CRISIS INVOICE

INSTRUCTIONS FOR COMPLETING CRISIS INVOICE (by numbered fields)

This standard invoice, or a modification of it, is to be used by persons or organizations to bill for Crisis services provided to individuals who have been approved for funding by the Community Living disABILITY Services Program.

Service providers may use a modified version of this invoice adapted to their needs. The use of a modified invoice, and its content and form must be approved by the Regional Office. As well, a modified invoice must comply with the standard invoice in terms of information that is provided.

FIELD

1. Facility/Program Name - The name of the facility/program providing the service. A separate invoice must be submitted for each facility/program. This field need not be completed where a supplier operates only one facility/program and the names of the supplier and facility/program are synonymous.

2. Invoice Date - Date on which the invoice is prepared by the supplier.

3. Billing Period - The start date and end date in year/month/day format of the period of service for which the invoice is being submitted. Invoices are to be submitted on a monthly basis.

4. Individual - Surname and given name(s) of individual who received the service for which the invoice is being submitted.

5. Number of Days - Number of days of service being claimed for the individual in the billing period.

6. Number of Hours - Number of hours of service being claimed for the individual in the billing period.

7. Per Diem - The individual's approved per diem.

8. Hourly - The approved hourly rate.

9. Amount - The figure derived by multiplying the number of days by the individual's approved per diem, or by multiplying the number of hours by the approved hourly rate.

10. Other costs – attach receipts and itemized list of costs.

11. Total Amount Payable - The sum of the amounts in item #9 plus item #10 for each individual.

12. Total (columnar) -The sum of the individual amounts in this column.

13. Total (columnar) - The sum of the individual amounts in this column.

14. Total Amount Payable (columnar) - The sum of the individual totals in this column. This sum must equal the columnar totals in item #12 plus item #13 and represents the total amount being claimed in the billing period for all individuals.

15. Authorized (Supplier) Signature - Signature of the person who has been authorized by the supplier to certify the accuracy of the invoice.

16. Payable To (Name and Full Mailing Address) - Legal name, mailing address and postal code of the supplier. This information must be accurate, as the cheque for services rendered will made payable and mailed in accordance with the information entered here.

COMMUNITY LIVING disABILITY SERVICES
Subject: **Support Services: Funding Supports - Appendix A - Crisis Invoice**

ADULT DISABILITY SERVICES

Crisis Invoice

FORWARD INVOICE TO:
MANITOBA
FAMILIES

INVOICE DATE: 2

BILLING PERIOD

FROM: 3
Year/Month/Day

TO: 3
Year/Month/Day

FACILITY/PROGRAM NAME:

1

INDIVIDUAL SURNAME	NUMBER DAYS	NUMBER HOURS	RATE PER DIEM or HOURLY	RATE HOURLY	AMOUNT	OTHER COSTS*	TOTAL AMOUNT PAYABLE
4	5	6	7	8	9	10	11
TOTAL					**12**	**13**	**14**

* Attach receipts and itemized list of costs.

I certify that supplies and/or services have been provided:

15

AUTHORIZED (SUPPLIER) SIGNATURE

PAYABLE TO: (NAME AND FULL MAILING ADDRESS)

FOR FAMILIES USE ONLY

Certified Goods Received and/or Services Performed and Payment Authorized
SIGNATURE:
SAP DOCUMENT NUMBER:

COST ELEMENT	COST CENTRE/ INTERNAL ORDER #	FUND RESERVATION #	FUND RESERVATION ITEM #	$ AMT.
			TOTAL	

VENDOR #:

AUTHORITY - T.B.#:

MG-2515 Rev./19

POSTAL CODE

Date Issued:	January 1, 2019
Replacing:	January 1, 2001

MANITOBA
FAMILIES

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Location	Section	Page