____

Home Address: _____

AGENCY/INDEPENDENT PROVIDER INFORMATION

Name: _____

EIN #/SSN #: _____

Address: _____

Email Address: _____ Telephone Number: (____) _____ - _____

Service Provider Name (FOR AGENCIES 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 sessions 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: _____