



NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, Chancellor

RSA-2 Form: Student, Parent/Guardian and Independent Provider Information

Please complete the information requested. Attach a copy of the independent provider's New York State Education Department registration or certificate. In addition, Independent Providers of bilingual Related Services must attach one of the following: (a) a New York City Department of Education (DOE) license as a teacher of a foreign language; (b) New York State Education Department Certification as a teacher of foreign language; (c) the passing results of the Language Proficiency Assessment; or (d) a New York State Education Department Bilingual Extension Certificate. All Independent Providers are subject to security clearance and must have been fingerprinted by the New York City Department of Education after July 1, 1990 and maintain security clearance with the cost to be incurred by the provider.

Please Note: It should be noted that agencies under contract to the Department of Education for the period of 2004-2007 serving as an independent provider for the provision of a specific Related Service shall be paid for those assignments at the same rate as the original contractor who was unable to provide the services.

Please sign this form and return this material to:

Region/District/High School CSE /Citywide Issuing RSA: District 75
Address: 400 1st Ave./Room 662-A
City, State and Zip: New York, NY 10010
Telephone #: (917) 256-4249 / Fax #: (917) 256-4216
Contact Person: Maria Leo

Name of Student:
Student ID No.:
Student's Address:
City, State and Zip:
School: Region: District:

Related Service Recommended: Language:
No. of Sessions Per Week: Length of Session:
Name of Parent/Guardian:
Work Telephone No.: Home Telephone No.:

Name of Independent Provider:
(Please print the name of the actual therapist providing the service)
Social Security No.:
Professional Title/Discipline:
NYS License/Certificate No.:
Actual Date of Initiation of Service:

(Please check one)

Services to be provided at: Student's School Student's Home
Provider's Place of Business

Provider's Address:
City, State and Zip :
Telephone No.:
Name of Agency (if appropriate):
Employer Tax ID No. (if agency):
Agency Address:
City, Sate and Zip Code:
*Rate: \$
Cannot exceed maximum allowed - Contract agencies see above note in BOLD type
Payment/correspondence to be mailed to:
Provider Agency

FOR NEW YORK CITY DEPARTMENT OF EDUCATION USE ONLY

Date RSA-2 Form Approved Authorizing Signature

Name of Individual Authorized to Approve Services: (Please print)

MARIA LEO (09/06)

By providing the Related Service to the student named above, the provider agrees to:

- Serve the student at the frequency, duration and in the language specified for the current school year as per the IEP.
Indicate start date of service initiation/termination on the enclosed form with the name of the individual providing service.
Maintain weekly progress notes, submits a Student Progress Report upon request, attend an IEP conference, and complete the appropriate pages of the IEP at no cost to the Department of Education.
Provide services in accordance with the New York City Department of Education school calendar.
Provide make-up sessions only during the same week. Make-up sessions may not be conducted on the same day as regular sessions.
Accept no more than the maximum rate allowed as payment in full for these services. The rate charged must be no higher than the lowest rate you normally charge. This rate is for direct service only and is the rate regardless of the size of the group being served. Providers will make no requests to the parent/guardian for payments for services provided. For Medicaid-eligible students, institutional providers should bill Medicaid directly.
Submit invoices directly to the New York City Department of Education in the format required with no out-of-pocket expenses accruing to the parent/guardian.
Carry his/her own professional malpractice/liability insurance.
Maintain daily attendance records on the official Department of Education attendance booklets and participate in the collection of data/information requested by the New York State Department of Social Services or other agencies at no additional cost to the DOE in order for the DOE to receive Medicaid reimbursement.
The monthly attendance forms are to be mailed to the following address no later than seven (7) days after the end of the month to:

SourceCorp
30 Wall Street
Binghamton, NY 13901-2518
Attention: Catherine Dangremond

Please Note: Any individual who is a current employee of the New York City Department of Education or any other city agency may not provide services under this agreement. Any individual who leaves the employ of the New York City Department of Education or any other New York City agency may not provide services under this agreement. These conditions are applicable for a minimum of one year in accordance with the provisions of the New York City Charter (i.e., Section 2604(h), and Chancellor's Regulation C-110 unless a waiver is obtained. In addition, the provider must not be the evaluator who completed the assessment unless permission has been granted by the Region/District/Citywide Programs/District 75.

Signatures below indicate approval of agreement by the parent and provider and grants permission to CSE to release your child's records to provider. If there is a change in provider a new Related Service Authorization- 2 Form must be submitted.

Signature of Provider Date

Signature of Parent/Guardian Date



NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, *Chancellor*

RSA-2 Form
for the
2006-2007 School-Year

FOR

Name of Student

Student Identification Number

Related Service

Language

SAMPLE