

Statement of Attorney's Fees

To: Department of Mental Health
1706 E. Elm
Jefferson City, Missouri 65102-0687

From: _____
Probate Division of Circuit Court

Name of Attorney _____

Address _____

Court Costs _____

Total to be reimbursed to Court _____

Client's Name _____

Case Number _____

Date of Detention _____

Date of Initial Contact _____

Date of Hearing _____ No. of hours spent: _____

X rate of Payment _____

= Subtotal: _____

+ Expenses: _____

Total Amount Due Attorney from State of Missouri: _____

Signature of Attorney

I hereby certify that the amount charged for attorneys fees pursuant to [section 632.415, RSMo](#), is true and accurate and has not been previously billed to and paid by The State of Missouri.

For Department of Mental Health Use

Probate Division Judge

Date check issued: _____

Date check mailed _____