(Please Print)

Service Provider Invoice

Remit at the end of each month

1. Service/Billing Period:

From: ________________

To: ________________

2. Service Provider Information

Provider Name: ___________________________________

Provider Address: ________________________________

____

City: ____

Postal Code: ________________ **Phone:** _____________

3. Client Name *(1 invoice per client)*	**Client Address**

4. Service Description – *As outlined in SMILE Letter*	**Date of Service (MMM/DD/YYYY)**	**# of Hours**	**Fee per Hour/Visit**	**Total**
Example: *Household Management*	*JAN/15/2019*	*2*	*15.00*	*30.00*
Week 1				
Week 2				
Week 3				
Week 4				
Week 5				
			Total $	

5. Client Signature: ____________________________

Date: ____________________________

(Must be signed/dated by client after last day of service)

6. Please submit to: VON SMILE Program
80 Division Street, Suite 14
Trenton, ON K8V 5S5
Fax: 1-866-965-4389

For SMILE Program Use Only		
Received in SMILE Office	Date Entered	Document Number

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Revised 2019
Next Review: 2022

Please fill out the Service Provider invoice using the following instructions.
Submit for payment at the end of each month.
If submitting by fax, please use a cover sheet
It is your responsibility to provide your own invoices.
You may use this template, photocopy it, and keep an appropriate supply for your use.

Instructions

1. Fill in service/billing period. From: (first date worked within billing period)
   To: (last day worked within billing period)

   **Services must have been provided prior to submission.*

2. Fill service provider information. It is important to fill in your name as it appears on your bank account, complete mailing address and phone number. ***Reminder – you are a private business; not a SMILE employee***

3. Fill in client's name and complete address.

4. Fill in each week's service, as outlined in your SMILE letter and include:
   - Service Description
   - Date of Service
   - Number of Hours
   - Fee per hour/visit
   - Total Amount

5. The client must sign and date the invoice prior to submission. Client must sign after last day of service.

6. Either mail OR fax invoice, (not both), to:
   SMILE Program
   80 Division Street, Suite 14
   Trenton, ON K8V 5S5
   Fax: 1-866-965-4389

Incomplete invoices will be returned to the service provider, delaying service provider payment
*Please Note: Invoices are payable 35 days after receipt in the SMILE office.

If you have any questions, please contact the SMILE Program at 1-888-866-6647.