Growing Abilities LLC
Individual Client Billing Document

Month/Year: _____

Page: _____ **of** _____

Provider Name: _____ **Consumer Name:** _____

Consumer ID: _____ **Field Supervisor:** _____ **PPL:__ FOCUS:__**

Service Codes:	**ATC = Attendant Care**	**HAH = Habilitation**	**RSP = Respite**
Location Codes:	**HCBS = Home /Community Based**	**CH = Certified Home**	**ADH/CDH = Adult/Child Foster Home**

Date	Time In AM/PM	Time Out AM/PM	ATC 1-1	ATC 1-2	ATC 1-3	HAH 1-1	HAH 1-2	HAH 1-3	RSP 1-1	RSP 1-2	RSP 1-3	Location Code	Responsible Person's Initials
Totals													

Provider Signature: _____ **Date:** _____

Responsible Person's Signature: _____ **Date:** _____

GA Administration: _____ **Date:** _____

Do not initial and/or sign until after services have been provided. By signing, the provider and responsible person certify the hours of service are correct. Billing document must be legible and accurate for payment to be made. Services can only be provided to the individual listed on the authorization form. Growing Abilities is not responsible to pay for services provided in excess of those authorized for this individual. Use blue or black ink only. Do not use white out and/or cross out information.