Cognitive Disability Strategy Invoice Form

INDIVIDUAL SUPPORTED (**First and last name, date of birth**):

_____

_____

_____

SERVICE PROVIDER (**First and last name, billing address, phone number**):

_____

_____

_____

DATE *(month/ day/year)*	**# of HOURS** *(if applicable)*	**SERVICE** *(or expenditure being invoiced)*	**MILEAGE**	**EXPENSES**
TOTAL				

WAGES:

TOTAL HOURS * $___ /HOUR		$ _____	
TOTAL MILEAGE * $0.___ /KM	+	$ _____	(IF APPLICABLE)
TOTAL EXPENSES	+	$ _____	(IF APPLICABLE)
TOTAL TO BE PAID FOR MONTH	**=**	**$ _____**	

***Complete form in full including the calculations for total invoice amount.**

Verification of hours and work from designated team member

_____ _____ _____

Name (please print) Signature Date

Verification from support worker that information provided is correct

_____ _____ _____

Name (please print) Signature Date

***PAYMENT WILL NOT BE ISSUED WITHOUT BOTH REQUIRED SIGNATURES.**

SUBMIT TO: cds.south@gov.sk.ca **(Regina, SK and south of Regina)**
cds.north@gov.sk.ca **(Anything north of Regina, SK)**
FAX: 306-694-3564

MAIL: **Invoice Payment Clerk, CDS**
Box 1300, Valley View Centre, Moose Jaw SK S6H 4R2

Saskatchewan