WASHINGTON COUNTY CHILDREN SERVICES FOSTER PARENT 2012 BILLING INVOICE

MONTH/YEAR: ______________________________

NAME: ______________________________

ADDRESS: ______________________________

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CHILD'S NAME	DATE(S)	PLACEMENT DAYS	RESPITE DAYS	TOTAL # OF DAYS	DAILY PER DIEM	AMOUNT BILLED
					TOTAL	

I certify that the statements made herein are true. I have returned this form to the Agency by the second day of the following month; and do understand if I have failed to do so, payment will not be processed until the following Board meeting.

______________________________ ______________
FOSTER PARENT SIGNATURE **DATE**

______________________________ ______________
FOSTER PARENT SIGNATURE **DATE**

NOTE: Please submit to the Fiscal Unit of Washington County Children Services, 204 Davis Avenue, Marietta, Ohio 45750.

INITIALS/DATE RECEIVED BY AGENCY