Department of Education

Christopher McKay, *Director*
Bureau of Non-Public School Payables

RSA-7a Billing Form for Independent Providers of Related Services (RSA)

Vendor Invoice # _____ Month: March Year: 2015

Section 1: Student Information

Student's Name: ACOSTA , JOSHUA
Last First
NYC ID #: 220943732
Date of Birth: _____/_____/_____
Service District: _____
Related Service: Speech
Recommendation on IEP:
2 30 2 EN
F requency Duration Group Size Language
Location where services are provided (Home, School or Place of Business): School
Comments:

Section 2: Provider Information

Provider's Name: Timothy Pagel
Address: 134 West 26th Street, Suite # 602
New York, NY 10001
Telephone #: 212-604-9360
Social Security #: 454893990
(Required)

Section 3: Agency Information

Agency Name: City Sounds of NY
Address: 134 West 26th Street, Suite # 602
New York, NY 10001
Telephone #: 212-604-9360
Federal Tax ID #: 270698698
(**Required**)

Section 4: Service Provision

DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE	DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE
1					17				
2	1	02:30 PM	03:00 PM	1	18				
3					19				
4	1	02:30 PM	03:00 PM	1	20				
5					21				
6					22				
7					23				
8					24				
9					25				
10					26				
11					27				
12					28				
13					29				
14					30				
15					31				
16									

Total # of Sessions: 4 Rate: Total Amount Due:

Section 5:Provider Certification for provision of Services

I hereby certify that I have provided related services on the dates and 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.

Signature of Provider Date

Parent/Principal/Guardian Certification

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.

Signature of Parent/Guardian/Principal Date