



**Maryland Legal Services Program
Court Appointed Attorney Program**

**Adult Guardianships
COMAR 07.01.13.07**

2023 Payment Invoice Form

I HEREBY CERTIFY:

1. **Attorney Appointed by Circuit Court** _____

Client Represented/Full Name: _____

Court Hearing Date _____

Circuit Court Jurisdiction _____

2. **Pursuant to the *Annotated Code of Maryland*:**

Estates and Trusts Article §13-705 or §13-709

Family Law Article, §14-202 (a)(5) or §14-404

Full Review

File Review

3. **Named Party To The Case:**

County/City Department of Social Services _____

County/City Area Agency on Aging _____

4. **Initiating Party:** _____

5. **Client was determined “Indigent” by means of:**

Aid to Families with Dependent Children (AFDC)/Temporary Cash Assistance (TCA)

Disability Entitlement Advocacy Program (DEAP)

Supplemental Security Income (SSI)

Income (Checking & Savings)

Other: _____

6. Client Information:

Date of Birth: _____/_____/_____ Age: _____

Gender: Male Female

Race: White/Caucasian Black/African American Hispanic/Latino Asian
 Native American Other: _____

7. Total Hours Spent On Case:

NOTE: The MLSP billable rate for Adult Guardianship CAAP Attorneys is **\$75.00 per hour**.
Please attach an itemized bill of your time with detailed explanation to this form.

Non-Hearing Hours: _____ Hearing Hours: _____

8. Payment Requested from State of Maryland Department of Human Resources:

Subtotal: Attorney Fees: \$ _____

Subtotal: Mileage: \$ _____

TOTAL Amount Requested: \$ _____

Attorney Signature: _____

Date: _____/_____/_____

SS# /Fed. ID #: _____

Payee If Other than Signatory: _____

Address / City / State / Zip: _____

Telephone Number: (____) _____

Email Address: _____