



THE NEW YORK CITY DEPARTMENT OF EDUCATION
JOEL I. KLEIN, *Chancellor*

Bonnie Brown, Superintendent – District 75
 Helen D. Kaufman, Administrative Assistant Superintendent for Clinical and Support Services

RSA-2A FORM
DATE OF INITIATION/TERMINATION OF RELATED SERVICES

Dear Independent Provider:

This form is meant for use in conjunction with the RSA-2 form to confirm the initial start date or termination date of services for students under the RSA procedure. This date will then be entered into the New York City Department of Education’s Child Assistance Program (CAP) as the official initial start/termination date for that specific service for this student. Your name and Social Security No. will also be added to the student’s computer file. Please ensure that you are the individual who will be providing services to this student. Any date of termination of provider services must also be noted.

It is important that you complete the information requested below and return this form to:

Name of Contact Person: _____	Region #:

Street Address: _____	Telephone #:

DATE OF INITIATION/TERMINATION OF RELATED SERVICES	
Student’s Name: _____	Related Service: _____
Student ID #: _____	Frequency: _____
	Duration: _____
Name of Provider: _____	Social Security No. _____
Provider’s Telephone No.: _____	
Related Service Start Date: _____	
Related Service Termination Date: _____	