FEE AGENT BILLING REPORT
Department of Health
Division of Public Assistance

Office Location:

Report Month:

Payee or Fee Agent's Name	Payee's VCUST	Address	GEN 50C (Interview Done)			GEN 50C (Interview Not Needed) GEN 72 GEN 152 GEN 60 HAP 1 or AKH2O 1			Monthly Work Hours for Temporary Assistance Clients			Total Amount Due
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
				$25	$0		$15	$0		$5	$0	$0
									TOTAL REPORT			**$0**

Submitted for payment by (Print Name): **Phone Number:**

Signature: **Date:**