Schenectady County Public Health Services

Children with Special Needs
107 Nott Terrace, Suite 306
Schenectady, New York 12308-3170
Phone: (518) 386-2815
Fax: (518) 386-2801

Keith M. Brown, MPH
Public Health Director

Claire Proffitt, MPH, BSN, RN
Deputy Public Health Director

Schenectady County Public Health Services
Children with Special Needs
Annual Billing Guidelines
(Aide – 1:1 Related Services)
Effective July 2024

The following billing guidelines apply to the Aide – 1:1 Related Services provided to children ages 3-5 eligible under section 4410 of the New York State Education Law.

Rates: Schenectady County will pay the most recent 2024 – 2025 school year NY SED approved rate for Aide- 1:1 Related Services.

Service Frequency: Schenectady County will only pay for the number of sessions that the child was in attendance per week as specified on the child's IEP.

Billing:

** Billing that has been returned for corrections must be resubmitted within 15 days or payment will not be made.

1. Billing for the Children with Special Needs Program is submitted on a monthly basis. All vouchers must be submitted within thirty days from the end of the month from which the services were delivered. Vouchers submitted after sixty days from the end of the month will not be accepted for payment.

2. Dates of submission are as follows:
   a. Submit each month in a single billing packet on or after the 1st of the following month.

3. The completed billing packet consists of:
   a. One County Voucher and one copy completed in accordance with the attached instructions.
   b. One original signed Delivery of Services: Aide – 1:1 Related Services Voucher Verification sheet.
   c. One original signed School District Classroom Attendance sheet. * Signed by Director *

Signatures:

1. All signatures must be original; photocopies are not acceptable
2. No pencil or white out is allowed.

Instructions for Completing
Schenectady County CWSN
Delivery of Services:
Aide – 1:1 Related Services Voucher Verification

1. **CHILD'S NAME:** Complete with the child's full name (last name, first).
2. **SCHOOL DISTRICT:** Complete with school district name.
3. **LOCATION:** Complete with location of service.
4. **SERVICE MONTH/YEAR:** The month and year the services are delivered.
5. **DATE OF SERVICE:** Place the numerical day of the month (i.e. 1st, 2nd, etc.) for each day the child is in attendance in this column. If the child is absent from program, you cannot claim payment for that day.
6. **START TIME**: Enter time service started.
7. **END TIME:** Enter time service ended.
8. **NUMBER OF UNITS:** Enter the **actual** number of units delivered per day. **One ½ hour = 1 unit.**
9. **TOTAL ½ HOUR UNITS:** Enter the total amount for the month.
10. **CALCULATE THE REIMBURSEMENT TOTAL AT THE BOTTOM OF THE FORM:**
    - **The total number of ½ hour units times the rate equal reimbursement total.**
    - Rate: Enter the 2024-2025 school year NY SED approved rate for Aide – 1:1 Related Services.
11. **1:1 AIDE SIGNATURE AND DATE:** The 1:1 aide must sign using their full name and date.
12. **DIRECTOR SIGNATURE AND DATE:** The director must certify the form on the director's signature line, using their full name and date. The form must be submitted with an original signature, photocopies are not acceptable.

Instructions for Completing
Schenectady County Voucher

1. **DATE:** This is the date in which the voucher was completed.

2. **CONTRACT NUMBER:** Please fill in the correct contract number assigned to you from the Children with Special Needs Program. **Note: contract numbers change yearly.**

3. **VENDOR NUMBER:** Please fill in the vendor number given to you from the Children with Special Needs Program.

4. **NAME AND ADDRESS:** Please use your complete name and mailing address, including zip code.

5. **CHARGE ACCOUNT NO(S):** The following information should be filled in under 'Charge Account No(s)':

"A542960.480300"

6. **DEPT. FURNISHED:** Please insert the "**CHILDREN WITH SPECIAL NEEDS PROGRAM".**

7. **DESCRIPTION:** Complete one county voucher for each Delivery of Services: Aide – 1:1 Related Services Voucher Verification, please insert the following information in the "Description" Section:

> **AIDE – 1:1 RELATED SERVICES PROVIDED AS PER THE ATTACHED DOCUMENTATION FOR THE PERIOD OF (MONTH/YEAR) __________."**

8. **AMOUNT:** This is the reimbursement total from the Delivery of Services: Aide – 1:1 Related Services Voucher Verification sheet.

9. **CERTIFICATION:** After the word, "I" print the full name of the person certifying the voucher. After the words "I am", corporations write the name of the officer and corporation/partnership name.

10. **SIGNATURE:** This must be an original signature on the 'Payee Signature' line.