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 or Collateral Contact or SAP groups only*)	HOURS (*Quarter hour increments*)	RATE *A: $100/hr PA: $50/hr CC: $45/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