TO: WELLWISE SERVICES AREA AGENCY ON AGING

Mail Invoice to:
P.O. Box 189
Brooklyn, MI 49230
Fax: 517-592-1975

Provider: _____ **Client:** _____ **Month:** _____

Units of Care Provided

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
CLS																																0.0
CLS-No Mileage																																0.0
RN																																0.0
LPN																																0.0
Mileage																																0.0
Chores																																0.0
Other																																0.0

CLS= Community Living Services

	Units	*Unit Cost*	*Sub-total*
CLS	0	@ $ 5.12	= $ -
CLS-No Mileage	0	@ $ 5.12	= $ -
RN	0	@ $ 11.12	= $ -
LPN	0	@ $ 9.45	= $ -

	Units	*Unit Cost*	*Sub-total*
Chores	0	@ $ 5.50	= $ -
Mileage	0	@ $ 0.66	= $ -
Other	0	@	= $ -

GRAND TOTAL **$ -** **Total Due**

Signed _____ Date _____