MONTHLY CASE MANAGEMENT BILLING AND REPORTING

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LIHEAP
SFN 339 (4-2024)

Clear Fields

NOTE: A separate form for each county per month must be submitted to each referral source.

Name (C.A.A.)			Residential County				
Address of Payee			Month/Year of Service				
City	State	ZIP Code	Cost Per Hour			Cost Per Unit	

NAME, LIHEAP BILLING NUMBER, AND CASE NUMBER	LIHEAP ELIGIBLE	YEAR OF ELIGIBILITY	NUMBER OF CONTACTS	UNITS OF SERVICE 1/4 Hr = 1 Unit	TOTAL COST
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
Name LIHEAP Billing Number / Case Number					
TOTAL					

I hereby certify that this is an accurate statement of the contacts and units of service delivered. (Attach monthly data report).

☐ By checking this box and typing my name, I am signing this Monthly Case Management Billing And Reporting form. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Community Action Agency Director	Date

☐ By checking this box and typing my name, I am signing this Monthly Case Management Billing And Reporting form. I agree that my electronic signature is the legal equivalent of my handwritten signature.

LIHEAP Policy Representative	Date

DISTRIBUTION: **CAA:** Complete, sign, and email a copy of the signed form along with the monthly data report(s) to: dhsliheapsys@nd.gov
Retain a copy for your records.