Washington State Department of Social & Health Services
CA Children's Administration

Adoption Support Monthly Counseling Billing

Adoption Support

MONTH OF SERVICE	CHILD'S NAME	DATE OF BIRTH	PARENT'S NAME

NAME OF COUNSELOR/PROVIDER	TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

AGENCY NAME	PROVIDER NUMBER	E-MAIL ADDRESS

DATE OF SERVICE	HOURS OF SERVICE	AMOUNT PRIMARY INSURANCE PAID	ADOPTION SUPPORT RESPONSIBILITY
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
	Total:	$	$

DATE BILL SUBMITTED	DATE AUTHORIZATION EXPIRES

NOTES:

FOR OFFICE USE ONLY

DATE APPROVAL SUBMITTED	DATE APPROVED	DATE BILL PAID	WARRANT NUMBER