



Monthly Billing Form for Service Providers

Month: February

Year: 2015

Section 1. Student Information

Student's Name: WAITE, KEIVA

NYC ID # 208478263

Address: _____

Date of Birth: ____/____/____

Frequency: 2 Duration: 30 Group Size 1 Lang. EN

School Name & Location Address Where Services are Provided: _____

Section 2. Provider Information

Name: Carrie Deutsch

S.S.#(required): 050783911

Telephone Number: 212-604-9360

Related Service: Speech

Section 3. Service Provision

Date	Start Time	End Time	Group	Signature	Date	Start Time	End Time	Group	Signature
1					17				
2					18				
3	09:45 AM	10:15 AM	1		19				
4					20				
5	01:45 PM	02:15 PM	1		21				
6					22				
7					23	09:45 AM	10:15 AM	1	
8					24				
9	09:45 AM	10:15 AM	1		25	09:15 AM	09:45 AM	1	
10					26				
11	10:15 AM	10:45 AM	1		27				
12					28				
13					29				
14					30				
15					31				
16									

Section 4. Certification for the Provision of Services:

I hereby certify that I have served on the dates and durations indicted herein.

Signature of Provider

Date

Approved By: Name & Title

Signature

Date

For Internal Use

Total # of Sessions: 6

Session Time: _____

Rate: _____

Total Amount Due: _____