



VENDOR INVOICES

HOW TO PREPARE AND SUBMIT YOUR MONTHLY INVOICES

U.S. PROBATION OFFICE & U.S. PRETRIAL SERVICES OFFICE
EASTERN DISTRICT OF CALIFORNIA

NAVIGATION

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- ▶ This presentation has been saved as a PDF document.
- ▶ To advance to the next slide, click the forward/backward arrows at the top or bottom of the screen on a slide to advance to the next slide.
- ▶ You may go to the Table of Contents any time, by clicking on the seal in the upper right corner
- ▶ In the Table of Contents, click on a page number to go to a specific section.

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INTRODUCTION

INTRODUCTION

Welcome & Purpose

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- ▶ Welcome to this Vendor Invoice presentation.
- ▶ The purpose of this presentation is to:
 - ▶ Help you prepare your monthly invoices
 - ▶ Ensure your invoices are correct and true for payment
 - ▶ Reduce errors
 - ▶ Reduce supplemental invoices
 - ▶ Help ensure invoices are paid timely to each vendor

INTRODUCTION

Invoice Template

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- ▶ An invoice template will be provided to you, which is specific to your BPA or contract.
- ▶ This template is a preformatted Microsoft Excel format:
 - ▶ Do not change the invoice format
 - ▶ Do not overwrite formulas (except where instructed)
- ▶ This Excel template:
 - ▶ Automatically calculates Section B, then
 - ▶ Transfers the total amount billed to Section A
- ▶ Keep the original template, and make a copy for your monthly invoice. This will keep the invoice from becoming corrupted.
- ▶ If your template becomes corrupted, or stops calculating properly, you may request an another copy

INTRODUCTION

Due Dates

- ▶ Invoices are due in our office by the 10th of each month, following the month in which services were performed.
- ▶ For Example:
 - ▶ January's invoices are to be received by the 10th of February
 - ▶ July's invoices are to be received by the 10th of August



INTRODUCTION

Program Plans



- ▶ Services are requested by U.S. Pretrial Services Officers and U.S. Probation Officers via a PROB 45, Program Plan.
- ▶ PROB 45s, Program Plans, must be signed by a “Referral Agent.” Only those officers listed on the Referral Agent list (included in the Delivery Order) may sign as referral agents.
- ▶ Only services authorized by a valid Program Plan may be billed.
- ▶ Services provided by the vendor without a valid Program Plan may be deducted from the vendor’s invoice before payment.

PROB 45 – Program Plan

Attachment 1.2

Prob. Form 45 Today's Date:

Client Identifying Information

Client:	FACTS:	Photo Not Available
Address:	Pretrial/Post Conviction:	
Officer:	Client Phone:	
Officer Phone:	DOB:	

Provider Information

Provider:	Procurement No:
Provider Location:	Effective Date:
Alt:	Termination Date:
Location Address:	

Phone:
Fax:

Authorized Services
Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copy Amount (per unit)
2010	Individual Substance Abuse Counseling		1.0	Weekly	\$0.00
2020	Group Substance Counseling		2.0	Monthly	\$0.00

Instructions to Provider Regarding Client Needs and Goals of Treatment

Officer: _____ Referral Agent: _____ Client: _____

INTRODUCTION

Invoice Validation

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- ▶ Invoices are validated by comparing:
 1. Information contained in Probation and Pretrial Services Automated Case Management System (PACTS),
 2. Your Invoice, and
 3. The support documentation, including:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
 - ▶ Treatment Plans (Due every 90 days)

INTRODUCTION

Validation Errors



A validation error occurs when a charge (or charges) can not be verified by:

- PACTS,
- The invoice, or
- The supporting documentation

When there is a validation error, the unverified or unauthorized charge(s) will be deducted from the invoice and a letter will be sent to you explaining the adjustment.

You will receive a Payment Authorization Adjustments letter, detailing the adjustment(s):

- The amount of the deduction(s)
- The reason for the deduction(s)

Cover Letter

UNITED STATES DISTRICT COURT | EASTERN DISTRICT OF CALIFORNIA

PROBATION OFFICE

ROBERT A. RAMIREZ
Chief U.S. Probation Officer

JACK C. ROBERSON
Deputy Chief U.S. Probation Officer

501 "I" Street, Suite 2-500
Sacramento, California 95814
Tel: (916) 930-4300



REPLY TO:

(Headquarters)
501 "I" Street, Suite 2-500
Sacramento, California 95814
Tel: (916) 930-4300
Fax: (916) 930-4300
www.caep.uscourts.gov

March 12, 2019

Service Provider

RE: Payment Authorization Adjustments

Dear Service Provider,

An invoice from your agency was adjusted by our office. Please see the adjustments below.

