

Family Care Service Invoice – United Steelworkers

Caregiver/Agency Name: _____

Street Address: _____

City and Postal Code: _____

Phone Number: _____

Licensed (circle one): Yes No

Related to claimant or person receiving care
(circle one): Yes No

Bill to:

USW Member Name: _____

Phone Number: _____

Date(s) of Care	Hours of Care	Type of Service Provided (e.g. elder care; child care)	Amount Charged
			\$
			\$
			\$
Total cost of care:			\$

Family Care Provider Signature:	
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Date: _____