COURT-ORDERED GUARDIANSHIP EVALUATION

INVOICE FORM

Guardianship Evaluation order for : _____Date of Court Order for Guardianship: _____
Full Name of Individual

Type:

Title 18: Public Guardian/Individual with Statutorily Defined Dx. Of Developmental Disabilities	☐
Title 14: Guardian/Individual in Need of Guardianship with Developmental Disabilities	☐
Title 14: Guardian/Individual with Dx. Mental Illness	☐
Title 14: Guardian/Individual with Dx. Dementia	☐
Title 14: Guardian/Individual with Dx. Traumatic Brain Injury	☐
Title 14: Guardian/Individual with other cognitive impairment/functional incapacity: Specify	☐

Evaluator Name:_____ Qualifications: QDDP ☐ Eligible Provider ☐

Date/s of Service					
Time Spent					

Billed to: Medicare ☐ Private Insurance ☐ Medicaid ☐ No Payment Source ☐

Compensation received prior to this invoice: $_____

	Total Time in this Activity	Total Actual Cost
Direct Evaluation Time		
Record Review		
Travel		
Interviews		
Report write-up		
Court or Testimony		
Other: Specify		

TOTAL ACTUAL COSTS

Minus reimbursement received from other sources	

TOTAL ACTUAL COST MINUS OTHER REIMBURSEMENT

IF TOTAL IS LESS THAN $800.00 – <u>STOP HERE. SIGN VERIFICATION BELOW AND SUBMIT INVOICE TO DAIL</u>. IF TOTAL IS <u>GREATER THAN $800.00</u> – CONTINUE TO PAGE 2 FOR EXTENUATING CIRCUMSTANCES AND COSTS CONSIDERATION AND SIGN ON PAGE 2.

Name of Individual or Organizational Entity submitting this reimbursement request:

_____

I have verified the accuracy of this information and this invoice submittal represents the actual cost of uncompensated guardianship evaluation services.

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COMPLETE THIS SECTION ONLY IF THE COST FOR EVALUATION SERVICE MINUS ANY REIMBURSEMENT RECEIVED EXCEEDS $800.00. Up to $120.00 per hour for uncompensated services is allowed.

Expenses in excess of $800.00 limit	

TOTAL ADJUSTED ACTUAL COST FROM PAGE 1

Expenses submitted for reimbursement	

TOTAL INVOICE AMOUNT

IDENTIFY EXTENUATING CIRCUMSTANCES THAT RESULTED IN GREATER COSTS FOR THIS GUARDIANSHIP EVALUATION. PLEASE BE AS DETAILED AS POSSIBLE FOR DAIL CONSIDERATION.

[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

Name of Individual or Organizational Entity submitting this reimbursement request:

_____

I have verified the accuracy of this information and this invoice submittal represents the actual cost of uncompensated guardianship evaluation services.

CONTACT AND MAILING INFORMATION FOR SUBMISSION:
Gordon Bullard (Gordon.bullard@vermont.gov)
Office of Public Guardian
81 River Street Suite 208
Montpelier, VT 05609-2210
802-828-2143

FOR DAIL USE ONLY:

Reviewed By: Approved☐ Denied☐

Reasons for Denial:

Date of Determination: