IN THE _____ JUDICIAL CIRCUIT, _____ COUNTY, MISSOURI

Probate Division	For the Month _____ of Year _____

Attorney Name and Address:

Tax ID Number or Social Security Number:

(Date File Stamp)

* Filing/Hearing Type

Mental Health	**Alcohol & Drug**
(A) 96 Hr.	(E) 96 Hour
(B) 21 Day	(F) 30 Day
(C) 90 Day	(G) 90 Day
(D) 1 Year	
(H) 180 Day	
(I) ECT	

Statement of Reimbursable Attorney Fees

Sections 630.130.6 and 632.415.2 RSMo

Case Number	**Filing Date and 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 and 632.415, 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, MO 65102