

EXHIBIT B: Invoice Form

Contractor : Thought Link		Invoice Number :						
Address Line 1 14561 Hillsdale St.		County PO No.:						
Address Line 2 Chino, CA 91710								
		Invoice Period :						
Tel. No.: 415-517-5470								
Fax No.:								
Contract Term: January 1, 2025 to June 30, 2026		Final Invoice : (Check if Yes)						
BH Division : Mental Health Services		BH Control Number						
	PROJECT DELIVERABLE(S) DURING INVOICE PERIOD	PROGRAM CODE	FUNCTION CODE	Total Maximum Annual Amount	Dollar Amount Requested this Period	Dollar Amount Requested to Date	Dollar Amount Remaining	% of Total Contract Amount
	BHSA Transition	BHSAADMIN	BHSA-00	\$ 141,000.00			\$ 141,000.00	100%
TOTALS								
TOTALS			Total for FY 2024-25	\$ 141,000.00	\$ -	\$ -	\$ 141,000.00	100%

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 Administration
	MCHDBHFinance@co.monterey.ca.us

Behavioral Health Authorization for Payment	
Authorized Signatory _____	_____ Date