Should you wish to rebill for any of these items, you must submit a separate invoice. Do not include them in the next month's bill. Any supplemental invoices and the supporting documentation must be received by the due date indicated.

Please ensure you review all invoices for correctness and completeness before submitting them. Instructions for submitting invoices may be found in the Statement of Work (SOW), Section G – Agreement Administration Data, Paragraphs G.3 (Invoices) and G.4 (Reimbursements or Copayments).

Should you have any questions please contact Dena Larkin, Procurement Administrator, at: (916) 930-4339 or dena_larkin@caep.uscourts.gov. Thank you for your continued support.

Sincerely,

Michael S. Smith
Contracts Specialist

MSS/dl

Attachment

Public safety and the fair administration of justice through professional and progressive interventions.

Adjustments

TREATMENT SERVICES INVOICE ADJUSTMENTS

Vendor's Name:

BPA No.:

Billing Period (From):

Billing Period (To):

Vendor's Original Invoice Total:

#	Client #	Client Name	Adjustment	Adjustment Description
1			\$0.00	
2			\$0.00	
3			\$0.00	
4			\$0.00	
5			\$0.00	
6			\$0.00	
7			\$0.00	
8			\$0.00	
9			\$0.00	
10			\$0.00	
11			\$0.00	
12			\$0.00	
13			\$0.00	
14			\$0.00	
15			\$0.00	

Total Adjustments:

Revised Invoice Total for Payment:

Supplemental Invoice Due Date:

Comments:

Public safety and the fair administration of justice through professional and progressive interventions.

INTRODUCTION

Supplemental Invoices

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- ▶ When you receive a Payment Authorization Adjustments letter, you will need to:
 - ▶ Research the error and make the necessary corrections
 - ▶ Prepare a “Supplemental” invoice (if the charge is valid) for the applicable month and submit it separately from your regular monthly invoices
- ▶ **IMPORTANT:** Do not add the corrected charge(s) to your next month’s invoice. Submit them separately, as a “Supplemental” invoice to the month the charge applies.

INTRODUCTION

Our Responsibility to the Taxpayer

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- ▶ Documentation supporting each and every charge in an invoice is required for two reasons:
 1. The Federal Government has a fiduciary responsibility to ensure that the taxpayer's money is spent wisely, and
 2. Congress, in authorizing treatment services to be provided to Federal Defendants and Offenders, requires that every invoice be fully supported by documentation which proves that each service was indeed provided by the vendor



PROCESS OVERVIEW

PROCESS OVERVIEW

Steps 1 & 2

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- ▶ Step 1 – Gather your documents from the clinicians and support staff:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
 - ▶ Treatment Plans (Due every 90 days)
- ▶ Step 2 – Prepare your invoice:
 - ▶ Part B – Itemized Invoice
 - ▶ Part A – Invoice Summary

PROCESS OVERVIEW

Steps 3 & 4

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- ▶ Step 3 – Review your invoice:
 - ▶ Compare Section A & B totals
 - ▶ Compare Section B with all support documentation
 - ▶ Ensure there is support documentation for every charge
- ▶ Step 4 – Submit your invoice:
 - ▶ By the 10th of each following month
 - ▶ U.S. Courts Electronic Reporting System (ERS)
 - ▶ Parts A & B **ONLY**
 - ▶ Mail or email:
 - ▶ Original Parts A & B, and
 - ▶ All supporting documents

PROCESS OVERVIEW

Quick Reference

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- ▶ For your convenience, attached is a Quick Reference guide you may download:

VENDOR INVOICE PROCESS
QUICK REFERENCE

- ❖ **Step 1 – Gather your documents:**
 - Including:
 - Monthly Treatment Reports (MTRs)
 - Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - Reports – Intake, Physical, Psychological, Polygraph, etc.
 - Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
 - Treatment Plans (Due every 90 days)
 - Compare the MTRs with the support documentation
- ❖ **Step 2 – Prepare your invoice:**
 - Part B – Itemized Invoice
 - Part A – Invoice Summary
- ❖ **Step 3 – Review your invoice:**
 - Compare Section A & B totals
 - Compare Section B with all support documentation
 - Ensure there is support documentation for every charge
- ❖ **Step 4 – Submit your invoice:**
 - By the 10th of each following month
 - U.S. Courts Electronic Reporting System (ERS)
 - Parts A & B ONLY
 - Mail or email:
 - Original Parts A & B, and
 - All supporting documents



GATHER YOUR DOCUMENTS

STEP 1

GATHER YOUR DOCUMENTS

Step 1 – Getting Ready



- ▶ Gather all your paperwork from clinicians and staff, including:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
 - ▶ Treatment Plans (Due every 90 days)
- ▶ These are the documents you will need to complete and submit your monthly invoice.

