

# Community Partner Invoice Form for State Services for the Blind

## Service Vendor Information

Community Partner Name:

SWIFT ID:

Business Name:

## Invoice and Authorization Information

Invoice Number:

Record ID or Customer Initials:

Authorization/PO Number:

Authorization Issue Date:

Authorized Service Date(s):

Date of Invoice:

Date(s) Services Provided:

## Remittance

Business Name:

Address:

Street

City

State

ZIP Code

Phone Number:

Fax Number:

Email Address:

Total Service Amount: \$

(Calculated from page 2)

Total Mileage Amount: \$

(Calculated from page 2)

Total Invoice Amount: \$

(Total Service + Total Mileage)

Check box if this is the final invoice:

**IMPORTANT:** Send all invoices to SSB Invoices, 2200 University Ave W, Suite 240, St. Paul, MN 55114.

Counselor Name (Direct Support Staff):

VR Tech Name (if applicable):

## Approval

**Staff use only:** Complete once the invoice has been approved for payment.

Ok to Pay Line 1: \$

Ok to Pay Line 2: \$

Ok to Pay Line 3: \$

Date Approved:

Signature:

Supervisor (Optional):

Business Name:

Invoice Number:

Record ID or Customer Initials:

### Service Expense

Date of Service (MM/DD/YYYY)	# of Units	Description or Type of Service Provided	Service Type: Title	Unit of Measure: (Hours, Weeks)	Unit Price	Subtotal (# of units x Unit Price)
					<b>Total:</b>	

### Travel Expense

Dates of Travel	Starting Location (Full Address)	Start Time	Ending Location (Full Address)	End Time	Total Time Traveled	Total Miles Traveled

Total Miles:

X Mileage Rate:

= Total Mileage Amount: \$