Cost Reimbursement Invoice Form
COUNTY OF MONTEREY, Behavioral Health Bureau

Contractor : 7th AVENUE CENTER, L.L.C.

Address Line 1 1171 7th Avenue, Santa Cruz, CA 95065
Address Line 2

Tel. No.: 831-476-1700
Fax No.:
Contract Term: FY 2012-13 thru FY 2014-15

Invoice Number :

County PO No.:

Invoice Period :

Final Invoice : (Check if Yes)

FUNDED PROGRAM:

AVATAR Program,Mode and Service Function Code

Financial Eligibility (Admision Criteria)

Unduplicated Number of Clients Served:

Identify

50%

Service Description	Mode of Service	SFC	Procedure Code	Units of Service (UOS) Delivered to Date	Total UOS Delivered as of Last Period	UOS Delivered this Period	SMA Rate per Unit	Amount of UOS at SMA Rate or Cash Flow Advance (CFA)	Dollar Amount Requested this Period (lower of Net Cost or SMA/CFA)	Total Dollar Amount Requested last Period	Dollar Amount Requested Year-to-Date	Estimated FFP	AVATAR System	Variance
											$ -	$ -		$ -
										$ -	$ -	$ -		$ -
											$ -			
TOTALS								$ -	$ -	$ -	$ -	$ -	$ -	$ -
Revenue)											$ -			
REMAINING AMOUNT											$ -			

Description	Provisional Rates	Cash Flow Advances	Total BUDGET	Total Dollar Amount Requested last Period	Gross Expenses this Period	Dollar Amount Requested Year-to-Date	Remaining Amout in the Budget
TOTAL ALLOWABLE PROGRAM EXPENDITURES	$ -			$ -		$ -	$ -
Less Other Revenues	$ -	$ -		$ -	$ -	$ -	$ -
Net Cost	$ -		$ -	$ -	$ -	$ -	$ -
Use of Deferred Revenue				$ -	$ -	$ -	$ -
Net Cost Due from Monterey County			$ -	$ -	$ -	$ -	$ -
Amount of UOS at SMA Rate					$ -		
Due from Monterey County - lower of Net Cost or SMA/CFA					$ -		
Federal Financial Participation (FFP) Revenue	$ -			$ -			$ -

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature:

Date:

Title:

Telephone:

Send to: MCHDBHFinance@co.monterey.ca.
Behavioral Health Claims Section

Behavioral Health Authorization for Payment

Authorized Signatory

Date