



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

Vendor Invoice # _____ Month: February Year: 2015

Section 1: Student Information

Student's Name: WICKWARE, WILLIAM

Last First

NYC ID #: 223522905

Date of Birth: 2 / 17 / 2015

Service District: _____

Related Service: Speech

Recommendation on IEP:

2 30 8 EN

Frequency Duration Group Size Language

Location where services are provided (Home, School or Place of Business): Office - Chelsea

Comments: _____

Section 2: Provider Information

Provider's Name: Glynn Pomerantz

Address: 134 West 26th Street, Suite # 602

New York, NY 10001

Telephone #: 212-604-9360

Social Security #: 589608261
(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					18				
3					19				
4					20	1	03:30 PM	04:00 PM	1
5					21				
6	1	03:30 PM	04:00 PM	1	22				
7					23				
8					24				
9					25				
10					26				
11					27	1	03:30 PM	04:00 PM	1
12	1	02:00 PM	02:30 PM	1	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.

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