Provider Invoice (Credentialed Services)

Invoice #:	
Date:	

Provider Information

Provider Logo	Company Name		DCF Provider ID#:	
	Address	City	State	Zipcode
	Phone:	Email:		

Child Information

Family Case Name:		Family Case ID:	
Child Name:		Person ID:	
Other children associated with billing *(For Supervised Visits Only)*:			

DCF Information

DCF Social Worker Name:		Regional Office:		
DCF Address:	Address	City	State	Zipcode
Phone:				

Services Information

Credentialed Services:

- ☐ After School (Clinical K-7) $295 or $450
- ☐ After School (Clinical 8-12) $236 or $450
- ☐ After School (Trad K-7) $182 or $364
- ☐ After School (Trad 8-12) $182 or $364
- ☐ Assessment (C/Y) Negotiated
- ☐ Assessment (DV) $100/hr - Ancillary $80/hr
- ☐ CHAP/CHEER Case Mngmnt $42/hr or $30.01 per diem
- ☐ Comm. Based Life Skills $50/hr
- ☐ Supervised Visitation $45/hr
- ☐ Support Staff $35/hr
- ☐ Therapeutic SS $40/hr
- ☐ Temporary Care $24/hr

Service Billing Information

Service Date (one date per line)	Individual Providing Service	Service Details	Rate of Service	# Hours of Service	Total
				Total:	0.00