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

MONTH	SPECIFIC DATES OF SERVICE	YEAR	INVOICE #

RECIPIENT'S NAME: _____

COUNTY: _____

SERVICE(S) APPROVED 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: _____

By signing and dating this form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand providing invalid, inaccurate or incomplete information may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

The **Family/Guardian/Recipient** certifies by the signature given below that services for the total amount shown for the month listed above have been provided.

_____

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

022019