INVOICE

Invoice Date	Invoice Number

Service Provider Name: _____

Mailing Address: _____

City: _____ Postal Code: _____

Phone Number:(_____)_____-_____

If payee is different from above complete this section

Payee Name: _____

Mailing Address: _____

City: _____ Postal Code: _____

Phone Number:(_____)_____-_____

Bill To: Autism Funding Unit
Ministry of Children and Family Development
PO Box 9776 STN PROV GOVT
Victoria BC V8W 9S5

Billing Number: _____

Client Name (Child): _____

Month Service Provided:

Type of Service	Dates	# of Hours	Rate Per Hour	Total Amount
			$	$
	TOTAL INVOICE AMOUNT			$

_____ _____

Service Provider Signature Parent Signature