Department of Intellectual & Developmental Disabilities
Family Support Program
Invoice for In-Home Services

MONTH	SPECIFIC DATES OF SERVICE	YEAR	INVOICE #

RECIPIENT'S NAME: ______________________________

COUNTY: ______________________________

SERVICE(S) APPROVED FOR: *(check one)*

Respite *includes babysitting*	Personal Assistance	Nursing	Homemaker	Other:

AMOUNT REQUESTED: $

MAKE CHECK PAYABLE TO:

NAME: ______________________________

ADDRESS: ______________________________

**If the check is written to the service provider the provider must give their SS# and Phone #*

SOCIAL SECURITY NUMBER: ______________________________

PHONE NUMBER: ______________________________

The **Family/Guardian/Recipient** certifies by the signature given below that services for the total amount shown for the month listed above have been provided.

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Family/Guardian/Recipient **Date**

The **Provider** certifies by the signature below that s*ervices for the total amount shown for the month listed above have been provided.*

Provider Printed Name: ______________________________

Provider Address: ______________________________

Provider Phone: ______________________________

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Provider (SIGNATURE) **Date**

For Agency Use:

Circle One: Approved Denied

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Agency Coordinator Date

All recipients of the Family Support Program sign an annual Service Plan with the agency. The Service Plan documents the service and amount approved for the year. This Invoice is to advance payment to you for the approved service. Additional funds will not be allocated until this completed form and a receipt is submitted.