San Bernardino County
Department of Behavioral Health
BHBH Hotel/Motel Shelter Monthly Summary - Claim for Reimbursement

Contractor: _____
Address: _____

_____

_____

Contractor # _____
DBH Agreement # _____
Phone: _____

Program and Cost Center

_____ **24 Hour Services** (HMLRECD)
_____ **CHOICE** (FOR109D)
_____ **DOORS** (DOORS)
_____ **HOST** (HOSTA7)
_____ **Regional Outpatient** (HMLSHTRD)
_____ **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
BHBH Hotel/Motel Shelter Reimbursement Form

To: **From:**

Department of Behavioral Health

Contractor Name: _____

Contractor Address: _____

_____

_____

Charges for the month of:

Choose a month/year

Program and Cost Center

_____ **24 Hour Services** (HMLRECD)
_____ **CHOICE** (FOR109D)
_____ **DOORS** (DOORS)
_____ **HOST** (HOSTA7)
_____ **Regional Outpatient** (HMLSHTRD)
_____ **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
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$0.00
	$90.00				$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.

Emergency 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
Emergency Shelter Monthly Summary - Claim for Reimbursement

Contractor:
Address:
Contractor #
DBH Agreement #
Phone:

Program and Cost Center

- **24 Hour Services** (HMLRECD)
- **CHOICE** (FOR109D)
- **DOORS** (DOORS)
- **HOST** (HOSTA7)
- **Regional Outpatient** (HMLSHTRD)
- **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 th responsible for the examination and settlement of accounts; and that the expenditures c supported in the accounting records.

Contractor Name:
Signature:
Title:
Date:

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
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)
- **CHOICE** (FOR109D)
- **DOORS** (DOORS)
- **HOST** (HOSTA7)
- **Regional Outpatient** (HMLSHTRD)
- **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

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.