GATHER YOUR DOCUMENTS

Step 1 – Review the Documents

- ▶ Compare the Monthly Treatment Reports (MTRs) with the support documentation, including:
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets: Breathalyzer, Sweat Patch & Urinalysis
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.



GATHER YOUR DOCUMENTS

Step 1 – Review the Documents



- ▶ Ensure the MTRs are correct and reflect all services provided:
 - ▶ Logs and Sign-In Sheets:
 - ▶ Ensure there is an entry on the MTR for each log
 - ▶ Ensure the sign-in and out times correspond with the duration on the MTR
 - ▶ Reports:
 - ▶ Ensure reports are complete and meet the Statement of Work (SOW) requirements
 - ▶ Ensure reports are signed and dated by the clinician
 - ▶ Receipts:
 - ▶ Ensure receipts correspond with any items posted on the MTR

GATHER YOUR DOCUMENTS

Step 1 – Review the Documents

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- ▶ Ensure your MTRs are complete, including:
 - ▶ Blocks 1 – 7 - General Information
 - ▶ Block 8 – All services provided
 - ▶ Block 9 – UA, Breathalyzer, or Sweat Patch testing information, and specific gravity results (if required by SOW)
 - ▶ Block 10a through f – Narrative.

NOTE: The narrative must be specific to each defendant/offender and not generic or repeated month to month.

- ▶ Block 10g – Any outstanding co-payment owed by the client.

NOTE: Outstanding co-payments may be entered elsewhere on the MTR, but the defendant's/offender's balances must be included.

- ▶ Counselor's signature and date signed.

NOTE: Counselors may electronically sign the MTR.

MONTHLY TREATMENT REPORT										
1. PROGRAM NAME: Substance Abuse					1a. PROVIDER NAME: Vendor's Name			2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): 10/1/2018		
3. CLIENT NAME: Last Name 1, First Name, MI			3a. PACTS NO: 012345		4. FOR PERIOD COVERING: January, 2019					
5. PHASE NO: Phase III		5a. TIME IN PHASE: 4 months		6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		7. CLIENT EMPLOYED: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other				
8. CONTACTS SINCE LAST REPORT										
a. Date	b. Service (Name & No.)			c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)			e. Co-pay (amount collected)		
1/11/19	2010 - Indv. Counseling			1 hr.				N/A		
9. URINE TESTING RECORD										
DATE COLLECTED	Schedule		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Co-pay (amount collected)
	Yes	No	Inst. Qty.	Stall	Yes	No				
1/10/19	X				X		Collector's Name	Spec. Gravity	1,014 (Neg.)	\$25.00
10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS										
a. Describe the treatment goals addressed this month (<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met): Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.										
b. Describe any steps taken by the client this month toward these goals (<input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative):										
c. Describe any obstacles or setbacks the client encountered this month:										
d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:										
e. If continued treatment is recommended, discuss the plan for next month (<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended):										
f. Discuss your observations of the client's behavior and commitment to treatment (<input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative):										
g. Comments: Co-payment - Amount Outstanding \$45.00.										
h. Overall Progress: <input checked="" type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable										
SIGNATURE OF COUNSELOR: Counselor's Typed Name <i>Counselor's Signature</i>							DATE: 1/31/2019			
DISTRIBUTION: ORIGINAL					CONTRACTOR					

GATHER YOUR DOCUMENTS

Step 1 – Supporting Documents



- ▶ Ensure you have supporting documents for every line item on the MTR, including:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.

- ▶ **NOTE:** Any charge not supported by the documents will be deducted from the invoice.

GATHER YOUR DOCUMENTS

Step 1 – Resolving Discrepancies

- ▶ Resolve any discrepancies with the clinicians and support staff before you begin your invoice.
- ▶ Review the PROB 45, Program Plan if there are any questions whether a service or the quantity of service was authorized.
- ▶ **NOTE**: Any charge not specifically authorized by a PROB 45, Program Plan, will be deducted from the invoice.



