San Bernardino County
Department of Behavioral Health
Emergency Shelter Referral Voucher

Consumer Information:

First Name: _____
Last Name: _____
Date of Birth: _____
Medical Record #: _____

Facility Information:

Vendor Name: _____
Shelter Address: _____
_____
Facility Phone: _____

Program, Cost Center and Contact Information

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

Case Manager: _____ **Phone:** _____
Program Manager: _____ **Phone:** _____
Billing Coordinator: _____ **Phone:** _____
Email: _____
After Hour Contact: _____
(if applicable)

FSP Client *(choose one)* Choose C

Placement and Payment Authorization

Date of First Shelter Night Authorized: _____ **Bed Hold Authorized:** _____

_____ _____ _____
DBH Staff **Signature** **Date**

_____ _____ _____
Program Manager/Designee **Signature** **Date**

Placement and Payment Termination

Date of Last Shelter Night Authorized: _____

_____ _____ _____
DBH Staff **Signature** **Date**

_____ _____ _____
Program Manager/Designee **Signature** **Date**

Disposition at Exit

☐ Moved to another shelter
☐ Residential Treatment (CRT, SUD, etc)
☐ Involuntarily discharged from shelter
☐ Voluntarily returned to homelessness
**Vendor Instructions on the back

☐ Self-Pay Housing
☐ Assisted/Supported Housing
☐ Temporary family/friends
☐ Long-term family/friends
☐ AWOL

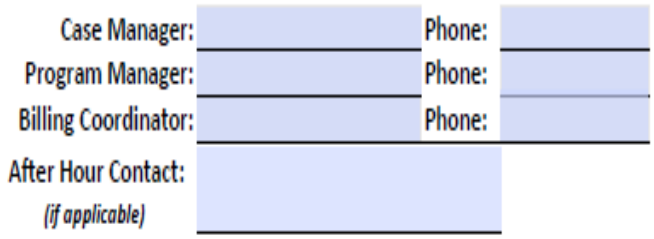
☐ Hospitalized - medical
☐ Hospitalized - psychiatric
☐ Incarcerated
☐ Other: _____

Voucher Instructions for the Vendor

This voucher will authorize admission of the DBH consumer into your shelter site, the dates indicated for services are reimbursable under contract. Information below are helpful tips regarding the information contained within the voucher and program contacts.

This section informs the vendor of which DBH Program is placing the consumer in their shelter. This will also advise the vendor of which program billing is submitted to for reimbursement on a monthly basis. Each program processes their own billing claims.

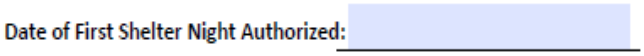
** CHOICE, DOORS, STAR/CSTAR and RISES are all under the umbrella of the Adult Forensic Services (AFS) program and billing is submitted to AFS.



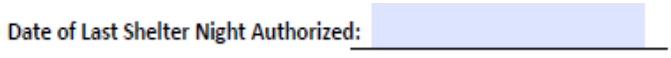
DBH Program must include the information for the assigned Case Manager, Program Manager and Billing Coordinator for their program. *If this is incomplete, the voucher is incomplete.* Each consumer is assigned a **Case Manager**, whom the vendor would reach out and communicate for the following: behavior concerns, medication compliance, etc…

The vendor would reach out to the **Program Manager** in the event they could not successfully reach the Case Manager, any **Urgent** placement issues, or crisis situation.

The **Billing Coordinator** receives and processes invoices for shelter services, each per program. You will submit monthly billing to them and may contact them regarding billing questions.



This is the first night in which payment is authorized for shelter bed services; should be reflected in the monthly invoice.



This is the last night in which payment is authorized for shelter bed services; this should also be listed on the monthly invoice when applicable.