San Bernardino County Department of Behavioral Health

BHBH Hotel/Motel Shelter Monthly Summary - Claim for Reimbursement

Contractor:		
Address:		
<u>-</u>		
Contractor #_		
DBH Agreement #_		
Phone:		
	Program and Cost Center	
24 Hour Se	rvices (HMLRECD)	
CHOICE (FC	DR109D)	
DOORS (DO	OORS)	
HOST (HOS	TA7)	
	utpatient (HMLSHTRD)	
RISES (RISE		
	R (FORSTRD)	
TAY (TAYCF	RTD)	
Month / Year being	g claimed:	
Number of Consum	er Nights:	
Monthly Amount	Claimed:	
	Contractor Certification	
Leartify under nanalty o	of perjury that I am the duly qualified and authorized official of	the herein claimant
	nination and settlement of accounts; and that the expenditures	
supported in the accour		s claimed are properly
	g . 000. 00.	
Contractor Name: _		
Signature:		
Title:	<u> </u>	
Date:		
FOR COUNTY LICE ONLY	1.	
FOR COUNTY USE ONLY	r:	
Reviewer:		
Signature: _	<u> </u>	
Date:		
Program Manager:		
Signature:		
-		

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

From:	
Contractor Name:	
Contractor Address:	
	Regional Outpatient (HMLSHTRD)
	RISES (RISES)
	STAR/CSTAR (FORSTRD)
	TAY (TAYCRTD)
	Contractor Name:

Consumer Name	Day	Dates In Shelter		Total	
(Must match Referral Voucher)	Rate	From	То	Days	Total Amount
	To	otal 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.

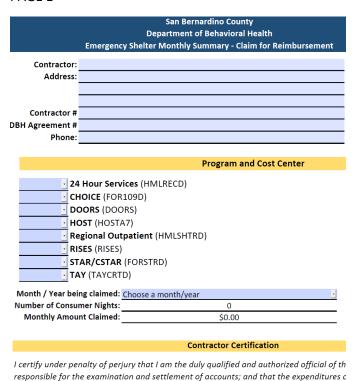
	Payment Authorization	
Reviewer:	Signature:	Date:
Program		
Program Manager:	Signature:	Date:

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



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.

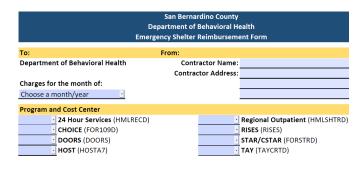
Contractor certification is important and cannot be left blank. If this section is not completed, the invoice will be returned to you for correction prior to processing and authorizing payment.

PAGE 2

supported in the accounting records

Signature: Title: Date:

Contractor Name:



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.

Consumer Name	Day	Dates In Shelter		Total	
(Must match Referral Voucher)	Rate	From	То	Days	Total Amount
	\$65.00				\$0.00
	\$65.00				\$0.00
	\$65.00				\$0.00
	\$65.00				\$0.00

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.