INVOICE
I/DD WAIT LIST SUPPORT GRANT FUND

AGENCY:	
AGENCY ADDRESS:	
Participant:	
Date(s) of Service:	

Service Provided Options 1 and 2		**Page**	**Number of Units Billed for Each Service**		**Amount for Each Service**
Case Management Services		**8**		**$200.00 qtr.**	
Behavioral Support Professional Day Services		**8**		**$12.80 unit**	
Supported Employment	1:1	**7**		**$7.52 unit**	
	1: group	**7**		**$3.02 unit**	
Prevocational Services	1:3-4	**7**		**$3.20 unit**	
	1:5-6	**7**		**$2.03 unit**	
Facility Day Habilitation	1:3-4	**7**		**$3.20 unit**	
	1:5-6	**7**		**$2.03 unit**	
Respite	1:1	**8**		**$6.36unit**	
	1:2	**8**		**$3.18 unit**	
	1:3	**8**		**$2.12 unit**	
Transportation *CAP =900 miles @ CURRENT MILEAGE RATE*		**8**		**$0.50mile or $9.89 trip**	
OPTIONS 3 AND 4					
Behavioral Support Professional II		**8**		**$15.34 unit**	
Case Management (CM)		**8**		**$100.00**	
EAA		**8**		**$1.00 unit**	
Annual	**CM**	**8**		**$100.00**	
			TOTAL AMOUNT OF INVOICE		

Please forward invoice to:
Title XIX ID/DD WAIVER SUPPORT GRANT FUND
Bureau for Behavioral Health
Division of Developmental Disabilities
350 Capitol Street, Room 350
Charleston, WV 25301
Email: pamela.a.ingram@wv.gov

Signature and Printed Name Date

I certify that this invoice is accurate to the best of my knowledge

BBH APPROVAL ___YES_____NO

BBH Representative Signature **Pamela A. Ingram** Title **BHSS** Date

To the best of my knowledge, I certify that this invoice corresponds with the approved Eligible Applicant Special Funds Application

Effective Date: January 13, 2025