CLARK COUNTY SOCIAL SERVICES
SENIOR NURSING FACILITY INVOICE

Facility Name

Billing Month

#	Client's Name	Case #	SENIOR NURSING FACILITY CHARGES						Total Amount Due
			Billing Dates		# Days	Daily Rate	Facility Charges	Authorized PL Amount	
			From	To					
1							$0.00		$0.00
2							$0.00		$0.00
3							$0.00		$0.00
4							$0.00		$0.00
5							$0.00		$0.00
6							$0.00		$0.00
7							$0.00		$0.00
8							$0.00		$0.00
9							$0.00		$0.00
10							$0.00		$0.00
11							$0.00		$0.00
12							$0.00		$0.00
13							$0.00		$0.00
14							$0.00		$0.00
15							$0.00		$0.00
16							$0.00		$0.00
17							$0.00		$0.00
18							$0.00		$0.00
19							$0.00		$0.00
20							$0.00		$0.00
21							$0.00		$0.00
22							$0.00		$0.00
23							$0.00		$0.00
24							$0.00		$0.00
25							$0.00		$0.00
26							$0.00		$0.00
27							$0.00		$0.00
28							$0.00		$0.00
29							$0.00		$0.00
30							$0.00		$0.00
							Invoice Total:		**$0.00**

FACILITY CONTACT NAME &TITLE PHONE # & EMAIL:	

Please email a copy of the invoice to
CCSSInvoices@ClarkCountyNV.gov by the **5th** of the month