GATHER YOUR DOCUMENTS

Step 1 – Last Check

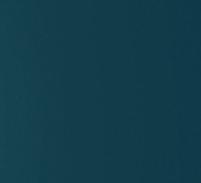
- ▶ Check to ensure you have all the:
 - ▶ MTRs, and
 - ▶ Supporting documents

AND

- ▶ You've resolved any discrepancy

Now, you're ready to prepare the invoice.





PREPARE YOUR INVOICE

STEP 2

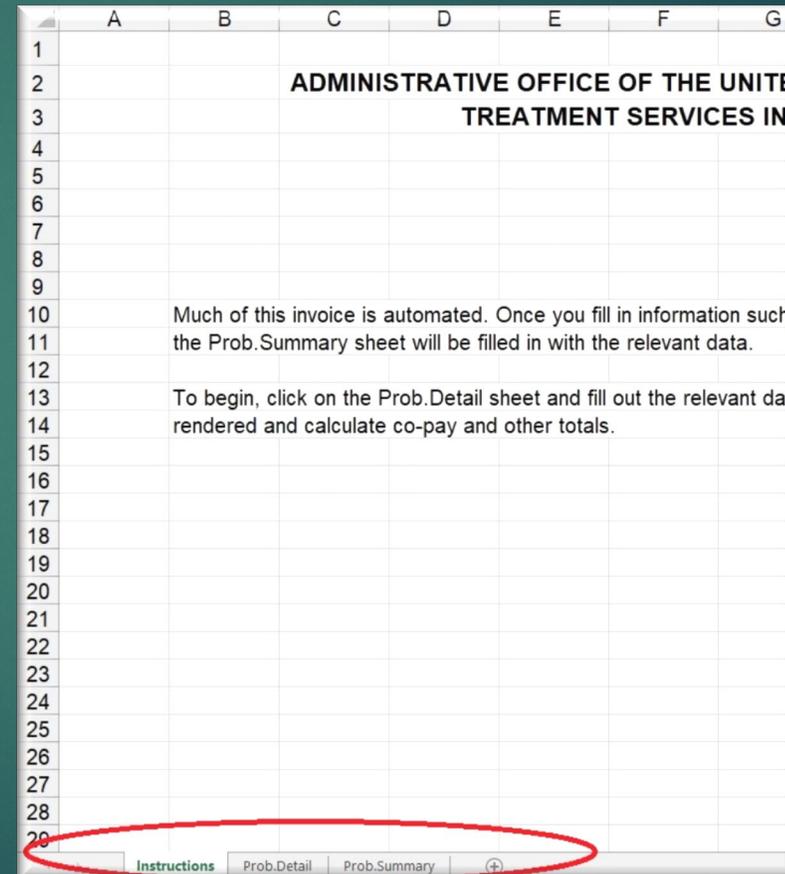
PREPARE YOUR INVOICE

Step 2 – Spreadsheet Navigation

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- ▶ Open the spreadsheet provided to your agency.
- ▶ Be sure to save a copy of the original, in case the one you're working with becomes corrupted.
- ▶ The Microsoft Excel spreadsheet is divided into three worksheets, as follows:
 - ▶ 1st Tab – Instructions
 - ▶ 2nd Tab – Part B, Invoice Detail
 - ▶ 3rd Tab – Part A, Invoice Summary



PREPARE YOUR INVOICE

Step 2 – Part B, Invoice Navigation

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- ▶ Begin on Part B.
- ▶ Part B is where you will enter the detailed billing information.
- ▶ Transfer the information from the MTRs to Part B of the invoice (see the samples on the next few slides).
- ▶ Remember:
 - ▶ Only those services specifically requested with a signed PROB 45, Program Plan, may be charged.
 - ▶ All unverifiable or unauthorized charges will be deducted from the invoice and a Payment Authorization Adjustments letter will be sent to you, advising of the changes.

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR



MTR – Client Name

Part B – Client Name

PROB 46 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: Substance Abuse		1a. PROVIDER NAME: Vendor's Name		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): 10/1/2018	
3. CLIENT NAME: Last Name 1, First Name, MI		3a. FACTS NO. 012345		4. FOR PERIOD COVERING: January, 2019	
5. PHASE NO. Phase III	5a. TIME IN PHASE: 4 months	6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		7. CLIENT EMPLOYED: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other	

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)
1/11/19	2010 - Indy. Counseling, 1 hr.			N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Instr. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X					X	Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):
Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ 25.00	\$ -
		1/11/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/15/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 4, First Name MI	3456012	1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
		1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ -	\$ -
		1/8/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
Last Name 5, First Name MI	01276543	1/2/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR

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MTR – PACTS No.

Part B – Client Number

PROB-16 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: **Substance Abuse** 1a. PROVIDER NAME: **Vendor's Name** 2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): **10/1/2018**

3. CLIENT NAME: **Last Name 1, First Name, MI** 3a. PACTS No.: **012345** 4. FOR PERIOD COVERING: **January, 2019**

5. PHASE NO.: **Phase III** 5a. TIME IN PHASE: **4 months** 6. PRETRIAL CLIENT: Yes No 7. CLIENT EMPLOYED: Yes No Student Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)
1/11/19	2010 - Indv. Counseling, 1 hr.	1 hr.		N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Instr. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X				X		Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):
Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ 25.00	\$ -
		1/11/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/15/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 4, First Name MI	3456012	1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
		1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ -	\$ -
		1/8/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
Last Name 5, First Name MI	01276543	1/2/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR



MTR – Date

Part B – Date of Service

PROB 46 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: Substance Abuse		1a. PROVIDER NAME: Vendor's Name		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): 10/1/2018	
3. CLIENT NAME: Last Name 1, First Name, MI		3a. PACTS NO. 012345		4. FOR PERIOD COVERING: January, 2019	
5. PHASE NO. Phase III	5a. TIME IN PHASE: 4 months	6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		7. CLIENT EMPLOYED: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other	

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)
1/11/19	2010 - Indv. Counseling, 1 hr.	1 hr.		N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X					X	Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):
Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ 25.00	\$ -
		1/11/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/15/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
Last Name 4, First Name MI	3456012	1/6/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
Last Name 5, First Name MI	01276543	1/2/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR

MTR – Service (Name & No.)
and Urine Testing Record

Part B – Service Rendered

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PROB-46 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: **Substance Abuse**

1a. PROVIDER NAME: **Vendor's Name**

2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): **10/1/2018**

3. CLIENT NAME: **Last Name 1, First Name, MI**

3a. PACTS NO.: **012345**

4. FOR PERIOD COVERING: **January, 2019**

5. PHASE NO.: **Phase III**

5a. TIME IN PHASE: **4 months**

6. PRETRIAL CLIENT: Yes No

7. CLIENT EMPLOYED: Yes No Student Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)
1/11/19	2010 - Adv. Counseling	1 hr.		N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X					X	Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):
Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ 25.00	\$ -
		1/11/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/9/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
Last Name 4, First Name MI	3456012	1/8/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/28/2019	1501	1.00	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
Last Name 5, First Name MI	01276543	1/2/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR

MTR – Length of Contact and/or Number of UAs

Part B – Quantity (Units)



PROB-46 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: **Substance Abuse**

1a. PROVIDER NAME: **Vendor's Name**

2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): **10/1/2018**

3. CLIENT NAME: **Last Name 1, First Name, MI**

3a. PACTS NO.: **012345**

4. FOR PERIOD COVERING: **January, 2019**

5. PHASE NO.: **Phase III**

5a. TIME IN PHASE: **4 months**

6. PRETRIAL CLIENT: Yes No

7. CLIENT EMPLOYED: Yes No Student Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Show, Parolness, Issues Addressed)	e. Copay (amount collected)
1/11/19	2010 - Indy. Counseling	1 hr.		N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X					X	Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):

Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	15.00	\$ 15.00	\$ 25.00	\$ -
		1/11/2019	2010	2.00	30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	15.00	\$ 15.00	\$ -	\$ -
		1/15/2019	1010	1.00	15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	15.00	\$ 15.00	\$ -	\$ -
Last Name 4, First Name MI	3456012	1/28/2019	1501	1.00	1.25	\$ 1.25	\$ 25.00	\$ 25.00
		1/28/2019	1501	1.00	1.25	\$ 1.25	\$ -	\$ -
		1/8/2019	2010	2.00	30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	30.00	\$ 60.00	\$ -	\$ -
Last Name 5, First Name MI	01276543	1/28/2019	1501	1.00	0.50	\$ 0.50	\$ 10.00	\$ 10.00
		1/28/2019	1501	1.00	0.50	\$ 0.50	\$ -	\$ -
		1/2/2019	2022	3.00	25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR

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- ▶ Unit Price:
 - ▶ Most Project Code unit pricing will be a 30-minute session (i.e. 1 unit = 30 minutes).
 - ▶ However, some Project Codes have different units (See the chart).
 - ▶ Review the Project Code pricing in Section B of the Statement of Work (SOW) for the appropriate unit charge.

Service	Unit	Example
Most Counseling	Per Session (30 minutes)	1 unit = 30 minutes
Intensive Outpatient Treatment	Per Day (3 hours per day, 3 days per week minimum)	1 unit = 1 day
Intake, Psychological & physical Reports	Per Report	1 unit = 1 report (regardless of the time it takes to complete)
Psychotropic Medication	Per Month	1 unit = 1 month (regardless of the number of medications prescribed)
Medication Monitoring & Administering Medications	Per Visit	1 unit = 1 visit
Administrative Fees	Per Expense	1 unit = 5% of the related charge
Co-Payments	Per Co-Payment	1 unit = 1 co-payment
Physiological Exams	Per Exam	1 unit = 1 exam
At Cost Services	Actual Cost	1 unit = actual cost of service provided
Polygraph Tests	Per Test	1 unit = 1 test

PREPARE YOUR INVOICE

Step 2 – Part B, Transfer Data from the MTR

MTR – Co-Pay (Amount Collected)

Part B – Co-Pay Received

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PROB 46 (Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME: Substance Abuse		1a. PROVIDER NAME: Vendor's Name		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): 10/1/2018	
3. CLIENT NAME: Last Name 1, First Name, MI		3a. PACTS NO. 012345		4. FOR PERIOD COVERING: January, 2019	
5. PHASE NO. Phase III	5a. TIME IN PHASE: 4 months	6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7. CLIENT EMPLOYED: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other		

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Co-pay (amount collected)
1/11/19	2010 - Indv. Counseling	1 hr.		N/A

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Co-pay (amount collected)
	Yes	No	Instr. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X					X	Collector's Name	Spec. Gravity	1.014 (Neg.)	\$0

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (Met Not Met):
Ensure the narrative is: 1.) Specific to the each client, 2.) Don't use generic statements, 3.) Do not repeat month to month, and 4.) Attach second page if required in the SOW.

b. Describe any steps taken by the client this month toward these goals (Positive Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
Last Name 1, First Name MI	012345	1/10/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/11/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 2, First Name MI	543210	1/6/2019	2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
		1/8/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/15/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 3, First Name MI	32104	1/1/2019	1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
		1/1/2019	1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/16/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		1/28/2019	1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
Last Name 4, First Name MI	3456012	1/28/2019	1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
		1/28/2019	1501	1.00	\$ -	\$ -	\$ -	\$ -
		1/8/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		1/15/2019	2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
Last Name 5, First Name MI	01276543	1/2/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/14/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		1/28/2019	2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part B, Manual Entries

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- ▶ Unit pricing for Administrative Fees (items which are a percentage of their parent cost), and actual cost items, will need to be manually entered (See Project Codes to the Right.)
- ▶ In these cases you will need to overwrite the formula in the Unit Price column.

NOTE: *Because you may need to overwrite a formula, it's important to save a copy of the original invoice.*

Project Code	Description	Price Base
4010	Physical Exam	Actual Cost
4020	Lab Studies & Rpt.	Actual Cost
6040	Psychotropic Med.	Actual Cost
6041	Psychotropic Med, Admin. Fee	5% of Actual Funds Expended Under PC 6040
6050	Administering Meds.	Actual Cost
1201	Client Transportation, Admin. Fee	5% of PC 1201
1202	Client Transportation	Actual Cost
1301	Emergency Assist., Admin. Fee	5% of PC 1302
1302	Emergency Assistance	Actual Cost
1501	Co-Payments & Admin. Fee	Actual Cost + 5% of Amount Collected

PREPARE YOUR INVOICE

Step 2 – Part B, Manual Entries



- ▶ In our sample, there were several items for which Block # 6, Unit Price, needed to be manually entered.

(PART B)

Summary Tab

4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED
1010	1.00	\$ 15.00	\$ 15.00	\$ 25.00	\$ -
2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -
2011	1.00	\$ 300.00	\$ 300.00	\$ -	\$ -
1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -
1202	1.00	\$ 45.00	\$ 45.00	\$ -	\$ -
1201	1.00	\$ 2.25	\$ 2.25	\$ -	\$ -
2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
1010	1.00	\$ 15.00	\$ 15.00	\$ -	\$ -
1501	1.00	\$ 1.25	\$ 1.25	\$ 25.00	\$ 25.00
		\$ -	\$ -	\$ -	\$ -
2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
2010	2.00	\$ 30.00	\$ 60.00	\$ -	\$ -
1501	1.00	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
		\$ -	\$ -	\$ -	\$ -
2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
2022	3.00	\$ 25.00	\$ 75.00	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -
		\$ -	\$ -	\$ -	\$ -

PREPARE YOUR INVOICE

Step 2 – Part A, Data Entry

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- ▶ Information is entered into Part A in three different ways:
 - ▶ Pre-Populated Information – The invoice will come with some information already entered for you.
 - ▶ Manual Entry Fields – Some information you will need to enter yourself.
 - ▶ Automated Fields – Some information will populate with the information entered into Part B of the invoice.

