Lancaster County Drug and Alcohol Commission
Recovery House Scholarship Invoice

Facility Name: _____
Address: _____
_____

Vendor Number: ___ ___ ___ ___ ___ ___
Month/Year of Invoice: ____/_____

#	Resident Name	Resident Date of Birth	Scholarship Start Date	Scholarship End Date	Cost Per Night	# of Nights	Total	Is Resident Employed? (Yes or no)	Is Resident Seeing a Case Manager (Yes or no)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
				TOTALS					

Provider Signature: _____ Date: _____

Phone #: _____ Email Address: _____

S://0D&A Fiscal Forms and Documents/Invoices
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