DPHHS-AD-017
(Rev. 7/2014)

STATE OF MONTANA
Department of Public Health and Human Services

Quality of Life Survey Assessment Invoice

Phone Number: **Agency #: 69010**

Invoice Number: SLTC - MFP 0001 Date:

BILL TO:	**MAIL CHECK TO:**
Montana Department Of Health and Human Services **Senior and Long Term Care** **Money Follows the Person Demonstration Grant** **PO Box 4210** **Helena, Mt 59604**	

DATE OF SERVICE	ITEM DESCRIPTION	UNIT	QUANTITY	UNIT PRICE	AMOUNT
				$100.00	

DOCUMENT ORIGINATOR | Date: | Phone: | **TOTAL**: $

I CERTIFY THAT THIS CLAIM IS CORRECT AND JUST IN ALL RESPECTS, AND THAT PAYMENT OR CREDIT HAS NOT BEEN RECEIVED.

Signed: Title: Date:

FOR DPHHS STATE USE ONLY

CUST. ID NO.	ACCT	FUND	ORG	PY	SUB-CLS	BY	PRJ/GRT	AMOUNT	SPEED CHART
								$	
								$	
								$	
								$	

Transaction Description:

Prepared/Entered By:	Date:	Approved By:	Date:

Comment [???1]:
IN ORDER FOR THE AUTOMATIC CALCULATION TO TAKE PLACE YOU MUST SELECT CALCULATE TABLE

FROM THE WORD PERFECT MENU (2ND LINE ON SCREEN) SELECT:
- TABLE
- CALCULATE
- CALCULATE TABLE
- OK