



Professional Services Billing Statement

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	
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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
Totals				
			Total Due	

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

Comments: