SONOMA COUNTY DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
3324 CHANATE RD
SANTA ROSA, CA 95404
SUD SERVICES INVOICE

FACILITY NAME:

FACILITY ADDRESS:

PROGRAM:

CONTRACT NUMBER:

INVOICE MONTH AND YEAR:

CONTRACTOR NAME:

REMIT ADDRESS:

INVOICE CONTACT PERSON/NAME:

CONTACT PHONE #:

Service Code	Total Units of Service	Unit of Service Rate	Total Claimed Amount
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
TOTALS	0		$ 0.00

Attestation of Claim: I hereby certify that I am the official who is responsible for claiming the amount of reimbursement specified in the attached documents. To the best of my knowledge and belief these claims are in all respect true and correct and are completed in accordance with applicable law. To the best of my knowledge and belief, the services were provided in accordance with clients written treatment plan and the services have been documented in the client record, if applicable. I understand that payment for these claims may be from Federal and/or State, and/or County funds and that any falsification or concealment of a material fact may be prosecuted under federal and/or State Laws.

APPROVED BY FACILITY EXECUTIVE DIRECTOR OR DESIGNEE SIGNATURE:_____DATE:_____

PRINT NAME:_____ **TITLE:_____**