MISCELLANEOUS CLAIM FORM

1. CHECK THE BOX INDICATING THE TYPE OF CLAIM:

☐ INTERPRETER: (LANGUAGE) ______________________

☐ CERTIFIED SHORTHAND REPORTER

☐ EVALUATION : ☐ Psychiatrist ☐ Psychologist

☐ EXPERT WITNESS: (EXPERTISE) ______________________

☐ INVESTIGATOR

☐ SHERIFF FEES/SUBPOENAS

☐ OTHER (EXPLAIN):

2. CASE INFORMATION:

COUNTY:	COURT NUMBER(s):
COURT APPOINTED ATTORNEY:	
CLIENT FULL NAME:	

JUVENILE CASES ONLY:

Enter LAST name of child/children of interest in the case: ________________________

Attorney represents: ☐ Juvenile ☐ Parent ☐ Other: ________________________

3. CLAIM INFORMATION:

CERTIFIED SHORTHAND REPORTER: DATE ORDERED _____/_____/______ DATE DELIVERED_____/_____/________

ALL OTHER CLAIM TYPES: DATE SERVICES BEGAN _____/_____/______ DATE SERVICES ENDED _____/_____/________

CLAIM TOTAL: $	ARE YOU A STATE EMPLOYEE? ☐ YES ☐ NO

4. CERTIFICATION: I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

DATE:	SIGNATURE:	FIRST NAME:	LAST NAME:
/ /			

5. MAKE PAYMENT TO: ☐ **Change of Information**

NAME:	SSN / FEDERAL ID NUMBER:	FAX NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
E-MAIL ADDRESS:			
TELEPHONE NUMBER:	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