

**INSTRUCTIONS FOR COMPLETING RESPITE INVOICE** (by numbered fields)

This standard invoice, or a modification of it, is to be used by persons or organizations to bill for Respite services provided to individuals who have been approved for funding by the Community Living disABILITY Services Program.

Service providers may use a modified version of this invoice adapted to their needs. The use of a modified invoice, and its content and form must be approved by the Regional Office. As well, a modified invoice must comply with the standard invoice in terms of information that is provided.

**FIELD**

1. **Facility/Program Name** - The name of the facility/program providing the service. A separate invoice must be submitted for each facility/program. This field need not be completed where a supplier operates only one facility/program and the names of the supplier and facility/program are synonymous.
2. **Invoice Date** - Date on which the invoice is prepared by the supplier.
3. **Billing Period** - The start date and end date in year/month/day format of the period of service for which the invoice is being submitted. Invoices are to be submitted on a monthly basis.
4. **Individual** - Surname and given name(s) of individual who received the service for which the invoice is being submitted.
5. **Number of Days** - Number of days of service being claimed for the individual in the billing period.
6. **Number of Hours** - Number of hours of service being claimed for the individual in the billing period.
7. **Per Diem** - The individual's approved per diem.
8. **Hourly** - The approved hourly rate.
9. **Total Amount Payable** - The amount derived by multiplying the number of days by the individual's approved per diem, or by multiplying the number of hours by the approved hourly rate.

Date Issued:	January 1, 2019
Replacing:	July 15, 1999

**MANITOBA**  
**FAMILIES**

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**COMMUNITY LIVING disABILITY SERVICES**  
**Subject: Support Services: Funding Supports**  
**– Appendix A – Respite Invoice**

**ADULT DISABILITY SERVICES**

10. **Total (columnar)** -The sum of the totals for each individual representing the amount being claimed in the billing period for all individuals.
11. **Authorized (Supplier) Signature** - Signature of the person who has been authorized by the supplier to certify the accuracy of the invoice.
12. **Payable to (Name and Full Mailing Address)** - Legal name, mailing address and postal code of the supplier. This information must be accurate, as the cheque for services rendered will made payable and mailed in accordance with the information entered here.

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**COMMUNITY LIVING disability SERVICES**  
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**– Appendix A – Respite Invoice**

**ADULT DISABILITY SERVICES**

Respite Invoice



FORWARD INVOICE TO:  
**MANITOBA**  
 Families

INVOICE DATE: 2

BILLING PERIOD

FACILITY/PROGRAM NAME:

1

FROM: 3

Year/Month/Day

TO: 3

Year/Month/Day

INDIVIDUAL		RESPITE SERVICES				TOTAL AMOUNT PAYABLE
Surname	Given Name	NUMBER		RATE		
		DAYS	HOURS	PER DIEM OR HOURLY	HOURLY	
4		5	6	7	8	9
<b>TOTAL</b>						<b>10</b>

I certify that supplies and/or services have been provided:

11

AUTHORIZED (SUPPLIER) SIGNATURE

PAYABLE TO: (NAME AND FULL MAILING ADDRESS)

12

POSTAL CODE

**FOR FAMILIES USE ONLY**

Certified Goods Received and/or Services Performed and Payment Authorized

SIGNATURE:

SAP DOCUMENT NUMBER:

COST ELEMENT	COST CENTRE/ INTERNAL ORDER #	FUND RESERVATION		\$ AMT.
		#	ITEM #	
<b>TOTAL</b>				

VENDOR #:

AUTHORITY - T.B.#:

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**FAMILIES**

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