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

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: _____ TIN #/SSN #: _____

Address: _____

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

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

DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION	DATE OF SERVICE	SESSION TIME	LENGTH OF SESSION

Total Number of Sessions: _____ Session Length: _____ Rate Per Session: $_____ 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/AGENCY:

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

PLEASE NOTE: FAILURE TO COMPLETE ALL FIELDS MAY RESULT IN THE DELAY OF PAYMENT. **Revised: 6/24/2019**