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

(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

TELEPHONE NUMBER

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

CHECK ☐ APPROPRIATE BOX THAT APPLIES:

☐ BOTH WAYS WITH PARENT STAYING WITH CHILD AT SCHOOL (2 TRIPS)

# of days/month

☐ BOTH WAYS (DROPPING OFF AND PICKING UP LATEF) (4 TRIPS)

# of days/month

☐ ONE WAY (AND BUS ONE WAY) (2 TRIPS)

# of days/month

INVOICE FOR THE MONTH OF

TOTAL NUMBER OF DAYS TRANSPORTED

PARENT TRANSPORTER

CHECK ☐ APPROPRIATE BOX THAT APPLIES:

☐ 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