

**STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
DIVISION OF PREVENTION AND BEHAVIORAL HEALTH SERVICES
NONRESIDENTIAL SERVICES BILLING/ACTIVITY SUMMARY**

A copy of this summary form is included on the top of each monthly billing submission.

Date of Bill ____/____/____ Provider Agency _____

Circle One: Outpatient Unit-Cost IOP Wrap-Around Aide

Person Preparing Bill/Activity Report _____

For Services Rendered in the Month of _____ 20____

Number of client fee sheets submitted this month	_____
Total number of clients <i>seen</i> this month	_____
Number of clients admitted this month	_____
Number of clients discharged this month	_____
1. _____ Group Therapy Hours @ \$35.00	1. Amount due: _____
2. _____ Psychiatry Hours @ \$165.00	2. Amount due: _____
Other Direct Service Hours (In-Office)	
3. _____ Hours @ \$95.00 (Intake)	3. Amount due: _____
4. _____ Hours @ \$85.00 (Other Sessions)	4. Amount due: _____
Other direct services (Out-of Office)	
5. _____ Hours @ \$110.00 (Intake)	5. Amount due: _____
6. _____ Hours @ \$105.00 (Other Sessions)	6. Amount due: _____
7. Wrap-Around Aide @ 30.00	7. Amount due: _____
8. IOP Unit-Cost (All but psychiatry) @ \$90.00	8. Amount due: _____
9. Drug Screens – Include itemized bill (Substance abuse clients without other insurance- SA agencies only)	9. Amount due: _____
10. Flex Funds – Include itemized bill included on the client billing sheet with date and type of expenditure	10.Amount due: _____

Total Amount Due This Invoice _____