

Note: This form is for use by GAL Conflict Attorneys appointed prior to July 1, 2009 instead of AOC-G-200.

STATE OF NORTH CAROLINA Administrative Office Of The Courts	REQUEST FOR PAYMENT OF IDS APPOINTED GAL CONFLICT ATTORNEY SERVICES
Name, Address, Email Address, and Phone Number Of Attorney	County
	File No.
	Additional File No.

INFORMATION AND INSTRUCTIONS

1. Requests for payment are signed by the judge and submitted to AOC, after completion of designated court hearing and entry of order. A detailed timesheet showing the billable hours should accompany this form.
2. Submit request for payment to:
AOC, PO Box 2448, Raleigh, NC 27602 Attention: GAL Services Division

IDS CONFLICT ATTORNEY REPRESENTATION

Child(ren)/Case Name	Date of Appointment
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ORIGINAL PROCEEDING

<input type="checkbox"/> Abuse/Neglect/Dependency (Juvenile GAL, Program Conflict)	<input type="checkbox"/> DSS Initiated TPR (Juvenile GAL, Program Conflict)
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DISPOSITION (most recent disposition)

<input type="checkbox"/> Adjudicated Abused, Neglected, or Dependent <input type="checkbox"/> Initial Disposition Entered <input type="checkbox"/> Review Order Entered <input type="checkbox"/> Permanency Planning Order Entered	<input type="checkbox"/> Parental Rights Terminated <input type="checkbox"/> Dismissed <input type="checkbox"/> None (Attorney Withdrew) <input type="checkbox"/> Other: _____
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COMPLETE FOR THIS FEE: (Attach detailed time sheets. Time must be reported in decimals, not minutes.)

Beginning Date This Fee Requested	Ending Date This Fee Requested	Prior Total Fees And Expenses Allowed By Judge	
Disposition Date (if final fee)	Time in Court	Time Out of Court	TOTAL AMOUNT \$

APPROVAL FOR PAYMENT

Under Penalties of perjury, I certify this is a true and accurate accounting of the time incurred as conflict attorney for GAL. Attached is a detailed timesheet.	Signature of Attorney	Date
If payment is to be made to individual, write attorney's own taxpayer ID No. (either Social Security No. or Federal Employer ID No.) If payment is to be made to attorney's firm, give firm name and taxpayer ID No.	Tax Payer ID No./or Social Security No. (last 4 digits of Social Security No.)	
I have reviewed this accounting and find that it is reasonable based on the complexity of case. Requested payment is approved.	Signature of Judge	Date

FOR USE BY AOC ADMINISTRATIVE SERVICES

COMPANY/ACCOUNT	CENTER	AMOUNT	1099
532110026	1300134034__		
Date		Verification For Payment (By GAL)	