INVOICE FOR SERVICES
Respite Care (Days)

TO: **CHIPPEWA COUNTY DEPARTMENT OF HUMAN SERVICES**
711 N. Bridge St., Room 305
Chippewa Falls, WI 54729-1877

Attention: _____ (Case Worker)

FROM: _____

_____

_____

Client's Name: _____

Services for the month of _____, 20_____

Dates of Services: **From _____ to _____**

From _____ to _____

From _____ to _____

From _____ to _____

Total Number of Days: _____   at $_____ per day.   PAYMENT DUE $_____

Provider's Signature _____   Date _____

For Agency Use Only		
Division and Program	**Account Code**	
☐ **78-54500** Child/Family-Ongoing Services	78-54500-212-00103-03561	**Vendor #:** _____
☐ **78-54500** Child/Family Reunification	78-54500-212-00103-03341	
☐ **79-54516** Youth Services - Ongoing	78-54516-212-00103-00366	**Client #:**
☐ **80-54529** CWDA-Autism Ongoing	80-54538-212-00002-00561	
☐ **80-54530** CWDA-Crisis Services	80-54530-212-00203-00561	**Total Units:** _____
☐ **80-54531** CWDA-Family Support	80-54531-212-0111L-00577	
☐ **80-54532** CWDA-SED Waiver	80-54538-212-00002-00561	**Unit Cost:** _____
☐ **80-54533** CWDA-DD Waiver	80-54538-212-00002-00561	
☐ **80-54534** CWDA-PD Waiver	80-54538-212-00002-00561	**Total Cost:** _____
		Approved: _____
	☐ **Waiver Respite Child** Put on TPA Auth Spreadsheet	