DATE OF INVOICE

|  |  |  |  |
| --- | --- | --- | --- |
| Provider Information | | | |
| Provider’s Name |  | FamLink Provider ID |  |
| Provider’s Address |  | Provider’s Phone |  |
| Name of person who did the services |  | Degree or Level |  |
| **DCYF Information** | | | |
| DCYF Office |  | DCYF Caseworker |  |
| Phone Number |  |  | |
| **Client Information** | | | |
| Client’s Name |  | FamLink Case ID |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Referral** | | | |
|  | Chemical Dependency Assessment / Treatment |  | Parenting Assessment |
|  | Mental Health Therapy w/ Intake Assessment |  | Parenting Instruction (group only) |
|  | Developmental Assessment |  | Sexual Deviancy Evaluation (adults only) |
|  | Domestic Violence Perpetrator Evaluation |  | Adult Sex Offender Treatment |
|  | Domestic Violence Perpetrator Treatment |  | **EBP** - Mental Health Therapy w/ Intake Assessment |

Allowed hours & rates are posted at <https://www.dcyf.wa.gov/services/child-welfare-providers/contracted-services>. Billed hours cannot exceed what DCYF authorized.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Service Description** (face to face, reports etc.) | **Hours** | **Rate** | **Amount** |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  |  |  |  | $0.00 |
|  | **Totals** | 0.00 |  | $0.00 |
|  | | **Total Due** | | $0.00 |

**Include a copy of the signed referral and the final report with this invoice.**

**Comments:**