

DFCS FOSTER CARE INVOICE

1. Foster Home
 Institution
 Emerg. Shelter
 Respite
 Other
2. CASEWORKER NAME _____
3. CHILD'S NAME _____ AGE _____
4. UAS PROGRAM CODE (S) (CASEWORKER USE ONLY) _____

5. _____ COUNTY DFCS

6. _____
 Foster Home or Institution Address City State Zip Code

7. EXPENDITURES DESCRIPTION AMOUNT USE ONLY FUND SOURCE
 (PLEASE ATTACH RECEIPTS) (CASEWORKER)

	FROM _____ TO _____ Inclusive FOR _____ DAYS @ \$ _____ PER DAY		
b. CLOTHING			
c. SUPPLEMENTAL SUPERVISION			
d. MEDICAL			
e. INCIDENTALS (List)			
f. OTHER EXPENSES (List)			

8. GRAND TOTAL: \$ _____

I hereby certify that the above services have been rendered by me, and that payment, in whole or in part, has not been received from any source.

9. FOSTER PARENT SIGNATURE _____ DATE: _____

I hereby certify that this invoice has been checked and is approved for payment.

10. APPROVING AUTHORITY OR DESIGNEE SIGNATURE _____ DATE: _____

ITEMS 11-14 DFCS USE ONLY

11. VENDOR # _____ 12. CHILD'S # _____

13. EXPENDITURES	CODE	STATE	CODE	COUNTY	CODE	RESTRICTED	TOTAL
a. Per Diem – Regular							
b. Per Diem – Special							
c. AIDS Approved Per Diem							
d. State App. Per Diem Waivers							
e. Initial Clothing							
f. Annual Clothing							
g. Clothing (County/R.F.)							
h. Supplemental Supervision							
i. Child Restraint Devices							
j. Medical Needs							
k. Incidentals							
l. Written Waiver Item							
m. Other							
14. TOTALS:							