Impartial Hearing Order Implementation Unit
Division of Specialized Instruction and Student Support

Department of Education
Carmen Fariña, Chancellor

VENDOR MONTHLY SERVICE INVOICE FORM

CASE INFORMATION

Case Number: _____ Service Period: Month _____ Year _____ Today's Date: _____

Service Type: _____ Service Location: _____ Invoice Number: _____

STUDENT INFORMATION

Name: _____ Student ID/OSIS #: _____

Home Address: _____

AGENCY/INDEPENDENT PROVIDER INFORMATION

Name: _____ EIN #/SSN #: _____

Address: _____

Email Address: _____ Telephone Number: (_____) _____ - _____

Service Provider Name (**FOR AGENCIES ONLY):**_____

DATE OF S ERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF S ERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF S ERVICE	SESSION TIME	LENGTH OF SESSION

Total Number of Hours: _____ **Rate Per Hour: $**_____ **Total Amount Due: $**_____

I hereby certify that I have provided services on the dates for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the NYC Department of Education (DOE) and is relied upon by the DOE to make payment and any material misrepresentation may subject me to criminal, civil, and/or administrative action.

Provider Full Name (please print): _____

Provider Signature: _____ Date: _____

By my signature, I acknowledge that I have reviewed this billing form and that, to the best of my knowledge, these sessions were provided as indicated.

FOR SERVICES PROVIDED AT HOME:

Parent Full Name (please print): _____

Parent Signature: _____

Date: _____

FOR SERVICES PROVIDED AT SCHOOL:

Principal Full Name (please print): _____

Principal Signature: _____

Date: _____

Submit original invoices to: **New York City Department of Education**
Impartial Hearing Order Implementation Unit
65 Court Street - Room 1503
Brooklyn, New York 11201
ATTN: Barbara Thorpe

PLEASE NOTE: FAILURE TO COMPLETE ALL FIELDS MAY RESULT IN THE DELAY OF PAYMENT.

rev. 4/11/2014