N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

BILLING FOR MINI CENTER INSTRUCTORS

For the Period _____ to _____ 20_____

_____ _____

Authorization Number County

Day of Month	Hours Worked
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
26	
27	
28	
29	
30	
31	

_____

Mini Center Instructor's Name (Print or Type)

_____

Social Security No. (**Last 4 Digits Only**)

_____

Address

_____ _____

City State

_____

Zip Code

Hours Worked _____ at $ _____ Gross: $ _____

_____ _____

Signature of Mini Center Instructor Date

_____ _____

Counselor Initials Date

_____ _____

Payment Start Date Payment End Date / Invoice Date

_____

Consumer

Original and Copy to Business Affairs and Copy to Counselor.

Business Affairs Mails Copy to Mini Center Instructor with Check.