

**SUPPORTED FAMILY LIVING SERVICES
MONTHLY INVOICE AND TIME SHEET
MR/DD RESIDENTIAL SERVICES**

Family's Name: _____

Month: _____

Child's Name: _____

Year: _____

Submit signed original to: Jodi Rivera
Address: Lakemary Center
5940 A Dearborn
Mission, KS 66202
Phone: (913)671-1800
Fax: (913)671-1809

Week of: _____ through _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Week of: _____ through _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Week of: _____ through _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Week of: _____ through _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Week of: _____ through _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Attendance Codes:

P - Present Overnight R - Runaway

V - Approved Visit H - Hospitalization Overnight Amount Due: _____ Days @ \$ _____ per day = \$ _____
TOTAL = \$ _____

“We have provided the supports documented herein and/or we were available to provide the necessary supports to each individual.”

Caregiver Signature: _____ Date: _____

(LMC use) **Authorizing Signature: _____**