Alaska Department of Health
Division of Public Assistance

ATAP Work Services Performance Invoice

Report Month:	Date Completed:	Contract Year:	DPA Reviewer:	Date Reviewed by DPA:
Service Provider:		Contract Number:	Invoice Number: □ Original □ Revised/Revision Date: _____	

Performance Billing
(Completed by Work Services Provider)

Metric	Possible	Met	Rate	PFP Total	Core Amount	Total Billed
1. Employed in 90 days				$	$	$
2. Cases that closed with Earnings				$	$	$
3. Cases that Don't Return				$	$	$
4. Overall Participation				$	$	$
5. Two Parent Participation				$	$	$
6. Job Development				$	$	$
Current performance total				$	$	$
Rent Deduction (-)				$	$	$
Total Billed				$	$	$

Contractor Signature:	Date:
Printed Name:	
Contact Phone Number:	
Notes:	
DPA Approval Signature:	Date:

DOH Use Only

Encumbrance Number: PVN: Pay from line ___

Payment amount: $_____.___ Payment Method: ☐ EDI Transfer ☐ General Warrant