

INDEPENDENT RELATED SERVICE PROVIDER APPLICATION FORM

_____ of _____

- INDIVIDUAL PROVIDER -

TYPE OF RELATED SERVICE _____

This form must be completed by an independent related service provider whose name is to appear on the Municipality List of Independent Providers of Related Services for Preschool Students with Disabilities. IT IS NOT TO BE USED BY PROVIDERS WORKING FOR AN AGENCY.

NAME OF RELATED SERVICE PROVIDER: _____

District(s) in which you are able to provide related services (check as many as appropriate)

SOCIAL SECURITY: _____

MANHATTAN 1 2 3 4 5 6

ADDRESS: _____

BRONX 7 8 9 10 11 12

_____ ZIP CODE _____

BROOKLYN 13 14 15 16 17 18

19 20 21 22 23 32

BIRTHDAY: MONTH _____ DATE _____ DO NOT PROVIDE YEAR

QUEENS 24 25 26 27 28 29 30

STATEN ISLAND 31

TELEPHONE NUMBER: (_____) _____

E-Mail Address: _____

My capacity to serve preschool students is as follows:

Days available: _____ Hours from: _____ to: _____ # of students _____

=====
Possess a New York State Education Department bilingual extension?

(Circle one)

YES

NO

Evidence of passing Language Proficiency Assessment (BEA)?

(Circle one)

YES

NO

If yes, please specify the language(s) for which you have a bilingual extension and/or Language Proficiency Assessment (LPA).

NOTE: A copy of applicable licenses/certifications including bilingual proficiency must be affixed to this form. Providers are required to promptly update this licensure and/or certification as it is renewed, changed, suspended or revoked for any reason, and/or where revised expiration dates are issued by New York State. The Department of Education (DOE) also requires evidence of fingerprinting. Please attach the receipt for proof of fingerprinting by the DOE or provide us with the date of fingerprinting if the receipt cannot be found. DOE employee's names may not be put on the list. Mail Form to: NYC Department of Education, Office of Related Services, 28-11 Queens Plaza North, Room 508, LICity NY 11101 Attention: Rita Venekas or by fax (718) 391-8174.

Speech therapists must possess both an SLP certificate and TSHH license. The DOE does not accept "temporary" TSHH licenses.

INDEPENDENT RELATED SERVICE PROVIDER APPLICATION FORM AGENCY

_____ of _____

RELATED SERVICE _____
(Prepare separate documents for each related service)

This form must be completed for all independent related service providers whose names are to appear under your agency's name on the Municipality List of Independent Providers of Related Services for Preschool Students with Disabilities. (Please type or print all information)

NAME OF AGENCY: _____
 NAME OF CONTACT: _____
 TAX IDENTIFICATION NUMBER: : _____
 ADDRESS: _____
 _____ ZIP CODE _____
 TELEPHONE NUMBER: () _____ E-mail _____

District(s) in which this agency is able to provide related services (check as many as appropriate)

MANHATTAN 1 2 3 4 5 6
 BRONX 7 8 9 10 11 12
 BROOKLYN 13 14 15 16 17 18
 19 20 21 22 23 32
 QUEENS 24 25 26 27 28 29 30
 STATEN ISLAND 31

The agency's capacity to serve preschool students is as follows:
 Days available: _____ Hours from: _____ to: _____ # of students _____

Therapist/Clinician Name(s) & E-mail Address <small>(complete additional pages as necessary)</small>	Social Security Number	Zip Code	Birthday <small>Do not Provide Year</small>		Does the Therapist/clinician have a N.Y. State Education Department issued bilingual extension and/or Language Proficiency Assessment (BEA)? YES/NO	If yes, please specify the language(s) for which you have a bilingual extension and/or Language Proficiency Assessment (LPA).	For Speech Service Providers Please check Appropriate Box(es)	
			Month	Date			TSHH	SLP
Name: _____ E-mail: _____							<input type="checkbox"/>	<input type="checkbox"/>
Name: _____ E-mail: _____							<input type="checkbox"/>	<input type="checkbox"/>
Name: _____ E-mail: _____							<input type="checkbox"/>	<input type="checkbox"/>

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