

INVOICE FOR PAYMENT FOR GENERAL RELIEF ASSISTED LIVING SERVICE

ALH name: ABC ALH Co.	SDS Provider number: 123456	Taxpayer ID: 1234567
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Mailing Address: 123 1 st St. Anchorage, AK 99501	Phone: 907-123-4567 Fax: 907-123-4657
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Individual	Daily Rate	Start	End	Days	Monthly Total	Actual number of days individual was served
Resident name 1	\$70	6/1/11	6/30/11	30	\$2100	30
Resident name 2	\$70	6/1/11	6/30/11	30	\$2100	30
Resident name 3	\$70	6/1/11	6/30/11	30	\$2100	30
Resident name 4	\$70	6/1/11	6/30/11	30	\$2100	30
Resident name 5	\$70	6/1/11	6/30/11	30	\$2100	30
Resident name 5 Augmented Rate	\$20	6/1/11	6/30/11	30	\$600	30

Total: \$11,100

ASSISTED LIVING HOME ADMINISTRATOR: Please notify this office in writing if your client moves, transfers, dies, goes to the hospital or disappears from your assisted living home.

Signature _____

I certify that the named residents received the services specified in the prescribed manner for number of days indicated in the space above.

This form should be properly completed and sent to the address below for payment within 30 days of receipt.

Mail to:

Division of Senior and Disabilities Services
 Department of Health and Social Services
 550 W. 8th Avenue
 Anchorage, Alaska 99501
 Fax: (907) 269-3648

The Division of Senior and Disabilities Services is not liable for reimbursement for any services **unless performed in accordance with the provider agreement.** Prior to submitting this authorization, the provider should verify that the provider number is the same as on the license and the services were delivered to the individuals within the dates specified above, and was for the person/persons named hereon, and that the number of days is correct.

For SDS Use

General Relief Authorization for Payment: Initials: _____ **Date:** _____

Invoice training available on the SDS website www.dhss.alaska.gov