BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

Facility/Residence Invoice - Daily User Rate

The personal information requested on this form is collected and used by the Ministry of Social Development and Poverty Reduction pursuant to sections 26(c) and 32(b) of the *Freedom of Information and Protection of Privacy Act* for the purpose of administrating the *Employment and Assistance Act* and *Employment and Assistance for Persons with Disabilities Act*. If you have any questions about the collection or use of this information, please contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

Service Provider ID Number	Invoice Number

A: Facility/Residence Type

Mental Health	Substance Use	Community Care
☐ Licensed Mental Health - Residential Care	☐ Licensed Substance Use - Residential Treatment	☐ Licensed Community Care - Short Stay - Respite, Hospice, Convalescence
☐ Registered Mental Health - Assisted Living	☐ Registered Substance Use - Assisted Living Supportive Recovery Home	
☐ Mental Health - Family Care Home		
☐ Mental Health - Tertiary Residential Care		

B: Invoice Information

1. Invoice Date (yyyy/mmm)

2. Payee

Address

Postal Code

Telephone

Fax Number

3. Service Provider Name (if different than Payee)

4. License or Registration Number

Capacity

5. Certified That Services Were Rendered as Stated Below

Name and Title (please print)

Signature

Date Field (yyyy/mmm/dd)

C: Client Invoice Lines

	A	B	C	D	E	F	G	H
	SIN or PHN	Name	Birth Date (YYYY/MMM/DD)	Number of Days	Daily Rate	Total Charged	Deduct Recipient Contribution For the Month (if any)	Total Billed
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
					Totals:			

Completion Instructions - HR0150A
Facility/Residence Invoice - Daily User Rate

Service Provider

A: Facility/Residence Type

1. Indicate the type of facility/residence by checking the appropriate box

B: Invoice Information

1. Enter the 'Year' first then the 'Month' to which the invoice applies
2. Enter the Payee name
3. Enter the Service Provider name in which care is provided if different from above
4. Enter the license or registration number of the facility/residence and bed capacity supporting the Facility/ Residence Type indicated in Section A. If not registered or licensed, enter N/A (not applicable) in both boxes
5. Service provider signing officer must certify the information recorded is correct and the date they certified this information

C: Client Invoice Lines

A. Enter Social Insurance Number (SIN) or Personal Health Number (PHN)
B. Enter the first and last name for each client being billed for (this form may be used for more than one client)
C. Enter the birth date of each client being billed for
D. Enter the number of days that the client was in care during the billing period
E. Enter the daily rate
F. Calculate the total charged based on the number of days the client was in care
G. Enter the total dollar amount contributed by the client, and/or contributed on behalf of the client
H. Enter the total dollar amount billed by subtracting the amount shown in (G) from the amount shown in (F), and enter the answer in (H)

Note: *do not balance forward* (every page is separate).

Total separately, columns F and H. In each "Total" box, enter the applicable figure.