

CORNERSTONES OF CARE

GILLIS • HFCS • MARILLAC • OZANAM • SPOFFORD

Date	Maintenance code	Location of child
1		
2		
3		
4		
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25		
26		
27		
28		
29		
30		
31		
Total by Maintenance Code		

PLACEMENT PROVIDER MONTHLY BILLING STATEMENT

Please complete one statement for each child served this month.

Placement Provider Name	
Child Name	
Case Manager Name	
Month/Year	

Maintenance Code: Use the following key to indicate the payment type for the child's placement for each date served:

T	Traditional Foster Care
M	Medical Foster Care
B	Behavioral Foster Care
C	Career Foster Care
E	Emergency Foster Care
R	Respite Care
CR	Career Foster Parent Respite Care
CA	Career Foster Parent Availability/Transitional Services
	Leave blank when the child was not placed in the home on this date or this day does not exist in this month

Location of the child: On days during placement when the child does not spend the night in the caregiver's home, indicate the child's location at midnight.

RC	Respite care	R	Run away
HV	Home visit	D	Detention
H	Hospital	O	Other – specify:
Leave blank when the child's location is in the home.			

RECORD FOR THE OLDEST SIBLING ONLY: I attended (check & date)

Family Support Team meeting on: _____

Court hearing on: _____

Placement Provider's Signature

Date

Submit this form to the Case Manager by the 2nd of the following month via email, fax, mail, or hand deliver:

Clay County
4321 NE Vivian Road, Suite 103
KCMO 64119
FAX 816.453.2869

Andrew/Buchanan Counties
817 Monterey
St. Joseph, MO 64503
FAX 816.233.0774

Jackson County
3100 Main, Suite 206
KCMO 64111
FAX 816.508.6299

MBCH CFM
4001 NE Lakewood Way
Lee's Summit, MO 64064
Fax# (816) 795-6637

Date entered in CORE: _____ Case Manager Initials: _____