AdoptionLinks

A Program of Jewish Family Service
of Greater Harrisburg, Inc.

Resource Family Program

INVOICE SUBMITTED FOR: ____
month/year

Name of child: ____Child'

County of Dependency: ___________________________________

Name of family: ____

Address: ____

Telephone: ____

Child's level of care AA___ AX___BB ___BX ___CC___ CX___DD___

Per diem rate $_________ X _____ days of month child in home = $________________

For Agency use only:

Invoice sent to county:

Payment request for Resource Family:

Check mailed to Resource Family:
10/17