Guthrie Mainstream Services LLC
Employee Monthly Billing Document

Provider Name: _____ **Phone No.:**_____ **Pay period:** _____**201**___
(Please print legibly)
Address: _____ **City:**_____ **Zip:**_____ **Field Supervisor:**_____

Change of Address needs to be filed with your Field Supervisor

Consumer Name (Alphabetical order)	**Attendant Care**	**Day Treatment**	**Habilitation**	**Respite**	$$$$$	Office Use Only

Last Name	First Name	ATC 1-1	ATC 1-2	ATC 1-3		DTT DTS 1-1	DTT DTS 1-2	DTT DTS 1-4		HAH 1-1	HAH 1-2	HAH 1-3		RSP 1-1	RSP 1-2	RSP 1-3		$ Amt Due	NTS	ATC	D&R	T/S
Totals																						

Service Hours Due (total of all hours):	**Training Hours _____x $/hr =_____**	
Admin:		**Total $ due this pay period:**

_____ _____ _____ _____
Provider Signature (Required) **Date** **GMS Administration** **Date**

The above hours are true and accurate and represent all payments due for the pay period indicated. I understand any errors on my part may result in late payment.