

CONDITIONAL RELEASE **SUPERVISED RELEASE**

INVOICE

Completion of the form is required for reimbursement of services.

Name—Patient (Last, First MI)	ID Number	Invoice Period (Month/Year)
CATEGORY	COSTS FOR MONTH	COSTS YEAR TO DATE
Communication		
Equipment		
Insurance / Liability		
Miscellaneous Costs		
Postage		
Rent / Occupancy		
Salaries / Benefits		
Sub-Contract Costs		
Supplies		
Support Services Salaries / Benefits		
Training / Professional Fees		
Travel		
SUB-TOTAL DIRECT SERVICES		
Indirect Administrative Costs		
GRAND TOTAL		
Name - Reporting Agency	Name - Authorized Agency Representative	
SIGNATURE - Authorized Agency Representative	Date - Signed	Date - Submitted