



Office of the State Superintendent for Education (OSSE)
OSSE FINANCE - Non Public Provider Program
441 4th Street, NW, Suite 350 North
Washington, DC 20001
ANNUAL SCHOOL COST SHEET
School Year 2009-2010

School/ Provider Name _____	Federal Tax ID _____
Address _____	
Contact Person _____	Telephone _____ Fax _____
Check One: Day _____ Res. _____ Length of Program Year: _____ months Begin Date ____/____/____ End Date ____/____/____	
Total # of days in Program: Education _____ Residential _____ ESY _____	
Does your Facility participate in a Medical Assistance Program? Yes _____ No _____ Jurisdiction _____	

	QUARTERLY DAYS ATTENDED:	ANNUAL SERVICE:
A. Education and Basic Related Services (DAYS: _____ PER DIEM: \$ _____)	Q1 _____ Q2 _____ Q3 _____ Q4 _____	(A) \$ _____
B. Residential Services (non-education) (DAYS: _____ PER DIEM: \$ _____)	Q1 _____ Q2 _____ Q3 _____ Q4 _____	(B) \$ _____
C. Extended School Year (DAYS: _____ PER DIEM: \$ _____)	Q1 _____ Q2 _____ Q3 _____ Q4 _____	(C) \$ _____
D. Related Services (see below)		

RELATED SERVICES/ ASSESSMENTS	Unit of service (hour, day, week)	Cost Per Unit	TOTAL COST
Screening			
Initial Assessment			
Re-evaluation			
Occupational Therapy			
Physical Therapy			
Speech-language pathology			
Social Work Services			
Audiology/Hearing			
Psychiatric			
Psychological			
Family Training/Counseling			
Group Therapy/Counseling			
Trained Healthcare aide (fill-in below)			
Behavioral aide			
Mental health aide			
Physical health aide			
Neuropsychological Testing			
Extended Day			
Consultation			
Behavior Management:			
Vision:			
Nursing:			
Other:			

I hereby certify that the above services as outlined above are necessary and responsible for the basic care, treatment, and/or education of District of Columbia children, and that said services will be provided at the cost based on the current delineated rate above and/or the current Medicaid rate for the indicated services for the above named facility. I also agree that the above named facility will not recover more than the applicable portion thereof unless a modified billing data form has been submitted and approved.

Signature _____ Date _____

Director of Education