At Home Program
School-Aged Extended Therapies
Sample Invoice

Invoice Date	Invoice Number

Therapist/Agency Name : ______________________________
(must match Therapist/Agency Name provided on School-Aged Extended Therapies Request form)

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: At Home Program Medical Benefits
Ministry of Children and Family Development
PO Box 9763 STN PROV GOVT
Victoria, BC V8W 9S5

Child's Name: ______________________________

MCFD Authorization Number: ______________________________

Month Service Provided:

Type of Service	Date(s)	# of Hours	Rate Per Hour	Total Amount
			$	$
	TOTAL INVOICE AMOUNT			$

______________________________ ______________________________
Service Provider Signature Parent Signature