

**SUPPORT INVOICE**  
**For Reimbursement of Support Costs(s) as per Agreement**

Payment To: \_\_\_\_\_

Name of Person Supported: \_\_\_\_\_

**Return Invoice To:**  
CLW  
7025 Enterprise Way  
Windsor, ON  
Phone: 519-974-4221  
Fax: 519-946-0250

**Support Information for Reimbursement:**

Date Worked	Time Worked eg. 5:00 pm - 10:00 pm	Total Number of Hours	Type of Support Provided & Where eg. Personal Care at Home, Recreation @ YMCA	Self Employed Contractor(s) Name PLEASE PRINT	Self Employed Contractor Signature

Total: \_\_\_\_\_ Hours/Days  
Rate of Pay: \$ \_\_\_\_\_ per hour/day

**TOTAL:** \$ \_\_\_\_\_

**OTHER EXPENSES AS OUTLINED IN YOUR INDIVIDUALIZED FUNDING COST SUMMARY**  
**OFFICIAL/STORE RECEIPTS MUST BE ATTACHED**

DESCRIPTION	COST

**TOTAL TO PAY:** \$ \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE**  
**OR PERSON SUPPORTED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADMINISTRATION USE ONLY**

4715-510	\$	4715-	\$
4715-540	\$	4850-	\$
		4310-	\$

<b>AUTHORIZATION FOR PAYMENT</b>	
_____	
DD:	CC: