## **HOME HELP AGENCY INVOICE**

Michigan Department of Health and Human Services

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Home Help Agency Name							Home Help Agency Provider Number							
							5844640							
Home Help Agency Telephone Number					Cor	Contact Person Date Submitted					:d			
(616) 432-4595							FELICIA NICHOLSON							
Client N														
Client M		l ID Nu	mber											
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1	COMPLEX CARE TASKS									
Color   Colo	Days of Billing Month	Bowel Program	Catheters for Leg Bags	Colostomy Care	Eating or Feeding Assistance	Peritoneal Dialysis	Range of Motion Exercises	Specialized Skin Care	Suctioning	Wound Care
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## **Total Time for Services Billing Period:**

Instructions: Add the total hours and minutes of	of ADL, IADL and Complex Care tasks provided to the client
and, if applicable, the total travel hours and mi	inutes for shopping and laundry. Authorized payments will
not include billed time in excess of the agency	's approved Time and Task amount.
I certify that	has provided all the services as checked above.

Signature of Authorized Representative	Date	
MSA-1904 (7-19)	2	