SUPPLEMENTAL CLIENT INVOICE DAY CARE

INVOICE NUMBER: _____

PROVIDER NAME: _____ **MONTH & YEAR:** _____

PROVIDER NUMBER: _____

LINE #	CLIENT INFORMATION	SERVICE DATES	BILL UNIT	# OF HOURS	BILL RATE	BILL AMT	BILL UNIT	# OF HOURS	BILL RATE	BILL AMT	BILL UNIT	# OF HOURS	BILL RATE	BILL AMT	TOTAL BILL
01		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
02		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
03		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
04		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
05		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
06		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
07		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
08		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
09		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
10		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
11		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
12		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
13		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.
14		/ /	HR DA				HR DA				HR DA				
		/ /	WK MO		$.	$.	WK MO		$.	$.	WK MO		$.	$.	$.

I CERTIFY THAT THE AMOUNT SHOWN ON THIS INVOICE IS CORRECT. I UNDERSTAND THAT DELIBERATE MISINFORMATION OR FALSIFICATION OF INFORMATION MAY BE SUBJECT TO RECOVERY AND/OR PENALTIES AS PROVIDED BY STATE LAW. (NOTE TO PROVIDERS OF CARE IN THE CHILD'S OWN HOME: SCF WILL DO WHAT IS REQUIRED PURSUANT TO SECTION 3054 I.R.S. FOR THE PURPOSE OF PAYING SOCIAL SECURITY TAXES).

_____ _____

SIGNATURE OF AGENCY DIRECTOR OR PROVIDER DATE