Connecticut Department of Children and Families

BILLING INVOICE: ONE-TO-ONE THERAPEUTIC SAFETY STAFFING

DCF-383B
1/19 (Rev.)

USE ONE FORM PER CHILD				
Agency Name:	Program Name:			Program LINK #:
Address: (No. and Street):	City:	State: CT	Zip:	Phone:

SECTION I – IDENTIFYING DATA OF CHILD RECEIVING ONE-TO-ONE STAFFING				
Child LAST Name:	Child FIRST Name:	Link#:	DOB:	Gender: Select One or enter your own
SW LAST Name:	SW FIRST Name:	SW E-mail:		SW Phone:
DCF Office: Select DCF Office				Date of Admission:

SECTION II – ONE-TO-ONE STAFFING DATA (*add additional pages, if necessary*)

This invoice cannot be processed unless it is accompanied by a copy of the authorization/re-authorization (DCF-383A) signed by DCF

Provide the information below to document the full duration of the one-to-one staffing provided for this child (this should cover the initial authorization and all subsequent re-authorizations).

1. The number of times the one-to-one staffing was authorized and re-authorized: _____
2. Was monthly waiver granted for re-authorization? ☐ Yes ☐ No If yes, for how many months? _____
3. The reason(s) for the one-to-one staffing
   - ☐ Risk for Suicide
   - ☐ Risk for self-mutilation/self-injury
   - ☐ Risk for sexually acting out
   - ☐ Current Psychiatric Decompensation
   - ☐ Risk for AWOL
   - ☐ Risk for Physical Aggression/Injury of Others
   - ☐ Other: _____
4. The outcome of the one-to-one staffing:
   - ☐ Returned to lower level of staffing/supervision in facility/program
   - ☐ Maintained at 1:1 level of staffing/supervision in facility/program
   - ☐ Placed in another facility/program providing a higher level of staffing/supervision (e.g. hospitalization)
   - ☐ Other _____
5. The total dates, shifts and hours for the one-to-one staffing: _____
6. The total number of staff providing one-to-one staffing: _____
7. The work title of the staff that will be providing the one to one services: _____
8. Agency status of the staff that will be providing the one to one staffing (e.g. full time child care staff, child care relief staff, outside agency child care staff, etc.):

SECTION III – ONE-TO-ONE STAFFING CHARGES			
☐ Please check if this is an interim bill (one-to-one staffing continued)	Total hours of one-to-one staffing provided:	Approved hourly rate of one-to-one staffing:	Total one-to-one staffing charges: $ 0.00

Name of Agency/Program Administrator requesting payment authorization:	Signature of Agency/Program Administrator requesting payment authorization:	Title of Administrator:	Date:

SECTION IV – DCF AUTHORIZATION FOR PAYMENT

Authorization Not Valid Without Both Agency/Program and DCF Signatures. This Authorization Is for A Maximum Of 72 Hours Within a 10 Day Period, UNLESS a DCF Administrator or his/her designee has granted a waiver for a monthly re-authorization and has signed this form.

☐ Payment is Authorized

☐ Payment is NOT Authorized:

Remarks / Reasons:

Name of DCF Staff making payment authorization decision:	Signature of DCF Staff making payment authorization decision:	Title of DCF staff:	Date: