

COMMUNITY LIVING disABILITY SERVICES

Subject: **Supported Employment: Follow-up Services –
Appendix C – Service Record and Invoice**

ADULT DISABILITY SERVICES

FOLLOW-UP SERVICES

Two documents are required when submitting an invoice for payment:

- a) Service Record
- b) Invoice

1. SERVICE RECORD

This is a 2 page report which must be attached to the Invoice. Page 1 provides for the first 15 days of the month and page 2 provide for the balance of days in the month.

- **Billing Period** - Indicate the start date and end date of the period for which the invoice is being submitted.
- **Participant Name** - As recorded on the Participant Identification form, list all persons for whom follow-up service was provided during the billing period.
- **Days Service Provided** - Calendar dates are indicated.
- **Days Service Provided** - Indicate the day of the week to correspond with the date that service is provided – M., T., W., Th., F., S., Sun.
- **Total Days** - Enter the total number of days that follow-up service was provided for each participant.
- **Total** - Enter the total number of days service was provided to all participants during the billing period.

NOTE: Total days for each participant between the 1st and 15th of the month is to be carried forward from page 1 to page 2 and the Total days for the month entered in the last column on page 2 for each participant.

- **Authorized Signature** - Signature of person authorized to certify the accuracy of the report.

Date Issued:	January 1, 2019
Replacing:	November 15, 1998

**MANITOBA
FAMILIES**

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2. INVOICE

- **Invoice Date** - Date on which the invoice is prepared by the service provider.
- **Billing Period** - Indicate the start date and end date of the period for which the invoice is being submitted.
- **Agency/Supplier Name** - Enter the legal name of the agency or supplier who provided the services
- **Number of Participants** - Enter the total number of participants to whom service was provided during the billing period.
- **Total Days** - Enter the total number of days that service was provided during the billing period.
- **Per Diem** - Enter the approved daily rate per terms of the agreement.
- **Amount Payable** - Multiply the total days by the per-diem and enter the amount.
- **Authorized Signature** - Signature of person authorized to certify the accuracy of the invoice.
- **Payable To** - Indicate the legal name and full mailing address including the postal code to which payment is to be made.

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FOLLOW-UP SERVICES
SERVICE RECORD
 (To be attached to invoice)

Billing Period _____ to _____
 Year/Month/Day Year/Month/Day

	PARTICIPANT SURNAME GIVEN NAME	DAYS SERVICE PROVIDED															TOTAL DAYS
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
																TOTAL	

I certify that the above service have been provided for the days billed.

 AUTHORIZED SIGNATURE

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**FOLLOW-UP SERVICES
 SERVICE RECORD
 (To be attached to invoice)**

Billing Period _____ to _____
 Year/Month/Day Year/Month/Day

	PARTICIPANT SURNAME GIVEN NAME	DAYS SERVICE PROVIDED																TOTAL DAYS		
		TOTAL DAYS FWD	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		31	
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
																		TOTAL		

I certify that the above service have been provided for the days billed.

 AUTHORIZED SIGNATURE

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Follow-up Services Invoice

FORWARD INVOICE TO:
 Manitoba Families 

Invoice Date: _____

Billing Period

From: _____
 Year/Month/Day

Agency/Supplier Name: _____

To: _____
 Year/Month/Day

Number of Participants	Total Days	Per Diem	Amount Payable

Per attached service record.

I certify that the above services have been provided for the days billed.

 AUTHORIZED SIGNATURE

PAYABLE TO: _____

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		DOLLAR AMOUNT
		#	ITEM #	
TOTAL				
VENDOR #:			AUTHORITY - T.B. #:	

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