Smart Choice Therapy Inc

Special Education & Multidisciplinary Evaluation Program

1250 Hylan Blvd, Suite 9B, Staten Island, NY 10305

Phone: (718) 414-2596 Fax: (929) 274-7419

SEIT (10 Months) School Year 2022-2023 Regular Hours: 8:00 am - 6:00 pm (Mo-Fri)

	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	Total Hours
SEPTEMBER							6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	28	30	
							2.0	1.0	1.0	1.0	1.0	A	1.0	1.0	1.0	0.5	2.0	1.0	P	P	1.0	1.5	1.5	0.5	0.5	17.5
OCTOBER	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31					
	1.0	2.0	H	1.0	1.0	H	2.0	2.5	A		1.0	1.0	1.0	P	1.0	1.0	1.0	1.0	1.0	1.0	2.5					21.0
NOVEMBER		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30			
										H									H	H						0.0
DECEMBER				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30	
																					H					0.0
JANUARY	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31				
	H										H															0.0
FEBRUARY			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28				
																H										0.0
MARCH			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31	
																										0.0
APRIL						3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	
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MAY	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31			
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JUNE				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30	
																H										0.0

H - Holiday A - Student's Absence P - Provider's Absence

CHILD'S NAME: Jack Smith NYC ID: 123-456-789 LOCATION: ABC Daycare/home

THERAPIST NAME: Jane Doe SIGNATURE: JDoe TITLE: SEIT

Special Education Itinerant Teacher Services – Service Form

Student Name: Smith, Jack NYC ID#: 123-456-789

Provider Name: Doe, Jane 4410 SEIT Provider: Smart Choice Therapy Inc NYC Preschool Code: C-594

Frequency: 10 Duration: 30 Group Size: 3:1 Language: English Location: ABC Daycare, home

Directions: Fill out one form per week. The relevant signature must attest to sessions occurring during the preceding week.

Date: 10/25/21 Start Time: 8:20 AM End Time: 10:20 AM If make-up, date of missed session: ______
Type (Direct/Indirect): Direct Location: School/Daycare Group Size: 1

Date: 10/26/21 Start Time: 8:50 AM End Time: 10:50 AM If make-up, date of missed session: ______
Type (Direct/Indirect): Direct Location: School/Daycare Group Size: 1

Date: 10/27/21 Start Time: 5:30 PM End Time: 6:30 PM If make-up, date of missed session: ______
Type (Direct/Indirect): Direct Location: Home Group Size: 1

Date: 10/29/21 Start Time: 11:30 AM End Time: 12:00 PM If make-up, date of missed session: ______
Type (Direct/Indirect): Direct Location: School/Daycare Group Size: 1

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Date: ______ Start Time: ______ End Time: ______ If make-up, date of missed session: ______
Type (Direct/Indirect): ______ Location: ______ Group Size: ______

Total Sessions: 4

I hereby certify that I have provided SEIT 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 misrepresentation may subject me to criminal, civil and/or administrative action.

[signature] 10/29/21
Signature of Provider Date

Jane Doe 10/29/21
Print Provider Name Date

By my signature I acknowledge that I have reviewed this SEIT services form and that, to the best of my knowledge, the sessions identified above as having occurred in the child care location were provided as indicated.

ABC Daycare (646) 646-6464
Name of Child Care Location Phone Number

Margaret Hastings teacher
Print Name of Director/Designee Title Of Child Care Location

Margaret Hastings 10.29.21
Signature of Director/Designee of Child Care Location Date

By my signature I acknowledge that I have reviewed this SEIT services form and that, to the best of my knowledge, the sessions identified above as having occurred at a site other than the child care location were provided as indicated.

DSmith 10/27/21
Signature of Parent Date

Diana Smith
Print Parent Name

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MONTHLY INVOICE

Service Period: Month October Year 2021

Provider Information

Name: Jane Doe

Address: 123 Seaver Avenue, Staten Island, NY 10305

Student Information

Name: Jack Smith

NYS ID #: 123-456-789 IEP Mandate: 10x30/w

Date of Service	Time In-Out	Location	Session Type R-Regular M-Make Up	Date of Missed Session (for Make Ups)	Length of Session
			◉ R ○ M		
			◉ R ○ M		
			◉ R ○ M		
			◉ R ○ M		
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Total Number of Hours 17.00 Rate per Hour $ 50.00 Total Amount Due $ 850.00

Provider Signature [signature] Date 10/31/2021

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

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PROVIDER SCHEDULE

Date: 10/29/21

Student's Name: Jack Smith **IEP Mandate:** 20x30

Student's NYC ID #: 123-456-789 **DOB:** 1/1/2018

Provider's Name: Jane Doe

Arranged schedule for service provision

Services	Monday From – To	Tuesday From – To	Wednesday From – To	Thursday From – To	Friday From – To	Location
SEIT 1	9-10	9-10	9-10	9-10	9-10	ABC Daycare
ST	1:30-2		1:30-2	1:30-2		ABC Daycare
OT	To be	established				
PT	To be	established				
SEIT 2	2-3	2-3	2-3	2-3	2-3	ABC Daycare

Services	IEP Mandate	Provider's Name	Phone #
SEIT 1	10x30	Jane Doe	917-917-9191
ST	3x30	Anne Michaels	347-347-3434
OT	2x30	To be established	
PT	2x30	To be established	
SEIT 2	10x30	Mary Daniels	718-718-7878

Please notify Smart Choice Therapy Inc of any absences, schedule and location change

Provider's Signature: