Recovery Housing Billing

LOS ANGELES COUNTY - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
RECOVERY HOUSING INVOICE

ATTACHMENT III

PROVIDER NAME:
ADDRESS:
CITY: ZIP:
SERVICE CATEGORY:
CONTACT PERSON: PHONE:

CONTRACT NO.:
CLAIM PERIOD:
DATE PREPARED:
PROVIDER NO.:
Invoice Type: Original / Supplemental

Facility Address | Contracted Beds

Bed #	Participant First Name	Participant Last Name	Date Placed	Date of 1st Day Claimed this month	Date of Last Day Claimed this Month	Total Days Claimed	Total Amount Claimed
1						0	$0.00
2						0	$0.00
3						0	$0.00
							$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00
						0	$0.00

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Needed Info

- **Facility Address**: Must be contracted sites.
- **Contracted Beds**: Limited to bed count in contract.
- **Patient Name**: Limited to SAPC placed patients.
- **Date Placed**: This is the date that SOC placed the patient.
- **First Day**: The first night that the patient slept in the bed.
- **Last Day**: The last day patient slept in bed.

The Recovery Housing Supplemental Invoice is a supplemental invoice that must be submitted for every site, with the bed count, every month. The invoice captures patient days spent in the beds and is formulated to calculate th e number of days and total amount claimed.