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|  | Washington State Department of CHILDREN, YOUTH & FAMILES  **PSYCHIATRIC SERVICES BILLING STATEMENT** | DATE OF INVOICE |

|  |  |  |  |
| --- | --- | --- | --- |
| Provider Name |  | FamLink Provider ID |  |
| Provider’s Address |  | Provider’s Phone |  |
| DCYF Caseworker |  | Phone Number |  |
| DCYF Office |  | FamLink Case ID |  |
| Client’s Name |  | Client’s Phone Number |  |

**Type of referral:**  Psychiatrist or Advanced Registered Nurse Practitioner

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| --- | --- | --- | --- | --- | --- |
| Service Provided | | | Service Time % | Amount Billed\*\* | Total Due |
|  | Diagnostic Evaluation  (with report) | | # of hours | $       per hour | $ |
|  | Parenting Evaluation/Parenting Component  *(Conducted in addition to a diagnostic evaluation)* | | # of hours | $       per hour | $ |
| 1 Unit = 30 minutes | | | | | |
|  | | Psychotherapy with written report | # of units | $       per unit | $ |
|  | | Medication Management with report | # of units | $       per unit | $ |
|  | | Professional Consultations with DCYF staff or other authorized parties with report | # of units | $       per unit | $ |
|  | | Case Related Travel | # of units | $       per unit | $ |
| 1 Unit = 15 minutes | | | | | |

Allowed hours & rates are posted at <https://www.dcyf.wa.gov/sites/default/files/pdf/Fee_PsychServices.pdf>

% cannot exceed what DCYF authorized.

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| **Date** | **Description of Tasks** *(client interview, written testing, report writing, etc.)* | **Hours** |
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**Include a copy of the signed referral and the final report with this invoice.**

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| **COMMENTS:** |

**VENDOR'S CERTIFICATE**: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington. Also that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, disability, religion, or Vietnam era or disabled veterans status.

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*Provider Signature*