

FAMILY SUPPORT SERVICES INVOICE

Family Information

Household Contact: John Beno

Individual's Name(s): Zak Beno

Address: 12479 Meadowview Lane **Phone:** (440) 345-9876
Mayfield Heights, OH 44119 **Phone:** _____

Check if this is a new address

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

Name: John Beno

Address: 12479 Meadowview Lane
 Street Address (Include PO Box, if mail is delivered to a PO Box.)
Mayfield Heights Ohio 44119
 City 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 | |
|--|--|----------|--|----------------------|-----------------------|
| Diapers | | \$24.97 | | Received: | _____ |
| Camp | | \$200.00 | | Processed: | _____ |
| | | \$ | | Paid: | _____ |
| TOTAL COST NEON WILL PAY: | | | | \$224.97 | Auth. Initials: _____ |

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

Excellent
 Good
 Satisfactory
 Fair
 Poor

HOUSEHOLD CONTACT SIGNATURE: John Beno

PROVIDER / VENDOR SIGNATURE: John Beno

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.

