ATTACHMENT E

STUDENT ASSISTANCE PROGRAM : INVOICE/REPORT SUMMARY

CONTRACTED AGENCY INFORMATION

NAME:
ADDRESS:
CITY/STATE: **BILLING PERIOD:** ________to ________

DATE	TYPE OF SERVICE	CUMULATIVE HOURS *(Quarter hour increments)*	RATE PER HOUR	CUMULATIVECOST
	Assessment		$70.00	
	Program Activity		$40.00	
	Collateral Contact		$35.00	
			TOTAL	

Provider Signature **Date**

SCA Approval **Date**