**INVOICE FOR PAYMENT FOR GENERAL RELIEF ASSISTED LIVING SERVICE**

| **ALH name:** | **SDS Provider number:** | **Taxpayer ID:** |
|---|---|---|
| **Mailing Address:** | | **Phone:**<br>**Fax:** |

| **Individual** | **Daily Rate** | **Start** | **End** | **Days** | **Monthly Total** | **Actual number of days individual was served** |
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**Total:**

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
1835 Bragaw Street, Suite 350
Anchorage, Alaska 99508
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 https://health.alaska.gov/en/senior-and-disabilities-services/