Growing Abilities LLC

Employee Monthly Billing Document

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Provider Name:_____ **Phone No:** _____ **Pay period:** _____ 202__
(Please print legibly)

Address:_____ **City:**_____ **Zip:**_____ **Field Supervisor:**_____

CHANGE OF ADDRESS NEEDS TO BE FILED WITH YOUR FIELD SUPERVISOR

Consumer Name (Alphabetical order)	**Attendant Care**	**Habilitation**	**Respite**		**$$$$$**	Office Use Only

Last Name	First Name	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						$ Amt Due	NTS	ATC	D&R	T/S
	Totals																					

Service Hours Due (total of all hours):	**Training Hours** _____ **x $/hr =**_____	
Admin:		**Total $ due this pay period:**

_____ _____ _____ _____
Provider Signature (Required) **Date** **GA Administration** **Date**

The above hours are true and accurate and represent all payments due for the pay period indicated. I understand any errors on my part may result in late payment.