FAMILY SUPPORT SERVICES INVOICE

Please mail invoice at the end of each month to: NORTH EAST OHIO NETWORK
Attn: George Callow
Or fax to: 330-793-8284 721 Boardman-Poland Rd. Suite 103 Youngstown, Ohio 44512
Phone: 234-254-5874

ALL PAYMENTS ARE MAILED WITHIN 10 BUSINESS DAYS FROM RECEIPT OF INVOICE

Family Information

(PLEASE TYPE OR PRINT NEATLY)

Household Contact: George
Individual's Name(s): Dimitri

☐ *Check if Parent / Individual has moved and please print new address & phone below*

New Address: _____

Phone: _____

Provider / Vendor Information

☐ *Check if New Address Below*

Name: Shirley Jones
Address: 1212 Tyler St.
Street Address *(For IRS tax purposes, do not use P.O. Box address)*

Austintown | OH | 44515
City | State | Zip

Phone #: (330) 793-6400 **Alternate Phone #:** Cell (330) 792-5555
Social Security #: w-9 form is sent (Individiual Provider) **Tax ID (EIN) #:** (Agency Provider)
Respite Hourly Rate: $ 7.00 / hr. *(Multiply this rate with the Total Time to calculate Total Cost below)*

DATE	TIME IN	TIME OUT	TOTAL TIME	TOTAL COST	REMAINING QUARTERLY AMOUNT	IN HOME	OUT OF HOME
6/1/08	9 a.m.	10 a.m.	1	$7.00	$368.00	✓	
6/9/08	5 p.m.	7 p.m.	2	$14.00	$352.00	✓	
6/14/08	3 p.m.	6 p.m.	3	$21.00	$331.00	✓	
6/15/08	10 a.m.	11 a.m.	1	$7.00	$324.00		✓
6/17/08	4 p.m.	7 p.m.	3	$21.00	$303.00	✓	
6/23/08	9 a.m.	2 p.m.	5	$35.00	$268.00		✓
				$105.00			

OTHER COSTS (Give Brief Description)

	$	
Total Cost for Month:	$105.00	***NEON USE ONLY***
Less Family Co-Pay (10 %)	$10.50	**Remaining Qtrly. Allocation:** $
TOTAL COST NEON WILL PAY:	$94.50	**Manager's Signature:**

Family Assessment of Services: *(Please rate level of care provided)*

___ Excellent ___ Good ___ Satisfactory ___ Fair ___ Poor

HOUSEHOLD CONTACT SIGNATURE: George Doe **DATE:** 6/30/10

PROVIDER / VENDOR SIGNATURE: Shirley Jones **DATE:** 6/30/10