

# 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 12<sup>th</sup> Street, Des Moines, Iowa 50319-0087