

NYS OPWDD Consolidated Supports and Services (CSS)



CSS-03

Invoice/Service Record for Contracted/Vendor Services

Financial Management Services Agency (FMS):
Contractor's Name:
Contractor's Title:

Participant's Name:
Participant's Medicaid CIN:
Primary Service Locations:

Invoice for the Month of: _____

Valued Outcomes: (Enter the participant's valued outcomes and the supports and services associated with each outcome.)

A)	
1.	
2.	
3.	

B)	
1.	
2.	
3.	

Put your initials in the "Initials" box below for each date a service was provided. This attests that the service was provided on that day.

Date: Mo/Day	Hrs. Worked From/To	Tot. Hours Charged	Face-to- Face (y/n)	Specify the <u>Contractor's Action</u> Provided in Support of a Valued Outcome (service locations may be noted)	Initials
	/				
	/				
	/				
	/				
	/				
Total Hours Charged:					

Additional Comments: _____

Invoice Amount = Total Hours Worked _____ x Hourly Rate \$ _____ = \$ _____
--

Check here if there is a shared staff arrangement (more than 1 person served at same time) Identify other persons served _____

Signing and submitting false information may lead to a charge of Medicaid fraud.

Signature of Contractor: _____ Initials: _____ Date: _____

Signature of Participant/Designee: _____ Date: _____

Participant: Original to FMS
For FMS Use Only – Payroll Authorization _____ (FMS Initials)

Revised 10/18/11
 Invoice/Service Record for Contracted/Vendor Services