



**INVOICE FOR PAYMENT FOR GENERAL RELIEF ASSISTED LIVING SERVICE**

<b>ALH name:</b>	<b>SDS Provider number:</b>	<b>Taxpayer ID:</b>
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<b>Mailing Address:</b>	<b>Phone:</b>
	<b>Fax:</b>

Individual	Daily Rate	Start	End	Days	Monthly Total	Actual number of days individual was served

**Total:**

ASSISTED LIVING HOME ADMINISTRATOR: Please notify this office in writing if your client moves, transfers, dies, goes to the hospital or disappears from your assisted living home.

**Signature**

*I certify that the named residents received the services specified in the prescribed manner for number of days indicated in the space above.*

<p><b>This form should be properly completed and sent to the address below for payment within 30 days of receipt.</b></p> <p><b>Mail to:</b>          Division of Senior and Disabilities Services          Department of Health          1835 Bragaw Street, Suite 350          Anchorage, Alaska 99508          Fax: 907 269-3648</p>	<p>The Division of Senior and Disabilities Services is not liable for reimbursement for any services <b><u>unless performed in accordance with the provider agreement.</u></b> Prior to submitting this authorization, the provider should verify that the provider number is the same as on the license and the services were delivered to the individuals within the dates specified above, and was for the person/persons named hereon, and that the number of days is correct.</p>
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**For SDS Use:**

General Relief Authorization for Payment    **Initials:**

**Date:**