

**Mountain State Family Alliance  
Mental Health Support Services (MHSS) Invoice Form**

IEP Pilot Project

Child's Name:	
Vendor Name:	
Vendor Address:	
Vendor Phone:	

Service	Description	Cost Per Session	Total Sessions	Total Due Vendor

**To Invoice for services provided:**

- 1) Fully complete the section above, detailing the number of sessions/cost per session.
- 2) Documentation that services were provided (complete summary statement below or attach to invoice)

I am invoicing a total amount of \$\_\_\_\_\_ for services provided to the child/family listed above for a period covering \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ **(A REVIEW IS REQUIRED EVERY 90 DAYS)**

*I hereby certify that services listed above were provided; and that no other payment has been received.*

\_\_\_\_\_  
VENDOR'S SIGNATURE

\_\_\_\_\_  
DATE

**MSFA OFFICE USE ONLY:**

\_\_\_\_\_  
CLINICAL COORDINATOR OR DESIGNEE

\_\_\_\_\_  
DATE

Summary Statement (Detailed description of services provided including progress): _____ _____ _____ _____
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