Provider Name:	
Provider Address:	
Provider City/State/Zip:	
Provider Contact Name:	
Provider Phone Number:	

Invoice Date:	12/3/2015

Invoice Number:	38526

SUBMT TO: La Crosse County Human Services
Attn: HS Fiscal Services
300 4th Street North
La Crosse, WI 54602

Services for the Month of:	November 2015

Total Amount Billed for Services:	$ 786.97

Program (Funding Source)	Participant Name (Client)	Date of Service	Service Description (CCS-Include travel separately)	Service Code	Service Units (CCS = Qthr)	Contracted Rate	Amount Billed	Performing Provider / Clinician Name	Credentials (Degree) of Provider
CCS	Joe Johnson	11/11/15	Indiv Psychotherapy In Home Hrly Mast		15	$ 22.00	$ 330.00	John Smith	Masters
CCS	Joe Johnson	11/12/15	Indiv Psychotherapy In Home Hrly Mast Travel		1	$ 22.00	$ 22.00	John Smith	Masters
CCS	Joe Johnson	11/13/15	Ind Skill Dev& Enhance Grp Hrly Bach		17	$ 12.00	$ 204.00	John Smith	Bach
CCS	Jill Johnson	11/14/15	Psychotherapy Individual Hourly Mast		10	$ 18.30	$ 183.00	Valerie Sill	Masters
CCS	Jill Johnson	11/15/15	Employ Related Skills Train Hrly PS		8	$ 5.33	$ 42.64	Valerie Sill	Peer Specialist
CCS	Jill Johnson	11/16/15	Employ Related Skills Train Hrly PS Travel		1	$ 5.33	$ 5.33	Valerie Sill	Peer Specialist
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I certify that all services have been provided. (Claims for services must reflect actual services provided.)

Total Amount Billed for Services:	$ 786.97

Provider Signature: _____
(Type or Sign Name)