PREPARE YOUR INVOICE

Step 2 – Part A, Signature

- ▶ Ensure the invoice is signed by the appropriate person at your agency.
- ▶ Unsigned invoices will be returned unpaid.

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DATE: 10/3/2007 ATTACHMENT J.8
PAGE__1__OF__2__

**ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE**

BOC: 2526 (PART A)

1. Judicial District	US Probation Eastern District, CA	3. B.P.A.#	BPA Number
2. Vendor	Vendor's Name	4. Service Delivery:	Month, Year
a. Address:	Vendor's Address Vendor's Address	5. Total # Individuals Served:	# of Individuals Served
b. Telephone:	Vendor's Telephone Number		

Vendors Certification: I certify that all expenditures and requests for reimbursement in this voucher are accurate and correct to the best of my knowledge and include only charges for services actually rendered to clients under the terms of the agreement and for which no other compensation has been received from either the client or the United States District Court.

Authorized Signature
Authorized Administrator

6. PROJECT CODE	7. QUANTITY	8. UNIT PRICE	9. TOTAL PRICE
1010	5	15	75
1012			
1201	1	2.25	2.25
1202	1	45	45
1301			
1302			
1401			
1402			
1501	Included Below	N/A	NA
2010	10	30	300
2011	1	300	300
2020			
2022	9	25	225
2030			
4010			



REVIEW YOUR INVOICE

STEP 3

REVIEW YOUR INVOICE

Step 3 – Verify

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- ▶ Compare Section A & B totals to ensure they agree.
- ▶ Once your invoice is complete, go back and compare the invoice with:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
- ▶ Review each line on Part B to ensure there is a support document for every charge.
- ▶ Make any adjustment needed.
- ▶ **NOTE:** *This is the same process our office will use to verify your invoice is correct.*



SUBMIT YOUR INVOICE

STEP 4

SUBMIT YOUR INVOICE

Step 4 – Submission Process

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- ▶ Invoices are submitted in two ways:
 - ▶ Electronically – Through the U.S. Courts Electronic Reporting System (ERS)
 - ▶ Parts A & B only
 - ▶ **NOTE**: We ask you to submit parts A & B through ERS, so staff can begin processing invoices early in the month, prior to receiving the support documentation.
 - ▶ Delivery – Through the U.S. Postal Service, or some other delivery service, or hand delivery
 - ▶ Parts A & B, and
 - ▶ All documents which support the charges on Parts A & B
 - ▶ **NOTE**: We ask you to include a copy of Parts A & B with the support documentation to ensure they are married with the correct invoices.

SUBMIT YOUR INVOICE

Step 4 – Email Submissions (Other than ERS)

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- ▶ You may submit Parts A & B with the supporting documents via email, if your agency allows you to send medical records via email and your agency's email system is HIPPA compliant.
- ▶ **NOTE:**
 - ▶ Service providers are bound by HIPPA regulations when emailing medical records.
 - ▶ However, the U.S. Pretrial Services Office and the U.S. Probation Office, as Government entities, are exempt from HIPPA regulations, and may receive medical records via email.

