Self-Directed Staffing Support Invoice

Fiscal Intermediary (FI): Person Centered Care Services	Participant's Name:
SD Staffing Support Name:	Participant's Medicaid/CIN #:
SD Staffing Support Address:	Participant's TABS #:
	Participant's Home Address:

Invoice for the Month/Year of: _____

Put your initials in the "Initials" box below for each date a service was provided. This attests that the service was provided on that day.

Date: Mo/Day	Hrs. Worked From/To am/pm	Total Hours Worked	Face-to-Face (y/n)	Specify the Staffing Support Action Provided in Support of a Valued Outcome (service locations may be noted)	Initials
Total Hours Charged:					

Invoice Amount = Total Hours Worked _____ x Hourly Rate $_____ = $ _____

Signing and submitting false information may lead to a charge of Medicaid fraud.

Signature of SD Staffing Support: _____ Initials: _____ Date: _____

Signature of Participant/Designee_____ Date: _____

For FI Use Only:
Person Centered Care Services
150 Granite Avenue, Staten Island, NY 10303

Date received:_____