State of Delaware
The Department of Services For Children, Youth and Their Families

Division of Prevention and Behavioral Health Services

Non-Residential Services /Activity Billing Summary Form

A copy of this summary form MUST be included on the top of each monthly billing submission

Date of Bill _____ Provider Name _____

Check One: ☐ Outpatient ☐ OP - FFT ☐ TSF ☐ MST

☐ DBT ☐ FBMHS ☐ Day TX ☐ PHP ☐ Residential

☐ Inpatient ☐ Crisis

Person Preparing Bill/Activity Report _____

For Services Rendered in the Month of _____ 2016

Number of client fee sheets submitted this month	_____
Total number of clients *seen* this month	_____
Number of clients admitted this month	_____
Number of clients discharged this month	_____
Total Amount Due This Invoice:	$