DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Susan I. Hamilton, M.S.W., J.D.
Commissioner

M. Jodi Rell
Governor

November 2, 2007

Dear Provider:

Welcome to both new and returning providers. You have been credentialed to provide one or more services to DCF clients. Please be advised of DCF billing requirements below and review the sample invoice attached.

Invoices should be billed to the DCF area office that authorized the service. Submit only one bill per client for each month for each service type, and the amount billed should be no less than 15 minute increments. The bill should include minimally the following information:

- Name of client served;
- Name of your agency worker or workers who provided the service;
- Actual date of service delivery (include any day upon which a service was delivered);
- Number of service hours provided on each date of service,
- Service rate billed should not exceed the DCF Discretionary Services Fee Schedule.
- Identify any time that is billed for non-face to face staff time, such as time spent in court, with a supervisor, meeting with DCF and/or participating in a PPT meeting.

DCF can pay only from an invoice. You may provide a balance forward for information purposes only, however, the DCF area office will need to have the invoice which details the service in order to process payment.

When providing one of the credentialed services, please ensure that the proper service description is used on your invoice. For credentialed services, these are:

Assessment
Behavior Management
Temporary Care
Supervised Visitation
Therapeutic Support Staff
Support Staff

Reimbursement for activity costs are separate from these services and may be made only if approved in advance by the area office. Please provide the date and a description of the item to be reimbursed. You should have receipts available to support these reimbursements.

The Department appreciates your commitment to serve our children and families.

Sincerely,

Greg Messner
Chief Financial Officer

SAMPLE Agency
*[**Your Company Slogan**]*

INVOICE

123 Billing Address Street
Your City, CT 06000
Phone [**(509) 555-0190**] Fax [**(509) 555-0191**]
DCF Provider Identification Number:

INVOICE #[**100**]
DATE: NOVEMBER 5, 2007

TO:	**FOR:**
DCF Social Worker Name DCF Local Area Office [**Street Address**] [**City, ST ZIP Code**] [**Phone**]	Client name and other identifying information

DESCRIPTION	SERVICE DATES	HOURS	RATE	AMOUNT
Service Type; Employee Name				
Reimbursements (must be pre-approved by DCF AO) Please itemize the item(s) to be reimbursed				

TOTAL

Make all checks payable to [**Your Company Name**]

Thank you for your business!