

MONTHLY INVOICE: _____ (school name)

Invoice # _____

Month of Service _____ # of days billed this period _____

Per Service Rate \$ _____

*Status : C= change in IEP service from previous month
 N = New student
 D= Student is no longer enrolled (if billed in previous month)

UNITS PER MONTH (in minutes)
 Related services and assessments should be separated. E.G. Occupational
 Therapy: Related service #1 : Occupational Therapy Assessment, Related
 Service #2: Occupation Therapy service

	Student Name		DOB	D.C. Student ID#	Status*	Date of entry/exit	Program Information			Related Service #1		Related Service #2		Related Service #3		Related Service #4		TOTAL COST
	Last Name	First Name					Billable Days	Tuition	Room and Board	Units of Service	Total Cost							
1																		\$ -
2																		\$ -
3																		\$ -
4																		\$ -
5																		\$ -
6																		\$ -
7																		\$ -
8																		\$ -
9																		\$ -
10																		\$ -
11																		\$ -
12																		\$ -
13																		\$ -
14																		\$ -
15																		\$ -
16																		\$ -
17																		\$ -
TOTAL										0	\$ -	0	\$ -	0	\$ -	0	\$ -	\$ -

NOTES: For example, any make-up sessions offered.