SSAH INVOICE

FAMILY RESPITE SERVICES

3295 Quality Way Unit 101A N8T 3R9
Phone: 972-9688 FAX: 972-8902

******TO BE SUBMITTED BY THE 10TH OF EACH MONTH******

PARENT NAME: _____

CHILD NAME: _____

ADDRESS: _____
CITY POSTAL CODE

PHONE NUMBER: _____

FAMILY COORDINATOR: _____

DESCRIPTION OF SERVICE	Amount Paid	Name of Service Provider	Date of Service Provided	Receipt Attached
TOTAL:	**$**			

☐ Please mail cheque to above address ☐ I will pick up cheque

*** I agree that I am the employer of any person who provides services for my child through Special Services at Home funding for purposes other than the agreed upon In home hours outlined in the Three Party Agreement completed with Family Respite Services.**

_____

PARENT'S SIGNATURE / LEGAL GUARDIAN DATE

****RECEIPTS MUST BE ATTACHED TO INVOICE FOR PAYMENT.***
INVOICES MUST BE SUBMITTED WITHIN 30 DAYS OF RECEIPT DATE.*