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:**