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:

Individual's Name(s):

☐ ***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:

Address:

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

OH

City State Zip

Phone #: **Alternate Phone #:**

Social Security #: **(Individiual Provider)** **Tax ID (EIN) #:** **(Agency Provider)**

Respite Hourly Rate: **$** *(Multiply this rate with the Total Time to calculate Total Cost below)*

(Max $15/hr)

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

OTHER COSTS (Give Brief Description)

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

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

☐ **Excellent** ☐ **Good** ☐ **Satisfactory** ☐ **Fair** ☐ **Poor**

HOUSEHOLD CONTACT SIGNATURE: **DATE:**

PROVIDER / VENDOR SIGNATURE: **DATE:**