STUDENT ASSISTANCE PROGRAM : FEE FOR SERVICE INVOICE/REPORT SUMMARY

CONTRACTED AGENCY INFORMATION

NAME:
ADDRESS:
CITY/STATE: **BILLING PERIOD:** __/ /__ to __/ /__

DATE	TYPE OF SERVICE	CUMULATIVE HOURS *(Quarter hour increments)*	RATE PER HOUR	CUMULATIVECOST
	ASSESSMENT		$100.00	
	PROGRAM ACTIVITY		$50.00	
	COLLATERAL CONTACT		$45.00	
	SAP GROUPS		$60.00	
			TOTAL	

_____   _____
Provider Signature   Date   SCA Approval   Date