

STUDENT ASSISTANCE PROGRAM : FEE FOR SERVICE INVOICE/REPORT

CONTRACTED AGENCY INFORMATION

NAME: _____
 ADDRESS: _____
 CITY/STATE: _____

BILLING PERIOD: _____ to _____

Please enter cumulative billing related to a specific client for the month before entering additional client billings. More than one date may be entered for each billing entry.

BERKS COUNTY SCHOOL BUILDING & DISTRICT:						
DATE RENDERED	SCA CLIENT NUMBER <i>(Assessment or Collateral Contact only)</i>	TYPE OF SERVICE <i>A: Assessment PA: Program Activity CC: Collateral Contact</i>	DESCRIPTION OF SERVICE <i>(Program Activity or Collateral Contact only)</i>	HOURS <i>(Quarter hour increments)</i>	RATE <i>A: \$70/hr PA: \$40/hr CC: \$35/hr</i>	TOTAL COST
TOTAL						

Provider Signature _____ Date _____

SCA Approval _____ Date _____

Please sub-