NEON COUNCIL OF GOVERNMENTS

Portage THE PORTAGE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES DD

# FAMILY SUPPORT SERVICES INVOICE

***Please scan the QR code to securely submit invoice:***

***Or Mail to:***
***NORTH EAST OHIO NETWORK***
***Attn: Portage FSSP***
**721 Boardman-Poland Rd, Ste 103**
**Youngstown, Ohio 44512**

***Phone: 234-254-5874***
***Fax: 330-793-8284***

**Or Email to:** PortageFSS@neoncog.org

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

## Family Information

***(PLEASE TYPE OR PRINT NEATLY)***

**Household Contact:** _____

**Individual's Name(s):** _____

*Address:* _____

City _____ OH State _____ Zip _____ *Phone:* _____

☐ **Check this box if you are requesting to be reimbursed** Email: _____

## Provider / Vendor Information

☐ *Check if New Address Below*

**Name:** _____

**Address:** _____
Street Address ***(For IRS tax purposes, do not use P.O. Box address)***

City _____ State _____ Zip _____

**Phone #:** _____ **Email:** _____

**Last 4 of Social Security #:** _____ **Tax ID (EIN) #:** _____
**(Individiual Provider)** **(Agency Provider)**

**Respite Hourly Rate:** **$** _____ *(Multiply this rate with the Total Time to calculate Total Cost below)*
Max $20/hour

| DATE | TIME IN | TIME OUT | TOTAL TIME | TOTAL COST | REMAINING QUARTERLY AMOUNT | IN HOME | OUT OF HOME |
|---|---|---|---|---|---|---|---|
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |
| | | | | $ | | ☐ | ☐ |

***OTHER COSTS (Give Brief Description)***

| | | |
|---|---|---|
| | $ | |
| | $ | |
| | $ | |
| *Total Cost:* | $ | |
| *Less Family Co-Pay (___ %)* | $ | |
| **TOTAL COST NEON WILL PAY:** | $ | |

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

◉ **Excellent** ○ **Good** ○ **Satisfactory** ○ **Fair** ○ **Poor**

**HOUSEHOLD CONTACT SIGNATURE:** _____ **DATE:** _____

**PROVIDER / VENDOR SIGNATURE:** _____ **DATE:** _____