VT Dept. for Children & Families | Children's Integrated Services
Invoice for Initial Evaluation to Determine Eligibility for CIS Early Intervention

Program Name:	**Preparer:**	**Host Agency + Invoice Date + Sequence = Invoice Number :** Choose One
Remittance Address (must agree with the address in VISION):		**VISION Vendor #** (if known):

	Child Information	Initial Eval.	Screening Done	Screening NOT Done	CIS Use Only
Child 1	Child Name (Last, First): Date of Birth: ☐ Private Ins. ☐ No Ins. ☐ No Medicaid coverage ☐ No medical auto-eligibility	Evaluation Date: Cost: $ 0.00 Result: ☐ Eligible ☐ NOPR	☐ Further evaluation needed ☐ NO further evaluation needed **Screener Name(s):**	☐ Due to information received at referral ☐ Due to parent request	☐ Approved ☐ Not approved Note:
Child 2	Child Name (Last, First): Date of Birth: ☐ Private Ins. ☐ No Ins. ☐ No Medicaid coverage ☐ No medical auto-eligibility	Evaluation Date: Cost: $ 0.00 Result: ☐ Eligible ☐ NOPR	☐ Further evaluation needed ☐ NO further evaluation needed **Screener Name(s):**	☐ Due to information received at referral ☐ Due to parent request	☐ Approved ☐ Not approved Note:
Child 3	Child Name (Last, First): Date of Birth: ☐ Private Ins. ☐ No Ins. ☐ No Medicaid coverage ☐ No medical auto-eligibility	Evaluation Date: Cost: $ 0.00 Result: ☐ Eligible ☐ NOPR	☐ Further evaluation needed ☐ NO further evaluation needed **Screener Name(s):**	☐ Due to information received at referral ☐ Due to parent request	☐ Approved ☐ Not approved Note:
Child 4	Child Name (Last, First): Date of Birth: ☐ Private Ins. ☐ No Ins. ☐ No Medicaid coverage ☐ No medical auto-eligibility	Evaluation Date: Cost: $ 0.00 Result: ☐ Eligible ☐ NOPR	☐ Further evaluation needed ☐ NO further evaluation needed **Screener Name(s):**	☐ Due to information received at referral ☐ Due to parent request	☐ Approved ☐ Not approved Note:
Child 5	Child Name (Last, First): Date of Birth: ☐ Private Ins. ☐ No Ins. ☐ No Medicaid coverage ☐ No medical auto-eligibility	Evaluation Date: Cost: $ 0.00 Result: ☐ Eligible ☐ NOPR	☐ Further evaluation needed ☐ NO further evaluation needed **Screener Name(s):**	☐ Due to information received at referral ☐ Due to parent request	☐ Approved ☐ Not approved Note:

***Certifying Signature*:**	**Total Requested:**	**Total Approved:**	**CIS Manager Approval**	**Date**
	$ 0.00			

Certification: By submitting this Invoice for Initial Evaluations, the agency or provider affirms that the information provided is accurate, current, and compliant with CIS EI guidance.
http://cispartners.vermont.gov/manual

Instructions: Complete and submit this Invoice by:
email AHS.DCFCDDCISEI@Vermont.gov
or fax 802-241-0168
or mail: Children's Integrated Services
280 State Drive, NOB 1 North
Waterbury, VT 05671-1040

Save Form **Print Form**

***Host Agencies**: **ADD** Addison | **BEN** Bennington | **BRA** Brattleboro | **BUR** Burlington | **HAR** Hartford | **LAM** Lamoille
NEW Newport | **RUT** Rutland | **SPR** Springfield | **STA** St Albans | **STJ** St Johnsbury | **WAS** Washington

For DCF Business Office: Account 519090 Fund 22005 Dept ID 3440030000 Program 39600 Class (Grant Payment) NO

Rev. Dec 2021