HOME HELP AGENCY INVOICE

Michigan Department of Health and Human Services

Home Help Agency Name	Home Help Agency Provider Number	
TRU HOME HELP CARE	5844640	
Home Help Agency Telephone Number	**Contact Person**	**Date Submitted**
(616) 432-4595	FELICIA NICHOLSON	
Client Name		
Client Medicaid ID Number		
Hourly Rate	Services Billing Period Month/Year	
Bill To: KENT COUNTY MDHHS		

ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Days of Billing Month	Bathing	Dressing	Eating	Grooming	Mobility	Toileting	Transferring	Housework	Laundry	Travel Time for Laundry	Medication	Meal Preparation	Shopping	Travel Time for Shopping
1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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13	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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23	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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25	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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COMPLEX CARE TASKS									
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
1	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐	☐	☐
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13	☐	☐	☐	☐	☐	☐	☐	☐	☐
14	☐	☐	☐	☐	☐	☐	☐	☐	☐
15	☐	☐	☐	☐	☐	☐	☐	☐	☐
16	☐	☐	☐	☐	☐	☐	☐	☐	☐
17	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	☐	☐	☐	☐	☐	☐	☐	☐	☐
19	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	☐	☐	☐	☐	☐	☐	☐	☐	☐
21	☐	☐	☐	☐	☐	☐	☐	☐	☐
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27	☐	☐	☐	☐	☐	☐	☐	☐	☐
28	☐	☐	☐	☐	☐	☐	☐	☐	☐
29	☐	☐	☐	☐	☐	☐	☐	☐	☐
30	☐	☐	☐	☐	☐	☐	☐	☐	☐
31	☐	☐	☐	☐	☐	☐	☐	☐	☐

Total Time for Services Billing Period:

Instructions: Add the total hours and minutes of ADL, IADL and Complex Care tasks provided to the client and, if applicable, the total travel hours and minutes 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