ABC Home Care

123 Center Street Springfield, FL 33333 555-444-6666

Tax ID: 99-123456 License #: 1234567

Client: Joe Insured 456 Main Avenue Springfield, FL 33333

NEW CHARGES

Date	Service	Caregiver	Hours	Units	Rate	Charges
11/10/2014 HH	A for 4 Hours or More	Smith, Josephine	8:00AM - 8:00 PM	12.00	\$20.00	\$240.00
"11/11/2014 нн	IA for 4 Hours or More	Smith, Josephine	8:00AM- 8:00 PM	12.00	\$20.00	\$240.00
11/12/2014 нн	IA for 4 Hours or More	Smith, Josephine	8:00AM - 8:00 PM	12.00	\$20.00	\$240.00
11/13/2014 нн	IA for 4 Hours or More	Smith, Josephine	8:00AM - 8:00 PM	12.00	\$20.00	\$240.00
11/14/2014 нн	A for 4 Hours or More	Smith, Josephine	8:00AM- 8:00 PM	12.00	\$20.00	\$240.00

New Charges: \$1200.00

Total Amount Due: \$1200.00

Client Note: John Hancock Policy# 111222

SEE REVERSE FOR DETAILS

Invoice #: 9 – 1234 Client: Joe Insured Invoice Date: 11/18/14 Due Date: Upon Receipt Amount Due: \$1200.00

Please detach and return with payment. Make checks payable to: ABC Home Care 123 Center Street Springfield, FL 33333

Total Enclosed _____

INVOICE: 9-1234

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DATE: 11/18/2014

ABC HOME CARE

Invoice for HHA/CNA Services

This is an agreement between:

Client:

Joe Insured

and HHA/CNA: Josephine Smith

To support billing and reimbursement, as well as other documentation requirements, the HHA/CNA will specify below the services he/she provided to the Client, and will submit the completed form to ABC Home Care for filing and appropriate action. Also, the HHA/CNA will notify ABC Home Care regarding significant changes in the client's appearance, behavior or condition (including hospitalization). The signature of the Client provided for each item below indicates he/she has reviewed the information specified for accuracy, including actual hours worked.

The Client should not sign off on items below if the information specified is either incomplete or not correct.

						Activities of Daily Living/Supervision Services (mark all that apply with an X)							
Client Signature	Date (mm/dd/yy)	Time In (indicate a.m. or p.m.)	Time Out (indicate a.m. or p.m.)	Total Hour s	Hourly Charge	Bathing	Continence	Dressing	Eating	Toileting	Transferring / Mobility	Supervision/ Safetv	Other
J Insured	11/10/14	8AM	8PM	12	\$ <i>20.00</i>	X		X				X	
JInsured	11/11/14	8AM	8 <i>Р</i> М	12	\$ <i>20.00</i>	X		X				X	
JInsured	11/12/14	8AM	8PM	12	\$ 20.00	X		X				X	
J Insured	11/13/14	8AM	8PM	12	\$ 20.00	X		X				X	
J Insured	11/14/14	8AM	8PM	12	\$ 20.00	X		X				X	
	11/15/14				\$								
	11/16/14				\$								