

**MENTAL HEALTH/MEDICAL SERVICES VOUCHER**

**EXHIBIT II-G**

PROVIDER NAME: \_\_\_\_\_

**GAX 40A**

VC NUMBER: VC \_\_\_\_\_

DATE (MM/DD/YYYY): \_\_\_\_\_

ADDRES: \_\_\_\_\_

\_\_\_\_\_ (Number of hours at \$150 per hour)

TELEPHONE: \_\_\_\_\_

**TOTAL INVOICE AMOUNT \$** \_\_\_\_\_

I certify that no payment has been received, or promise of payment has been requested or accepted from or behalf of the individual(s) below, except as ordered by the Court, and further, that the above statement of time spent is true and correct.

SIGNED: \_\_\_\_\_

CLIENT'S LAST NAME	CLIENT'S FIRST NAME	DOCKET NUMBER	EVAL DATE (MM/DD/YYYY)	CLIENT TYPE	CASE TYPE	REV PREP	EVAL HOURS	REPORT HOURS	COURT DATE (MM/DD/YYYY)	COURT HOURS	TOTAL HOURS

Examiner's Notes:

- |                       |                        |                           |                        |                         |                      |
|-----------------------|------------------------|---------------------------|------------------------|-------------------------|----------------------|
| <u>Client Types</u>   |                        | <u>Case types</u>         |                        |                         |                      |
| A. Adult Defendant    | D. Parent (Protective) | 1. Homicide               | 4. Arson               | 7. Probation Revocation | 10. Child Protective |
| B. Juvenile Defendant | E. Other               | 2. Rape                   | 5. All other ABC       | 8. OUI                  | 11. Mental Health    |
| C. Child (Protective) |                        | 3. Sex offenses (A, B, C) | 6. Sex offenses (D, E) | 9. All other D, E       | 12. Other            |

DATE (MM/DD/YYYY): \_\_\_\_\_ AMOUNT APPROVED \$ \_\_\_\_\_

SIGNED: \_\_\_\_\_  
(JUDGE/JUSTICE)

AOC – APPROVED FOR PAYMENT					
FUND	DEPT	UNIT	SUBUNIT	OBJECT	AMOUNT
010	40A	9_____	012	4047	\$_____