



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

Table with 10 columns: DATE, FREQUENCY, START TIME, END TIME, GROUP SIZE. Rows 1-16.

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