|  |  |  |
| --- | --- | --- |
|  | **Adoption Support Monthly****Counseling Billing** | Month Year  |
| Case Number: |

|  |
| --- |
| **Email completed form to ASprofessionalsvcs@dcyf.wa.gov** |
| CHILD’S NAME      | DATE OF BIRTH | PARENT’S NAME |

|  |  |
| --- | --- |
| [ ]  Youth Counseling Service Referral Number:      Authorized Dates:       | [ ]  Parental CounselingService Referral Number:      Authorized Dates:       |
| NAME OF COUNSELOR/PROVIDER      | TELEPHONE NUMBER      |
| ADDRESS | CITY | STATE | ZIP CODE |

|  |  |  |
| --- | --- | --- |
| AGENCY NAME | PROVIDER NUMBER | E-MAIL ADDRESS |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE OF SERVICE | HOURS OF SERVICE | SERVICE PROVIDED | AMOUNT PRIMARY INSURANCE PAID | ADOPTION SUPPORT RESPONSIBILITY |
|       |       |  | $ | $ |
|       |       |  | $ | $ |
|       |       |  | $ | $ |
|       |       |  | $ | $ |
|       |       |  | $ | $ |
|       |       |  | $ | $ |
|  | **Total:** | $ | $ |
| DATE BILL SUBMITTED | DATE AUTHORIZATION EXPIRES |
| PROVIDER PLEASE ADD ADDITIONAL NOTES AND COMMENTS AS NEEDED: |
| **FOR OFFICE USE ONLY** |
| DATE APPROVAL SUBMITTED | DATE APPROVED | DATE BILL PAID | WARRANT NUMBER |

