Washington State Department of
CHILDREN, YOUTH & FAMILIES

Adoption Support Monthly Counseling Billing

Month Select Year Select
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