Print Form

STATE OF CALIFORNIA
CDCR 2131-D (REV. 09/08)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

# CONSOLIDATED AMENDED INVOICE
# PAROLE REVOCATION HEARING

**Prior Months Billing Adjustment**
**For Reimbursement Under Penal Code Section 4016.5**

| NAME OF CITY OR COUNTY | FISCAL YEAR |
|---|---|
| STREET ADDRESS | |
| CITY, STATE, ZIP CODE | |

| FROM: | TO: |
|---|---|
| FACILITY NAME | Department of Corrections and Rehabilitation<br>Accounting Services |
| STREET ADDRESS | STREET ADDRESS<br>P.O. Box 942883 |
| CITY, STATE, ZIP CODE | CITY, STATE, ZIP CODE<br>Sacramento, CA 94283-0001 |

| LINE | COLUMN 1 | COLUMN 2<br>DATE RATE APPROVED: | COLUMN 3 | COLUMN 4<br>REIMBURSEMENT PER HOUR ON HEARING |
|---|---|---|---|---|
| 1 | (New) Rate approved on: | _____ | $ _____ | |
| 2 | (Old) Rate of reimbursement | | $ _____ | |
| 3 | (Difference) Rate of increase<br>(Line 1 minus Line 2) | | $ _____ | |

| | MONTHS | TOTAL HOURS OR HEARINGS BILLED |
|---|---|---|
| 4 | July 20_____ | _____ |
| 5 | August | _____ |
| 6 | September | _____ |
| 7 | October | _____ |
| 8 | November | _____ |
| 9 | December | _____ |
| 10 | January 20_____ | _____ |
| 11 | February | _____ |
| 12 | March | _____ |
| 13 | April | _____ |
| 14 | May | _____ |
| 15 | June | _____ |

16 Total Number of Days _____

17 TOTAL: Parolee/Inmate Detention Reimbursement Requested $ _____
(Rate in Line 3 times number of days in Line 16)

| SIGNATURE OF CITY / COUNTY REPRESENTATIVE: | (TYPE) NAME AND TITLE: | DATE SIGNED: |
|---|---|---|
| CONTACT TELEPHONE NUMBER: | | |