OFFENDERS WITH A MENTAL HEALTH DISORDER ATTORNEY INVOICE

Statement of Services Rendered

HEARING DISPOSITION

Scan and send invoice via email to the Accounting Liaison Unit
BPHAccountingLiaison@cdcr.ca.gov

OFFENDER NAME: _____

CDCR Number: _____

LOCATION: _____

SCHEDULED DATE AND TIME OF HEARING: _____ _____

HEARING TYPE: _____

DATE OF SERVICE (Refer to section D2 of the OMHD Attorney Program Guide)	**DESCRIPTION OF SERVICES PERFORMED**	**INITIAL BELOW TO CONFIRM SERVICES PERFORMED**
_____	ATTORNEY APPOINTMENT, REVIEW OF HEARING PACKET, REVIEW DECS, LEGAL RESEARCH	_____ initials
_____	CENTRAL-FILE REVIEW (Certification Hearings Only)	_____ initials
_____	CLIENT INTERVIEW	_____ initials
_____	PERSONAL APPEARANCE AT THE HEARING, APPEAL "POST APPEAL DETERMINATION", ADMINISTRATIVE APPEAL, OR COURT WRITING.	_____ initials

I certify by my initials above that each service was rendered and acknowledge the total billing reimbursement rate, as set forth in the OMHD Attorney Program Guide, represents the maximum compensation per case.

I also certify I am duly licensed and in good standing to practice before all courts of the State of California and that I am an active member of the State Bar of California.

TOTAL BILLING	_____

ATTORNEY AT LAW (SIGNATURE)	NAME	STATE BAR NUMBER	DATE
_____			_____

MAILING ADDRESS ☐ *Change of address*	CITY	STATE	ZIP
_____	_____	_____	_____

DEPARTMENTAL APPROVAL

SIGNATURE	TITLE	DATE
_____	_____	_____