NORTHAMPTON COUNTY FAMILY SUPPORT SERVICES PROGRAM
INVOICE / REQUEST FOR PAYMENT

Contact Person or Participant Completes:

Participant 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 hereby 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 upon my statements above and that I approve payment of this invoice 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 participant if there is no other contact person)

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

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

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)

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