

**ANCILLARY SERVICE PROVIDER Payment Request
Office of Court Appointed Counsel**

TYPE OF PROVIDER: _____
(i.e. Expert Witness, Interpreter, Investigator, Paralegal, etc.)

CASE INFORMATION:

Case Number _____ Attorney _____
Defendant _____ Judge _____

BILLING INFORMATION:

Name _____ Billing: Initial Interim Final
Address _____ Phone _____ Fax _____

EMAIL Address: _____

	<u>Number of hours</u>		<u>Rate</u>		<u>Amount</u>
	_____	X	\$ _____	=	_____
	_____	X	\$ _____	=	_____
Travel (miles)	_____	X	<u>\$0.445</u>	=	_____
Expenses _____				=	_____
				=	_____
		Total Claim		=	_____

The statements in the above schedule are true. No compensation for the services described has been received. An accurate itemization of the time and expenses is attached.

Contractor Signature

Date

Attorney Signature

Date

For OCAC use only (Revised 06/04/14)

Approved: _____ Date _____

Math Checked Bill is within amount approved Necessary Approval and/or Receipts Attached

Case Ongoing Case Closed Disposition: _____ Date: _____