Advantage Communications
SUBSTITUTE CARE
Provider Billing Form

Date	Date of Week	__ to __	Hours
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
		Total Hours	0

Individual: _____

Service Month/Year: _____

Total Hours Billed: _____

Family Living Provider: _____

Signature: _____

Provider: _____

Provider Signature: _____

Advantage Communications Signature:

_____

Printed:

_____