Florida Developmental Disabilities Council, Inc.

INVOICE FOR PERSONAL CARE ASSISTANCE

FDDC/Task Force member who was provided services: _____

Meeting/Conference Attended: _____

Location of Meeting: _____

Dates of Service: _____ Location of Service: _____

Rate of Payment: _____* Payment Options/Basis: *(identify basis for payment)*
Daily Rates:
Blocks of Hours Rates:
Sleeping Rates:

Total Charge: $ _____
Travel Reimbursement: $ _____ *(attach Travel Reimbursement form)*

TIMESHEET				
Date	Start Time	End Time	Rate of Payment*	Services Rendered

Provider: _____ _____
Provider's Signature

Address: _____ _____
Date

I hereby certify or affirm and declare that this claim for reimbursement is true and correct in every material matter; that the expenses were actually incurred by me or allowed in accordance with Council travel policy as necessary in the performance of Council Business; and that these expenses have not and will not be reimbursed by another agency or entity.

Member's Signature_____ date_____

For Internal Use Only

Program Approval_____
Date_____
Account_____ Prepared by _____
Reviewed by _____

Exec Dir Approval_____ date_____

Revised 01/11

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