JUVENILE FORENSIC SERVICES INVOICE

Attachment D

Community Mental Health Center **Center #** **Month** **Year**

	Name of Service Recipient	Social Security Number	Date Evaluation Completed (date of court letter)	Service Provided (A-X)	Amount Billed	Amount Approved for Payment by TDMHSAS (For TDMHSAS use only)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
				TOTAL THIS PAGE		

Name of Person Submitting Claim (Please Print) **Date** **Phone Number**

Name of Forensic Coordinator

TDMHSAS Forensic Services Approval **Date**

A = Competency
B = Mental Condition
T = Competency Training
W = Evaluation (Diagnosis, Treatment, Psychological Service Recommendations, Committability, MR, A&D)
X = Psychosexual