CARE PROVIDER INVOICE FOR PAYMENT

Date Submitted:_____

Care provider Name:			Number of Pages:
CLIENT NAME: **HOURS WORKED**		**MY RATE**	**TOTAL:** (HOURS WORKED X RATE)
Total Weekday Hours:			
Total Weekend Hours:			
Approved Holiday Hours:			
Other Approved Hours:			
Total Miles(with client):			
			Client Total Due:

REIMBURSED EXPENSES:*					
Client:		Where:		Amount:	
Client:		Where:		Amount:	
Client:		Where:		Amount:	
Client:		Where:		Amount:	
			Total RE :		

*Attach Receipts for Reimbursement.

Invoice for services may be:

- faxed to 910-692-4436
- emailed to mytime@aosnc.com
- mailed to PO Box 2478 Southern Pines NC 28388
- dropped off at 676 NW Broad St. Southern Pines NC 28387

Invoices should be submitted per client