Provider's Name
Provider's Address
Phone number and Fax
FEDERAL TAX ID# _____

Delaware Health and Social Services
Division of Development Disabilities Services
Contract Manager
1054 South Governor's Avenue, Suite
Dover, De 19904

Invoice Number: _____
Invoice Date: _____
Terms: Due Upon Receipt
Services From: _____
Type of Service: _____

Client	Billable Units	Unit Rate	HCBS Waiver Monthly Billing	State Plan Monthly Billing	DDDS Non-Waiver Monthly Billing	DDDS Monthly Invoice
			-	-	-	-
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Totals	-		-	-	-	-

Total Amount Due This Invoice: **$** **-**