Family Support Services

Parents Time Away Monthly Invoice

DATE: ____________________

INDIVIDUAL RECEIVING SERVICE: ____________________ PROVIDER NAME : ____________________

SERVICE DATE	NUMBER OF UNITS AT HOURLY RATE	NUMBER OF UNITS AT DAILY RATE	PARENT'S INITIALS

Total Hourly Units _______ X $ ________________(negotiated hourly rate) = $ ________________

Total Daily Units _______ X $ ________________(negotiated daily rate) = $ ________________

Total for services = $ ________________

Family Copay % _______ FSS payment (copay applied) = $ ________________

Parent payment = $ ________________

My signature verifies that I have provided respite services to this individual for the above listed days/units.

PROVIDER SIGNATURE: ______________________________ Date: ________________

My signature and initials verify that the above Provider is at least 18 years of age and has provided the respite services for the above listed days/units. I accept responsibility for any financial obligation (due to service delivery) that exceeds the current year grant allocation.

PARENT/GUARDIAN SIGNATURE: ______________________________ Date: ________________

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

_____ Excellent _____ Good _____ Satisfactory _____ Fair _____ Poor

COMMENTS: ____

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