Alaska Department of Health
Division of Public Assistance

ATAP Work Services Supportive Services Invoice

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

Supportive Services Expenditures
(attach Supportive Services Spreadsheet)

Job Development $	Supportive Services: $	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