

JUVENILE FORENSIC SERVICES INVOICE

Attachment D

Community Mental Health Center

Center #

Month

Year

| Name of Service Recipient | Social Security Number | Date Evaluation Completed (date of court letter) | Service Provided (A-X) | Amount Billed | Amount Approved for Payment by TDMH (For TDMH use only) |
|---------------------------|------------------------|---|---------------------------|---------------|---|
| 1 | | | | | |
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| 10 | | | | | |
| TOTAL THIS PAGE | | | | | |

Name of Person Submitting Claim (Please Print) Date Phone Number

Name of Forensic Coordinator

TDMH Forensic Services Approval Date

- A = Competency
- B = Mental Condition
- T = Competency Training
- W = Evaluation (Diagnosis, Treatment, Psychological Service Recommendations, Committability, MR, A&D)
- X = Psychosexual