FAX: (615) 382-3079
or email to :
ebroyles@hatstn.org

Department of Intellectual & Developmental Disabilities
Family Support Program
Invoice for In-Home Services

MONTH	SPECIFIC DATES OF SERVICE	YEAR	INVOICE #

RECIPIENT'S NAME: _____

COUNTY: _____

SERVICE(S) APPROVED FOR: *(check one)*

Respite *includes babysitting*	Personal Assistance	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 *services for the total amount shown for the month listed above have been provided.*

Provider Printed Name: _____

Provider Address: _____

Provider 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 advance payment to you for the approved service. Additional funds will not be allocated until this completed form and a receipt is submitted.

DIDD-6001 RDA pending