ADULT FORENSIC SERVICES INVOICE

Attachment C

Community Mental Health Center _____ Center # _____ Month _____ Year _____

	Name of Service Recipient	Social Security Number	Date Evaluation Completed (court letter)	Service Provided (A - T)	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
DC = DOC eval. For comp. and/or mental condition
E = Additional Mental Health Assessment
F = Physician Services (MD services or evaluation participation)
J = Post conviction eval. under -301(a)(4)
K = NGRI Committability under -303(a)
L = Outpatient Treatment Planning -303(a)
T = Comptency Training (any type)