STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

VR/WAP - WORK SERVICES INVOICE SUMMARY

DR 373A (New 02/08)

Date:

Bill to DOR District Office Name & Address:	Work Services Provider Name & Address:

WAP #:	Federal Tax ID #:	Billing Month/Year:	Invoice # (optional):	# Detail Pages Attached:

INSTRUCTIONS:

- DR373A must be supported by the DR373B VR/WAP - Work Services Invoice Detail and DR372 VR/WAP - Monthly Work Services Report for each consumer listed on DR373B.
- Amounts invoiced on DR373A cannot exceed the authorized hours for each consumer listed on DR373B.
- Submit two (2) copies. Each summary page must have an original signature **in blue ink**.
- Write "VR/WAP Work Services Invoice" on the envelope.
- Mail to the DOR District Office, Attention: Account Technician.

Total Invoiced	Rate	Total Amount
Work Services Days		
Work Services Hours		
TOTAL INVOICE AMOUNT		$0.00

I certify that the reimbursements herein requested do not duplicate payments received or anticipated from any public or private not for profit agency for the same consumer, service, and service periods; and that I am authorized to make such certification for the named rehabilitation facility. Days/hours billed are for eligible and authorized consumers; consumers billed were in attendance and received authorized services; and days/hours billed were in accordance with all legislative and regulatory requirements.

Signature (use blue ink):	Completed by (type or print):	Phone Number:
✍		

DOR USE ONLY: Approved for payment based on documentation of services provided.	Approved by: ✍	Date:

Distribution: ☐ DOR District Office ☐ WAP Service Provider Attachments: ☐ DR373B ☐ DR372

NOTICE: This is confidential information from the records of the California Department of Rehabilitation. State law and departmental regulations prohibit you from making any further disclosure of this information without the informed, written consent of the person to whom this information pertains.

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