South Carolina Department of Social Services

FOSTER CARE RESPITE/COLLEGE YOUTH OVERNIGHT PAYMENT INVOICE

❑ Foster Care Respite Payment

OR

❑ College Youth Overnight Payment

Make check Payable to:

Name of Provider: _____

Mailing Address: _____

_____

Provider Social Security Number: _____

Form W-9 completed? ❑ Yes (First time only) Payment information may be reported to the IRS. If reported, provider will receive Form 1099 for tax reporting purposes.

Name of Foster Child: _____

Foster Parent Requesting Respite **OR** Name of College Youth Attends: _____

Date(s) of Respite/Overnight Visits: _____

Provider Signature: _____ Date: _____

Caseworker Signature: _____ Date: _____

FOR DSS STATE OFFICE ONLY

Amount Due: _____

Foster Parent Requesting Respite: _____

Provider ID No.: _____

_____ _____

Signature, Human Services Staff, State Office Date