San Bernardino County
Department of Behavioral Health
Emergency Shelter Monthly Summary - Claim for Reimbursement

Contractor: _____
Address: _____

_____

_____

Contractor # _____
DBH Agreement # _____
Phone: _____

Program and Cost Center

_____ **24 Hour Services** (HMLRECD)
_____ **HOST/Clubhouse/RBEST/CARE/AOT** (HOSTA7)
_____ **Regional Outpatient** (HMLSHTRD)
_____ **CHOICE** (FOR109D)
_____ **DOORS** (DOORS)

_____ **RISES** (RISES)
_____ **STAR/CSTAR** (FORSTRD)
_____ **TAY** (TAYCRTD)

Month / Year being claimed: Choose a month/year
Number of Consumer Nights: 0
Monthly Amount Claimed: $0.00

Contractor Certification

I certify under penalty of perjury that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts; and that the expenditures claimed are properly supported in the accounting records.

Contractor Name: _____

Signature: _____
Title: _____
Date: _____

FOR COUNTY USE ONLY:

Reviewer: _____

Signature: _____
Date: _____

Program Manager: _____

Signature: _____
Date: _____

Programs – Copy and send original forms with original Program Manager signatures to fiscal services. Copies are allowed for those that are DocuSigned.

San Bernardino County
Department of Behavioral Health
Emergency Shelter Reimbursement Form

To: **Department of Behavioral Health**

From:
Contractor Name: _____
Contractor Address: _____

Charges for the month of:
Choose a month/year

Program and Cost Center

_____ **24 Hour Services** (HMLRECD)
_____ **HOST/Clubhouse/RBEST/CARE/AOT** (HOSTA7)
_____ **Regional Outpatient** (HMLSHTRD)
_____ **CHOICE** (FOR109D)
_____ **DOORS** (DOORS)
_____ **RISES** (RISES)
_____ **STAR/CSTAR** (FORSTRD)
_____ **TAY** (TAYCRTD)

Consumer Name (Must match Referral Voucher)	Day Rate	Dates In Shelter From	Dates In Shelter To	Total Days	Total Amount
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
	$65.00				$0.00
			Total days and Claim Total:	0	$0.00

I certify under penalty of perjury, the consumers listed above were cared for in the named facility for the dates as noted above at the rates therein. This further authorizes the Department of Behavioral Health to make adjustments, if necessary, to this bill, to the amount allowed by State and Federal regulations.

Payment Authorization

Reviewer: _____ **Signature:** _____ **Date:** _____

Program Manager: _____ **Signature:** _____ **Date:** _____

Original form with original Program Manager signature is to be forwarded to Fiscal Services. Programs will insert the Cost Center Code before submitting originals to Fiscal Services.