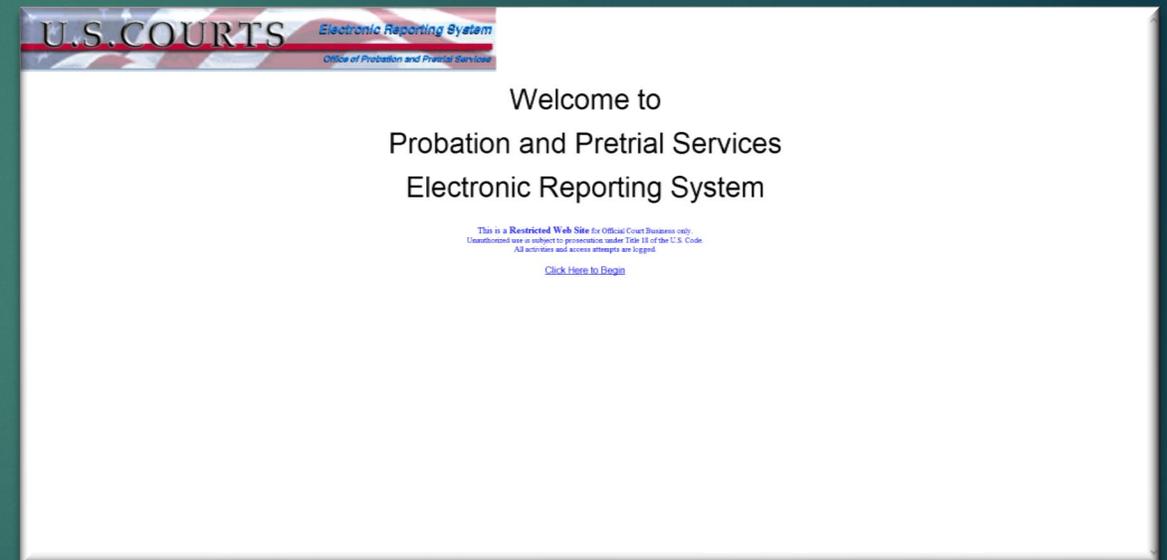
SUBMIT YOUR INVOICE

Step 4 – Electronic Reporting System (ERS)

50



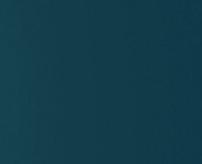
- ▶ To submit your invoice electronically, visit the U.S. Courts Electronic Reporting System (ERS)
- ▶ Website:
<http://ers.uscourts.gov/>



SUBMIT YOUR INVOICE

Step 4 – Electronic Reporting System (ERS)

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- ▶ Welcome Page:
 - ▶ Click the “Begin Here” button
- ▶ Address Page – Enter the following information:
 - ▶ The BPA Number
 - ▶ The email of the person you want your invoice to go to:
 - ▶ U.S. Probation Office – Dena Larkin dena_larkin@caep.uscourts.gov
 - ▶ U.S. Pretrial Services Office – Amanda Underwood amanda_underwood@caept.uscourts.gov
 - ▶ Select the Agency
 - ▶ Click “Next”

SUBMIT YOUR INVOICE

Step 4 – Electronic Reporting System (ERS)

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- ▶ Upload Page:
 - ▶ Click “Choose File” to upload your invoice
 - ▶ Check the box to certify your invoice is correct
 - ▶ Add any comments you wish
 - ▶ Click “Submit”
- ▶ **IMPORTANT:** You may submit through ERS only the following:
 - ▶ Parts A & B of your invoice – No supporting documents
 - ▶ Microsoft Excel documents – No Word or PDF documents

SUBMIT YOUR INVOICE

Step 4 – Sending the Support Documentation

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- ▶ When sending the support documentation:
 - ▶ You may transmit the support documentation via:
 - ▶ The U.S. Postal Service, or some other delivery service
 - ▶ Hand delivery, or
 - ▶ Email (if your agency allows and is HIPPA compliant)
 - ▶ Include the following support documents:
 - ▶ Monthly Treatment Reports (MTRs)
 - ▶ Logs and Sign-In Sheets – Daily Treatment Logs (DTLs) & Sign-In Sheets (Breathalyzer, Sweat Patch & Urinalysis)
 - ▶ Reports – Intake, Physical, Psychological, Polygraph, etc.
 - ▶ Receipts – Copayments, Emergency Funds, Medication, Transportation, etc.
 - ▶ Treatment Plans (Due every 90 days)
 - ▶ **NOTE**: You do not need to include the PROB 45, Program Plans.



COMMON ERRORS

COMMON ERRORS

55



- ▶ Billing U.S. Pretrial Services on U.S. Probation Office invoice, and visa versa
- ▶ Charging incorrect unit prices (See Section B of proposal)
- ▶ Charging for “No Shows”
- ▶ Charging for stalls or insufficient quantities on UAs
- ▶ Charging for both application and removal of sweat patches
- ▶ No original signatures on Part A of the invoice
- ▶ Not charging correct unit amounts: (e.g. 1 unit = ½ hour, 2 units = 1 hour, for most services)
- ▶ Not providing all support documentation with invoice



QUESTIONS?

QUESTIONS?

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▶ If you have questions about your BPA or contract, billing, or how to prepare your invoice, contact:

▶ **U.S. Probation Office:**

Michael S. Smith, Contracts Specialist
(916) 930-4306

michael_smith@caep.uscourts.gov

▶ **U.S. Pretrial Services Office:**

Amanda Underwood, Procurement Administrator
(916) 930-4363

amanda_underwood@caept.uscourts.gov

Thank
You

