INVOICE FOR PAYMENT FOR GENERAL RELIEF ASSISTED LIVING SERVICE

ALH name:	**DSM email:**	**PVN:**
Mailing Address:		**Phone:**

Individual	**Daily Rate**	**Start Date**	**End Date**		**Monthly Total**	**Actual number of days individual was served**
	$					

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_____ Date _____

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

I certify that I am authorized to negotiate, execute and administer this agreement on behalf of the Provider agency named in this agreement, and hereby consent to the terms and conditions of this agreement, and its appendices and attachments.

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