Revised 1/20/16

The Arc
Alliance Children's Services

INVOICE

Month/Year: _____

COUNTY: ☐ **Montgomery** ☐ **Chester** ☐ **Berks** ☐ **Bucks**

CHILD & SERVICE FREQUENCY

Sessions are 4 units. Please note in "Other - Units" if units are different as per the IFSP.

☐ weekly ☐ monthly ☐ EOW ☐ consult

☐ OTHER _____ UNITS ____

Last Name: _____
PRINT **Full** Last Name

First Name: _____
PRINT First Name ~ **NO** nicknames

DOB: _____

TEACHER/THERAPIST

Name: _____
PRINT NAME

Signature: _____

Discipline:

☐ SI ☐ ST ☐ BH ☐ OT ☐ PT

☐ NUT ☐ SW ☐ VI ☐ HR

NOTE: Enter duration of services in "minutes only". Use 15 minute intervals only

Service Date	Service Type/Duration Example: FO/time, FOC/time, N/time, NC/time, PC/time	TIME IN	TIME OUT	Make-Up Time	Make-Up Date	$ Amount
TOTALS						**$**

DISCIPLINE KEY:

SI: Special Instructor/Teacher
ST: Speech Therapy
BH: Behavior/FBA
OT: Occupational Therapy
PT: Physical Therapist
NUT: Nutrition
SW: Social Work
VI: Vision
HR: Hearing

SERVICE TYPE/ACTIVITY KEY:

FO: Family Oriented
FOC: Family Oriented Consult
N: Child No Show
NC: Child Cancel
PC: Provider Cancel

OFFICE USE ONLY

Data Entry:

_____ **Data Entered Initials**

_____ **Data Checked Initials**