ATTACHMENT D

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 (*Assessment or Collateral Contact only)*	TYPE OF SERVICE *A: Assessment PA: Program Activity CC: Collateral Contact*	DESCRIPTION OF SERVICE *(Program Activity or Collateral Contact only)*	HOURS *(Quarter hour increments)*	RATE *A: $70/hr PA: $40/hr*	TOTAL COST
			TOTAL			

Provider Signature ______________________ Date

SCA Approval ______________________ Date