



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

MONTH	SPECIFIC DATES OF SERVICE	YEAR	INVOICE #

RECIPIENT'S NAME: \_\_\_\_\_

COUNTY: \_\_\_\_\_

SERVICE(S) APPROVED					
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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 - Approved services and the total amount shown for the month listed will be provided. It is the responsibility of the Family/Guardian/Recipient to submit a receipt for provided services within 30 days of the completion of service.

\_\_\_\_\_  
**Family/Guardian/Recipient**

\_\_\_\_\_  
**Date**

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

**Provider Printed Name:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_ **Provider Phone:** \_\_\_\_\_

\_\_\_\_\_  
**Provider (SIGNATURE)**

\_\_\_\_\_  
**Date**

For Agency Use:

Circle One:      Approved      Denied

\_\_\_\_\_  
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.*