VOUCHER FOR ATTORNEY PAYMENT

Attorneys, you will either complete the top section OR the middle section of the Court Appointed Representative Voucher for Services, depending on if you would like to be paid at Kalamazoo County's rate of pay OR your county's rate of pay. Once you choose which rate of pay you would like, you cannot change it (i.e. if you choose to be paid at Kalamazoo County's rate, you may not switch to your county's rate of pay at a later time).

If you choose to be paid at your county's rate of pay, you will complete the middle section and attach a Billing Statement. A Billing Statement is required by our Finance Department.

If this is your first time requesting payment from Kalamazoo County, a W9 is required.

When completing the form, please make sure that you are listing the date of service, the amount, the total and signing the Voucher. If anything is missing, we will have to return the form to you for amendment. This will affect the processing time.

PLEASE NOTE: Vouchers are processed on a bi-weekly basis. Once they are processed through Kalamazoo Probate Court, they are sent to our Finance Department. Depending on the time of the month, it can take 4-6 weeks to receive a check from our Finance Department.

Thank you,

Kalamazoo County Probate Court

Account: 802.00 Vendor#: Document #:

STATE OF MICHIGAN PROBATE COURT COUNTY OF KALAMAZOO	**COURT APPOINTED REPRESENTATIVE VOUCHER FOR SERVICES**	FILE NO:

Court Address: 1536 Gull Road, Kalamazoo, MI 49048

Court Telephone No.: 269-383-8666

In the matter of: _____

MENTAL HEALTH SERVICES

☐ I wish to be paid at Kalamazoo County's rate:

Date	Event	Amount
_____	Deferral Hearing - $85.00	_____
_____	60 Day Hearing - $212.50	_____
_____	2nd/Continuing Hearing - $85.00	_____
_____	Follow-up Hearing - $85.00	_____
_____	Other: _____	_____

☐ The hearing was held in _____ county and I wish to be paid at that rate.*

Date	Event	Amount
☐ See Attached Billing Statement		_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**All out of county rates will be verified*

GAL/ATTORNEY SERVICES:

Rate: $85.00/hour for out of court time
$85.00/hour for in court time

Date	Event	Amount
☐ See Attached Billing Statement		_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL PAYMENT DUE: **$**

I certify I was appointed by the court to serve as the ☐ Attorney ☐ Guardian ad Litem for the above named individual and the above services have been rendered. I certify that compensation from any other source is not being sought.

_____
Date

_____
Attorney/Guardian ad Litem Signature Bar no.

_____
Attorney Name (Printed)

_____
Address

_____
City, State, Zip Telephone no

KCPC 07 (03/2025)

Court approval initials: _____