COMMUNITY LIVING
Wallaceburg

Service Delivery Invoice

Person Supported _____ Month/Year of Service _____

Parent/Guardian Name _____ Service Provider Name _____

Date	Hrs. of Service	Total hrs. of service	Rate/hr. or flat rate wage	Total to be paid	Support Provided (brief description)
i.e. 5	*4pm–10pm*	*4 hrs*	*$15.00*	*$60.00*	*movies*
i.e 18	*8am-7pm*		*Flat Rate*	*$200.00*	*Library, YMCS, dinner out*
1					
2					
3					
4					
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24					
25					
26					
27					
28					
29					
30					
31					
TOTALS			$	$	

REQUIRED SIGANTURES (Invoice must be signed by both parties in order to be processed)

I verify that the information submitted on this form is actual and correct.

_____ _____ _____ _____

Parent/Guardian **Date** **Service Provider** **Date**

To Submit This Form:

Email: invoice@getintocommunityliving.com Fax: 519-627-8905

Mail/Drop Off: 1100 Dufferin Ave., Wallaceburg, ON N8A 2W1