STUDENT ASSISTANCE PROGRAM : FEE FOR SERVICE INVOICE/REPORT

CONTRACTED AGENCY INFORMATION

NAME:
ADDRESS:
CITY/STATE:

BILLING PERIOD: ____________ **to** ____________

BERKS COUNTY SCHOOL DISTRICT/BUILDING:

DATE RENDERED	SCA CLIENT NUMBER *(Assessment or Collateral Contact only)*	TYPE OF SERVICE *A: Assessment* *PA: Program Activity* *PAPR02:Collateral Contact* *PAPR07:Collateral Contact* *PIR05:SAP Groups*	DESCRIPTION OF SERVICE *(Program Activity, Collateral Contact or SAP Groups only)*	HOURS *(Quarter hour increments)*	RATE *A: $70/hr* *PA: $40/hr* *CC: $35/hr* *SG: $60/hr*	TOTAL COST
			TOTAL			

Provider Signature **Date** **SCA Approval** **Date**

Please submit to the Council no later than 10 days following the month of service

10/19