Maryland Legal Services Program
Court Appointed Attorney Program

Adult Guardianships
COMAR 07.01.13.07

2016 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: ____

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Telephone Number: (_____) _______________________________

Email Address: ____