# LEHIGH COUNTY FAMILY SUPPORT SERVICES PROGRAM
# INVOICE / REQUEST FOR PAYMENT

**Contact Person or Consumer Completes:**

Consumer Name: _____

Address: _____ Phone: _____

_____ **HIGHLIGHT ADDRESS CHANGES**

Date(s) of Service: _____ Number of Hours of Service (if applicable): _____

Total Requested (attach receipts or invoices, if applicable): $_____

Service Purchased *(only one service per invoice):* ** = This service **must be approved** with an innovative service request before use.

***As of 7/01/2015, Family Aide and Respite service will be paid directly to the provider ONLY. Families WILL NOT be reimbursed for family aide and respite service after this date.***

_____ Family Aide (up to 16 hours per session - **4 sessions per month, maximum)**

_____ Respite (16 - 24 hours per session - **28 days per year maximum)**

_____ Recreation

_____ Camp (day or overnight)

_____ Family Education

_____ Home Maker Service **

_____ Speech Therapy **

_____ Adaptive Equipment/Appliance **

_____ Other Therapies or Services (Identify) **

Service Provided By: _____

Address of Provider: _____

Phone Number of Provider: _____

I herby certify that I am authorized to request payment and that the above services were received in a satisfactory manner. I also certify that payment is made based on my statements above and that I approve payment of this invoice is made to:

☐ CONTACT PERSON/FAMILY
**Reimbursement CAN NOT be made to the contact person/family for Family Aide or Respite service**.

☐ DIRECT TO PROVIDER
**Payments for Family Aide and Respite service MUST BE made directly to the provider.**

_____
Printed Name Contact Person (or consumer if there is no other contact person)

_____ _____
Signature of Contact Person (or consumer if there is no other contact person) Date

Mail completed invoices to: **Easter Seals Eastern Pennsylvania**
**1501 Lehigh Street, Suite 201**
**Allentown, PA 18103**

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Provider Completes (if applicable):

I hereby certify that the above information regarding the service, rate and amount is accurate. The services have been rendered to the consumer listed above. I agree that payment is to be made as indicated above.

_____ _____ _____
Signature of Provider Date Soc Sec Number or Federal ID
(**REQUIRED** for Family Aide or Respite payments.)

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**Easter Seals Completes:**

Balance of Allocation Available: _____ Amount Requested: _____

Amount to be Paid: _____ Date the Payment is Due: _____

Encumbrance / ID Number: _____ Balance ***after this Payment:*** _____

Prepared by: _____

White – Easter Seals Yellow – Easter Seals (returned to family after processing)

Updated: 3/30/2015