

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

Contractor: _____
Address: _____

Contractor # _____
DBH Agreement # _____
Phone: _____

Program and Cost Center

Behavioral Health Bridge Housing (BHBH)

Month / Year being claimed: _____
Number of Consumer Nights: _____
Monthly Amount Claimed: _____

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
Enhanced Shelter Reimbursement Form

To:	From:
Department of Behavioral Health	Contractor Name: _____
	Contractor Address: _____
Charges for the month of: _____	_____

Program and Cost Center	

Behavioral Health Bridge Housing (BHBH)

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

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.

Enhanced Shelter Reimbursement Form

Vendors will complete and submit one Monthly Billing and Reimbursement form to each respective program for payment of shelter services as outlined in the current contract. DBH requires one claim to be completed per program per month. The instructions below will provide guidance to vendors as they are completing these forms.

PAGE 1

San Bernardino County Department of Behavioral Health Enhanced Shelter Monthly Summary - Claim for Reimbursement	
Contractor:	
Address:	
Contractor #	
DBH Agreement #	
Phone:	
Program and Cost Center	
Behavioral Health Bridge Housing (BHBH)	
<div style="display: flex; justify-content: space-between; align-items: center;"> ▼ BHBH </div>	
Month / Year being claimed:	Choose a month/year ▼
Number of Consumer Nights:	0
Monthly Amount Claimed:	\$0.00
Contractor Certification	
<i>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.</i>	
Contractor Name:	
Signature:	
Title:	
Date:	
FOR COUNTY USE ONLY:	
Reviewer:	
Signature:	
Date:	
Program Manager:	
Signature:	
Date:	
<i>Programs – Copy and send original forms with original Program Manager signatures to fiscal services. Copies are allowed for those that are DocuSigned.</i>	

In this section, vendors need to complete all requested information. Page 2 will pre-populate the contractor's name and address for you, when completed on page 1. Your contract # and DBH Agreement # are found in your County Contract.

When completing this section, it is important to remember that you must complete one billing form per program; choose the appropriate program, month, and billing year. You will not be completing the **Number of Consumer Nights** or the **Monthly Amount Claimed**; those sections populate based on entries on Page 2.

Contractor certification is important and cannot be left blank. If this section is not completed, the invoice will be returned to you for correction prior to processing and authorizing payment.

PAGE 2

San Bernardino County

Department of Behavioral Health

Enhanced 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

Behavioral Health Bridge Housing (BHBH)

BHBH

Consumer Name (Must match Referral Voucher)	Day Rate	Dates In Shelter		Total Days	Total Amount
		From	To		
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
	\$150.00				\$0.00
Total days and Claim Total:				0	\$0.00

The entries in this section will populate from page 1 and there is no need to update. If the information did not populate, then page 1 wasn't completed in its entirety.

In this section, the vendor will use the provided vouchers for each consumer who was housed in the specific shelter site for the applicable month. Ensure consumer names and dates of service match for accurate reimbursement. Information entered in this section will assist populate Number of Consumer Nights and Monthly Amount Claimed sections of the form above.