



Statement of Services Rendered

A. I, _____, provider number _____, provided the following services for _____ during the month of _____.

B.

Specific Services	Rate	Units	Monthly Total
R0001 Personal care			
R0002 Homemaker			
R0003 Medication supervision			
R0004 Food preparation			
R0005 Transportation			
R0006 Other			
TOTAL			

Provider's Signature	Date
Client's Signature	Date

C. Client participation _____ + DHS payment _____ = Total bill _____

D. I, _____, certify that I received the above mentioned services from _____ for the month of _____.

Signature	Date
Signature	Date