|  |  |  |  |
| --- | --- | --- | --- |
| MONTH | SPECIFIC DATES OF SERVICE | YEAR | INVOICE # |
|  |  |  |  |

|  |  |
| --- | --- |
| RECIPIENT’S NAME |  |

|  |  |
| --- | --- |
| COUNTY | DAVIDSON |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SERVICE(S) APPROVED |  |  |  |  |  |
| FOR*(check one)* | Respite*Includes babysitting* | PersonalAssistance | 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 |  |

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 s*ervices for the total amount shown for the month listed above have been provided.*

**Provider (PRINT NAME – ADDRESS – PHONE#)**

**Provider (SIGNATURE) Date**

For Agency Use:

Circle One: Approved Denied

Agency Coordinator Date

***All recipients of the Family Support Program sign an annual Service Plan with the agency.***

***The Service Plan documents the service and amount approved for the year.***

***This Invoice is to reimburse you for the service you are approved for.***

July 2015