



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

Vendor Invoice # _____ Month: _____ Year: _____

Section 1: Student Information

Student's Name: _____

Last First

NYC ID #: _____

Date of Birth: ____/____/____

Service District: _____

Related Service: _____

Recommendation on IEP:

Frequency Duration Group Size Language

Location where services are provided (Home, School or Place
of Business): _____

Comments: _____

Section 2: Provider Information

Provider's Name: _____

Address: _____

Telephone #: _____

Social Security #: _____
(Required)

Section 3: Agency Information

Agency Name: _____

Address: _____

Telephone #: _____

Federal Tax ID #: _____
(Required)

Section 4: Service Provision

DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE	DATE	FREQUENCY	START TIME	END TIME	GROUP SIZE
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									

Total # of Sessions: _____

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.

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 Provider

Date

Signature of Parent/Guardian/Principal

Date