Department of Education

ENHANCED RATE SETSS

Provider Information

Providers Name: _____ Social Security Number: _____
Provider Address: _____
Email Address: _____ Telephone: _____

Student Information:

Students Name: _____ Date of Birth: _____ NYC ID: _____
Service District: _____ Frequency: _____Duration: _____ Hourly Rate: _____

Agency Information:

Agency Name: _____ Federal Tax ID #: _____
Agency Address: _____
Email Address: _____ Telephone: _____

Service Provision: Month _____ Year_____

Date	Frequency	Start Time	End Time	Date	Frequency	Start Time	End Time
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 Number of Sessions: _____ Rate: _____ Total Amount Due: _____

Certification:

I hereby certify that I have provided related services on the dates for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the Department of Education and that any material misrepresenting may subject me to criminal, civil and/or administrative action.

Signature of Provider: _____ Date: _____

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: _____