



**MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY
OF HARRIS COUNTY**

P.O. Box 25381
Houston, Texas 77265-5381

CONSULTANT CLAIM FORM

NAME _____ MAILING ADDRESS (Street, City, State, Zip) _____
TAXPAYER IDENTIFYING NUMBER OR SOCIAL SECURITY NUMBER _____

Written Report or Letter of Activity Required: Yes ___ No ___

DATE	NO. OF HOURS/ SESSIONS/DAYS WORKED	FEE PER HOUR/ SESSIONS/DAY	DESCRIPTION OF SERVICES(S) PROVIDED	FEE

CONSULTANT'S SIGNATURE

APPROVED BY

DATE

DEPARTMENT HEAD