Revised 7/21

DUTCHESS COUNTY PRESCHOOL SPECIAL EDUCATION PROGRAM MONTHLY BILLING FORM

Please submit to: **Preschool Special Education**
C/O Dutchess County Health Department
85 Civic Center Plaza – Suite 106
Poughkeepsie, NY 12601

Agency Name: _____

Address: _____

_____

Tax ID #: _____

For Billing Period: Month: _____ **Year:** _____

Check ONLY One Box:

TUITION ☐

SEIT ☐

RELATED SERVICES ☐

EVALUATIONS ☐

TOTAL: $_____

I certify that the services billed for in this claim were provided in accordance with each individual's IEP and that all documentation was reviewed prior to submission.

Agency Representative Signature:_____ ***Date:*** _____

Printed Name: _____ ***Phone #:*** _____

FOR COUNTY USE ONLY

Preschool Office Signature/Approval _____ ***Date:*** _____