

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control (DPH-SAPC)
Sexual and Reproductive Health (SRH) Project

Sexual and Reproductive Health Specialist Invoice

Provider Name: _____ Monthly Claim Period: _____
Street Address: _____ Phone Number: _____
City, State, Zip: _____ Contact Email: _____

	Number of Hours for Monthly Claim Period	Amount Requested for Monthly Claim Period (Hours x \$73.70)
SRH Specialist Activities:		\$
Outreach & Engagement		\$
SRH Education Services		\$
Client Screening, Appointment Scheduling, Reminders & Follow-Up		\$
Service Navigation, Referral & Linkages		\$
Total:		

Claims must be submitted by the **10th of each month** to Carina Dominguez cdominguez@ph.lacounty.gov and Teresa (Tere) De Anda tdeanda@ph.lacounty.gov. Payment may be delayed or withheld if this request contains any errors or omissions. **Supporting documentation must be submitted along with this invoice.**

Signature – Agency Supervisor Date

Signature – DPH-SAPC Date

Approved Amount by DPH-SAPC