

State of Oregon  
Department of Human Services  
Seniors and People with Disabilities

Cost Center: 9000  
Voucher No: 2011000001

**For DD-PC20 only: Return 1 completed original voucher to the address on the back of the voucher**

After completing payment voucher, save one copy for your records and return one copy to the branch office. (Attn: PROVIDER PAYMENTS UNIT)

Provider Name: BEAR, SMOKEY

Provider Number: 123456

Client Name: EVERGREEN, BABY

Prime Number: AA000A1A

Service Period Authorized: (08/01/11) thru (08/31/11)

Worked ( / / ) thru ( / / )

Services Authorized: ADL Aide Hourly

**To be completed by provider: Date ranges for services provided – e.g., 8/1/11 thru 8/20/11.**

	Rate:	Authorized Units:	Units Worked:
PCall ADL Aide Hourly	\$8.92	20.0	
Total:	\$8.92	20.0	

**To be completed by provider: Total hours worked for the date ranges reported above. Maximum 20 hours per month.**

**PROVIDER CERTIFICATION:**

I have read and fully understand the following agreement: Payment of this claim will be from federal and state funds. Any falsification or concealment of a material fact may be prosecuted under federal and state laws. I am NOT a provider of the Department of Human Services, any of its Divisions or any Area Agency on Aging.

The Department, in consideration of the services provided, agrees to pay the employee at authorized rates, upon receipt of proper invoices(s). Payment will not be made for any units worked over the Maximum Authorized. No additional charges shall be imposed to either the employer, or the Department, or the Area Agency on Aging under this agreement.

I will receive a payment for the total minus Taxes/WCD. The payment may be reduced by recoveries, overpayments, garnishments or other deductions.

By signing this invoice, I certify the above information is true, accurate and complete.

**Provider signs and dates first! This date must be the same or after the last date worked above – e.g., 8/20/11 or later**

Provider Signature

Date

**CLIENT CERTIFICATION:**

By signing this invoice, I certify that the service described above was received by me.

I hereby designate the Department as agent for the purpose of doing all that is required pursuant of Section 3504 I.R.C. (This designation is not applicable if the payee is a private firm or agency employee.)

Client/Employer Signature

Date

**(Client) Parent signs and dates after Provider. Be sure to verify the accuracy of Provider's entries.**

**Sample**

State of Oregon  
Department of Human Services  
Seniors and People with Disabilities  
PO Box 14990, Salem OR 97309-5083

Voucher No: 2011000001  
Phone Number:  
Cost Center: 9000

Smokey Bear  
01211 Forest Street  
Timberville, OR 97000

Provider Number:123456

SAMPLE

Sample