Crisis Facility Invoice

NAME OF CRISIS SHELTER/OFFICE ______________________

Address ______________________
Suite No. Street No. Street Name Suffix

____
Town/City Prov. Postal Code

Telephone No. ____________ Third Party No. ____________

Billing For: ____________ (mo yr)

Date Submitted: ____________ (mo day yr)

Date Received: ____________ (mo day yr)

Date Approved: ____________ (mo day yr)

Applicant	No. of Children in Facility	Length of Stay (mo day yr)	Number of Bednights	Costs	Applicant's Resources	Payment Requested	Codes	Payment Amount Approved
Surname: ____ Given Name: ____ Middle Name: ____		Admitted: Time: ____ Discharged: Time: ____	Previous Billing: Present Billing:	Per diem: ____ Transportation: ____ Drugs: ____ Telephone: ____ Total ____				
Surname: ____ Given Name: ____ Middle Name: ____		Admitted: Time: ____ Discharged: Time: ____	Previous Billing: Present Billing:	Per diem: ____ Transportation: ____ Drugs: ____ Telephone: ____ Total ____				
Surname: ____ Given Name: ____ Middle Name: ____		Admitted: Time: ____ Discharged: Time: ____	Previous Billing: Present Billing:	Per diem: ____ Transportation: ____ Drugs: ____ Telephone: ____ Total ____				
Surname: ____ Given Name: ____ Middle Name: ____		Admitted: Time: ____ Discharged: Time: ____	Previous Billing: Present Billing:	Per diem: ____ Transportation: ____ Drugs: ____ Telephone: ____ Total ____				

Sample

Authorized Facility Signature ______________________

OFFICE USE ONLY

Totals for present billing

Part 1 ~~ial Allowances Program~~ *Central Accounts*

Authorize artment Signature

MG-15013