

FAMILY SUPPORT SERVICES INVOICE

Family Information

Household Contact: Margaret Smith

Individual's Name(s): Elizabeth Smith

Address: 13456 Friend Avenue
Maple Heights, OH 44137

Phone: (216) 901-2345
Phone: _____

Check if this is a new address

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

Name: Jane White

Address: 2345 Theota Avenue
Street Address (Include PO Box, if mail is delivered to a PO Box)
Parma, Ohio 44134
City State Zip Code

Check if this is a new address

Phone #: (440) 346-9876 **Alternate Phone #:** _____

Hour Unit R \$7.00 **Day Unit Rate:** \$65.00

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
11/28/10	Hour / <u>Day</u>	1	\$65.00	\$65.00		
11/29/10	Hour / <u>Day</u>	1	\$65.00	\$65.00		
11/30/10	Hour / <u>Day</u>	1	\$65.00	\$65.00		
12/3/10	<u>Hour</u> / Day	4	\$7.00	\$28.00		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		
	Hour / Day			\$		

OTHER COSTS (Give Brief Description and attach receipt) **NEON USE ONLY**

	\$	Received: _____
	\$	Processed: _____
	\$	Paid: _____
TOTAL COST NEON WILL PAY:	\$223.00	Auth. Initials: _____

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

Excellent
 Good
 Satisfactory
 Fair
 Poor

HOUSEHOLD CONTACT SIGNATURE: Margaret Smith

PROVIDER / VENDOR SIGNATURE: Jane White

Please submit invoice to:

NORTH EAST OHIO NETWORK
Attn: Cuyahoga Family Support Services
5121 Mahoning Ave.
Austintown, Ohio 44515

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

