Statement of Reimbursable Attorney Fees

Sections 630.130.6, 632.415.2, and 632.610, RSMo

IN THE _____ JUDICIAL CIRCUIT, _____ COUNTY, MISSOURI

Probate Division For the Month _____ of Year _____

Attorney Name: _____

Attorney Address: _____

_____

Tax ID Number or Social Security Number: _____ Date File Stamp

Filing/Hearing Type*:

Mental Health
(A) 96 Hour
(B) 21 Day
(C) 90 Day
(D) 1 Year
(H) 180 Day
(I) ECT (Electroconvulsive Therapy)
(J) AOT (Assisted Outpatient Treatment)

Alcohol & Drug
(E) 96 Hour
(F) 30 Day
(G) 90 Day

Case Number	Filing Date	Hearing Date	*Filing/Hearing Type	Total Hours	Total to be Reimbursed
				Grand Total:	**$**

I certify the above amounts charged for attorney fees pursuant to sections 630.130, 632.415, and 632.610, RSMo, are true and accurate and have not been previously paid by the state of Missouri.

Attorney's Signature (Required) _____ Date: _____

Judge's Signature (Required) _____ Date: _____

Mail original completed form to:
Missouri Department of Mental Health, P.O. Box 687, Jefferson City, Missouri 65102