ERIE COUNTY DEPARTMENT OF HEALTH
PRESCHOOL 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 CPSE PHASE 1 IEP & 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/month		**#of days/month**
☐ BOTH WAYS WITH PARENT STAYING WITH CHILD AT SCHOOL (2 TRIPS)	_____	☐ BOTH WAYS (DROPPING OFF AND PICKING UP LATEF (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 7/09 RW

Dec. 2009