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|  | **Washington State Department of CHILDREN, YOUTH & FAMILES****PSYCHOLOGICAL SERVICES BILLING STATEMENT** | DATE OF INVOICE |

|  |  |  |  |
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|  Provider Name |          |  FamLink Provider ID |        |
|  Provider’s Address |          |  Provider’s Phone |        |
|  DCYF Caseworker |  |  Phone Number |  |
|  DCYF Office  |  |  FamLink Case ID |  |
|  Client’s Name |  |  Client’s Phone Number  |  |

|  |  |  |  |
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| **Service Provided** | **Service Time %** | **Amount Billed**  | **Total Due** |
|[ ]  Psychological Evaluation (Testing with interpretation and report) | # of hours        | $       per hour | $       |
|[ ]  Neuropsychological testing battery and neuro-behavioral status exam with interpretation and report *(Conducted in addition to a Psychological Evaluation)* | # of hours       | $       per hour | $       |
|[ ]  Parental Evaluation/Parenting Component *(Conducted in addition to a Psychological or Neuro-psychological evaluation)* | # of hours       | $       per hour | $       |
|[ ]  Professional Consultations with DCYF staff or other authorized parties With report | # of hours       | $       per hour | $       |
|  | **1 Unit = 30 minute**  |
|[ ]  Individual psychotherapy with report | # of units        | $       per unit | $       |
|[ ]  Family group of 2 or more -- Psychotherapy & report WITH client present  | # of units        | $       per unit | $       |
|[ ]  Family group of 2 or more -- Psychotherapy & report WITHOUT client present  | # of units        | $       per unit | $       |
|[ ]  Group Psychotherapy with unrelated individuals | # of units       | $       per hr, per person | $       |

**1 Unit = 15 minute**

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|[ ]  Case Related Travel | # of units       | $       per hr, per person | $       |

Allowed hours & rates are posted at <https://www.dcyf.wa.gov/sites/default/files/pdf/Fee-PsychologicalServices.pdf>

% cannot exceed what DCYF authorized.

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| **Date** | **Description of Tasks** *(client interview, written testing, report writing, etc.)* | **Hours** |
|       |       |       |
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**Include a copy of the signed referral and the final report with this invoice.**

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| **COMMENTS:**       |

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***Provider Signature***