(FACILITY NAME)

(ADDRESS)

(ADDRESS)

SCHOOL YEAR 2024-2025
INVOICE

(MONTH ENDING DATE)

Mississippi Department of Education
Attention: Educable Child Program
Office of Special Education
P. O. Box 771
Jackson, MS 39205

STUDENT NAME: _____

MONTH	NO. DAYS	DAILY RATE	AMOUNT DUE	APPLICATION TYPE (PARENT, DHS, PARENT MEDICAID, SCHOOL DISTRICTS)
AUGUST				
SEPTEMBER				
OCTOBER				
NOVEMBER				
DECEMBER				
JANUARY				
FEBRUARY				
MARCH				
APRIL				
MAY				

Verified By

Date