Ministry of Social Development and Social Innovation

STATEMENT OF ACCOUNT
ADULT RESIDENTIAL RESOURCES
For Monthly User Charges

SR Number: _____

The personal information collected on this form is to be used for the administration of the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. Disclosure of personal information is subject to the provisions of the Freedom of Information and Protection of Privacy Act. Any questions about the collection, use or disclosure of information should be directed to your local Employment and Assistance Centre.

INVOICE NO.

1. BILLING FOR THE MONTH OF — YEAR ____ MONTH ____

2. BILL TO: (CONTRACTED NAME ONLY)

ADDRESS

POSTAL CODE

SUPPLIER TELEPHONE

3. SERVICE PROVIDER NAME (IF DIFFERENT FROM ABOVE)

4. SERVICE PROVIDER TYPE

5. LICENSE NO. — LICENSED CAPACITY

6. CERTIFIED THAT SERVICES WERE RENDERED AS STATED BELOW

(PLEASE PRINT) NAME AND TITLE

SIGNATURE — YEAR — MONTH — DAY

	CASE NUMBER (For SDSI Use Only)	NAME	BIRTH DATE YYYY MMM DD	# OF DAYS	MONTHLY 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:			

Security Classification: LOW SENSITIVITY

COMPLETION INSTRUCTIONS - HR0150B
STATEMENT OF ACCOUNT - ADULT RESIDENTIAL RESOURCES

SERVICE PROVIDER

NUMBER 1 - 7

1. Enter the 'Year' first then the 'Month' to which the billing applies
2. Enter the name under which the Ministry has been **contracted** with.
3. Enter the name of the service provider in which care is provided if different from above.
4. Enter the type of service provider.
5. Check box if service provider is non-profit.
6. Check box if server provider is proprietary.
7. Enter the license number of the facility and licensed capacity number. If unlicensed, enter N/A (not applicable) in both boxes.
8. Service provider signing officer must certify the information recorded is correct and the date he/she certified this information.

COLUMN A - F

A. Enter the name(s) of the client(s) being billed for. (More than one client may be used per form)
B. Enter the birthdate(s) of each client being billed for.
C. Enter the number of days that the client was in care during the period billed for.
D. Enter the daily rate.
E. Calculate the total charged based on the number of days the client was in care.
F. Enter the total dollar amount contributed by the client, and/or contributed on behalf of the client.
G. Subtract the amount shown in (F) from the amount shown in (E). Enter the answer in (G).

NOTE: DO NOT Balance forward (every page is separate).

TOTAL SEPARATELY, COLUMNS C,E ,F AND G. IN EACH "TOTAL" BOX, ENTER THE APPLICABLE FIGURE.

NOTE: Ensure Employment and Assistance Office Address is stamped in the upper right hand box before distributing to facilities.