



**FAMILY SUPPORT SERVICES INVOICE**

**Family Information**

**Household Contact:** Margaret Smith

**Individual's Name(s):** Elizabeth Smith

**Address:** 13456 Friend Avenue **Phone:** (216) 901-2345  
Maple Heights, OH 44137 **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	<u>Hour</u> / Day	1	\$65.00	\$65.00		
11/29/10	<u>Hour</u> / Day	1	\$65.00	\$65.00		
11/30/10	<u>Hour</u> / Day	1	\$65.00	\$65.00		
12/3/10	<u>Hour</u> / <u>Day</u>	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: _____
<b>TOTAL COST NEON WILL PAY:</b> \$223.00	Auth. Initials: _____

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

\_\_\_ Excellent        X   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**

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.**

