ERIE COUNTY DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRAM

******PARENT INVOICE FORM******

RETURN TO:

ERIE COUNTY DEPARTMENT OF HEALTH
95 FRANKLIN STREET ROOM 828
BUFFALO, NY 14202

NOTE: MONTHLY INVOICE MUST BE SUBMITTED NO LATER THAN ONE MONTH AFTER SERVICE IS COMPLETED.

PARENT TRANSPORTER _____ TELEPHONE NUMBER _____
(NAME ON PARENT REGISTRATION FORM)

CHILD'S NAME _____ D.O.B. _____

CHILD'S ADDRESS _____
NUMBER AND STREET

_____
CITY STATE ZIP CODE

AGENCY NAME
AND SITE ADDRESS _____

INDICATE MILEAGE FROM HOME TO AGENCY SITE ▸ ▸ ▸ ▸ ▸ ▸ _____ **(ONE WAY ONLY)**

CHECK ☑ APPROPRIATE BOX THAT APPLIES:

# of Days		# of Days	
☐ BOTH WAYS WITH PARENT STAYING WITH CHILD AT SCHOOL (2 TRIPS)	_____	☐ BOTH WAYS (DROPPING OFF AND PICKING UP LATER) (4 TRIPS)	_____
☐ ONE WAY (AND BUS ONE WAY) (2 TRIPS)	_____		

INVOICE FOR THE MONTH OF ▸ ▸ ▸ ▸ ▸ ▸ ▸ _____ TOTAL NUMBER OF DAYS TRANSPORTED ▸ ▸ ▸ _____

Dates of Transportation:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	PER DAY MINIMUM	MAXIMUM
2 Trips	$10.00	$20.00
4 Trips	$20.00	$40.00

or $.55 per mile

X _____
PARENT (GUARDIAN) SIGNATURE (SAME PARENT AS ABOVE) DATE

X _____
AUTHORIZED AGENCY REPRESENTATIVE SIGNATURE (VERIFYING THE ABOVE DAYS ATTENDED) DATE

REVISED 06/14 SS