***Charter School Logo/Name***

Address for Payment Remittance

Appropriate Contact Phone for Billing Matters

**Invoice for Special Education Services**

Invoice Number

Date Invoice Printed

**Customer:** Name of District Responsible for Payment

**For:** Name of Charter School Child Attends

Special Education Services

School Year 2024-2025

**Student:** Last Name, First Name (**DOB**: MM/DD/YYYY) **SASID:**  Student A

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SASID** | **Service** | **IEP Hours/ Frequency** | **Service Period** | **Weeks** | **Billable hours per day** | **Billing days** | **Service Hours** | **Hourly Rate** | **TOTAL** |
|  |  |  |  |  |  |  |  |  |  |
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|  | **TOTAL** |  |