Monterey County Behavioral Health Invoice Form - Instructions

Contractor:	Enter your organization's name
Address Line 1	Enter your organization's street address
Address Line 2	Enter your oganization's city, state, and ZIP code
Tel. No.	Enter your organization's telephone number
Fax No.	Enter your organization's fax number
Contract Term:	according to your contract,contract term is pre-filled
BH Division:	Enter Mental Health if contracting to provide Mental Health Services, Enter Alcohol and Drug Programs if providing Alochol and Drug services
Invoice Number:	Enter your organization's invoice number
County PO#	Enter the purchase order number received from the county purchasing department
Invoice Period:	Enter the range of dates for which you are invoicing, i.e. if you are invoicing for services provided june 06 enter 06/01/2006 - 06/30/2006
Final Invoice:	Check this box only if this is the final invoice for the fiscal year in question. For instance if your invoice is for June 2006 check this box
Bh Control Number	Leave blank. This field is for BH use only
Service Description	according to your contract,service descriptions have been pre-filled
Mode of service	according to your contract, mode of services have been pre-filled
SFC	according to your contract, service function codes have been pre-filled
Procedure Code	according to your contract, procedure codes have been pre-filled
Rate of Reimbursement	according to your contract, Rate of Reimbursement, if applicable, have been pre-filled
Total contracted UOS	according to your contract, Total Contracted UOS, if applicable, have been pre-filled
UOS Delivered this Period	**Please enter the units of service delivered this period. (Not applicable to fixed rate programs)**
Total UOS deliverd as of last period	**Pleaes enter the total units of service from your last month's invoice column labeled "UOS Delivered to Date" (Not applicable to fixed rate programs)**
UOS Delivered to Date	Formula, do not enter any values
% Delivered to Date	Formula, do not enter any values
Remaining Deliverables	Formula, do not enter any values
% of Remaining Deliverables	Formula, do not enter any values
Total Contract Amount	Formula do not enter any values
Dollar Amount Requested This Period	**Please calculate the dollar amount requested this period. As default, the cell is formulated = Rate * UOS Delivered this period**
Dollar Amount Requested to Date	**Please calculate the dollar amount requested to date. As default, the cell is formulated = Rate * Total UOS Delivered to Date**
Dollar A,mount Remaining	Formula do not enter any values
% of total contract amount	Formula do not enter any values

Monterey County Behavioral Health - Invoice Form

Contractor :	Central Coast Center for Independent Living	**Invoice Number :**	
Address Line 1	318 Cayuga Street	**County PO No.:**	
Address Line 2	Salinas, CA 93901	**Invoice Period :**	
Tel. No.:	**(831) 757-2968**		
Fax No.:	**(831) 757-5549**		
Contract Term:	July 1, 2012 - June 30, 2013	**Final Invoice :**	(Check if Yes)
BH Division :	Behavioral Health	BH Control Number	

	Service Description	Total Contract Amount FY 2011-12	Dollar Amount Requested this Period	Dollar Amount Requested to Date	Dollar Amount Remaining	% of Total Contract Amount
	Benefits Counseling, Individual Advocacy, Housing assistance, Independent Living Skills and Assistive Technology (AT) Services	$80,282				
	Information and referral services	$7,510				
	Outreach presentations	$1,058				
TOTALS		88,850.00				

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:	Behavioral Health Accounting Office 1270 Natividad Road Salinas, CA 93906	Behavioral Health Authorization for Payment Authorized Signatory	Date