Placement Committee Checklist for Accounting

Client's Name: ____

Billing Contact Name: ____

Address: ____

____

Phone: ____________________ Fax: ____________________ E-mail: __________________________

Preferred invoicing method: ☐ Mail ☐ Email ☐ Individual pick-up file

Service Area(s): ____

Contact Coordinator: ____

Start Date: ____
Day Month Year

Funding Source	Invoicing
○ CFS (Child and Family Services) ○ SFP (Supports for Permanency) ○ FSCD (Family Supports for Children with Disabilities) ○ Fee for Service ○ Disability Services Contract ○ Canadian Mental Health ○ Other ____________________	○ Mileage ○ Daily Respite Rate/day $___________ ○ Room and Board House ________________ Amount $_______________ Cable $_________________ Internet $________________ Phone $_________________ ○ Trust Account requested Approved by: ___________________________________ Amount of funds coming into trust account monthly $________________________ Regular fixed expenses expected: • Rent $___________________ Paid to:________________________ • Cable $___________________ • Internet $__________________ • Phone $___________________ • Other______________________

____________________ ________________________ Reception _________________
Date Completed Signature Accounting ________________