INDIGENT DEFENSE ADULT FEE CLAIM FORM

1. COUNTY:	2. COURT NUMBER:	3. ORDER TO EXCEED:
		☐ Yes ☐ No

4. CLIENT FIRST NAME:	5. CLIENT LAST NAME

6. DATE OF APPOINTMENT:	7. REPRESENTING:	8. DATE OF SERVICE:
/ /	☐ DEFENDANT ☐ OTHER _____	/ /

9. IOWA CODE SECTION(S): Code Section Online

10. CLIENT CHARGED WITH THE OFFENSE(S):

11. CLAIM SUMMARY:		Dollar Amount:
12. Attorney Out of Court Hours:	0.00	
13. Attorney In Court Hours:	0.00	
14. Total Attorney Hours:		
15. Total Attorney Fee:	Rate: $60.00	
16. Paralegal Hours:	0.00	
17. Paralegal Fee:	Rate: $25.00	
18. Hourly Fee Subtotal:		
19. Expenses:		
	$0.00	
	$0.00	
	$0.00	
	$0.00	
20. Expense Total:		
21. Claim Total:		

22. DISPOSITION:

- ☐ Plea/Sentencing
- ☐ Verdict/Sentencing
- ☐ Acquittal
- ☐ Dismissal
- ☐ Withdrawal
- ☐ Warrant Issued
- ☐ Probation
- ☐ Parole
- ☐ Contempt
- ☐ Interim Claim
- ☐ Other (Describe)

23. BILLING STATUS:

Previous Billings? ☐ Yes ☐ No

Amount Billed Previously _____

I, the undersigned attorney, certify that I have completed my services under the appointment; that I have not received nor have I entered into any agreement to receive compensation for these services, direct or indirect, from any source other than the State Public Defender; and that the above information summarizes the services and expenses for which I am entitled to payment. I further state that an itemized statement of services and expenses is attached hereto and a copy has been provided to my client.

24. DATE:	25. SIGNATURE:	FIRST NAME:	LAST NAME:
/ /			

26. Make payment to ☐ **Change of Information**

NAME:	SSN / FEDERAL ID NUMBER:	FAX NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
		Iowa	
ATTORNEY E-MAIL ADDRESS:			
TELEPHONE NUMBER:	27. APPROVED FOR PAYMENT:	AMOUNT APPROVED (if changed):	
	_____ State Public Defender		

SUBMIT COMPLETE FORM WITH ATTACHMENTS AS SPECIFIED IN INSTRUCTIONS TO:
State Public Defender, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0087

Revised 11/2006