

**FAMILY SUPPORT SERVICES INVOICE**

**Family Information**

Household Contact: \_\_\_\_\_  
 Individual's Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_  
 Check if this is a new address

**Provider / Vendor Information     NA/ Family Reimbursement**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street Address (Include PO Box, if mail is delivered to a PO Box.)  
 \_\_\_\_\_ Ohio  
 \_\_\_\_\_ State      \_\_\_\_\_ Zip Code  
 Check if this is a new address  
 Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_  
 Hour Unit Rate: \_\_\_\_\_ Day Unit Rate: \_\_\_\_\_

DATE	UNIT (circle unit)	Number of Units	Unit Cost	TOTAL COST <small>(number of units X unit cost)</small>	<input checked="" type="checkbox"/> IN HOME	<input checked="" type="checkbox"/> OUT OF HOME
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		

OTHER COSTS (Give brief description and attach receipt)	NEON USE ONLY
	Received: _____
	Processed: _____
	Paid: _____
<b>TOTAL COST NEON WILL PAY: \$</b>	Auth. Initials: _____

**Family Assessment of Services:** (Please rate level of care provided.)  
 \_\_\_ Excellent    \_\_\_ Good    \_\_\_ Satisfactory    \_\_\_ Fair    \_\_\_ Poor

HOUSEHOLD CONTACT SIGNATURE: \_\_\_\_\_  
 PROVIDER/VENDOR SIGNATURE: \_\_\_\_\_

**Please submit invoice to:**  
**NORTH EAST OHIO NETWORK**  
**Attn: Cuyahoga Family Support Services**  
**5121 Mahoning Ave.**  
**Austintown, Ohio 44515**

Phone: 216-682-5527      FAX: 855-336-6968      email address: CuyFSS@neoncog.org

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

