|  |  |  |
| --- | --- | --- |
|  | **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 Counseling  Service 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 |

