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# VENDOR INVOICES

HOW TO PREPARE AND SUBMIT YOUR MONTHLY INVOICES

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

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# INTRODUCTION



# INTRODUCTION

## *Welcome & Purpose*

- ▶ 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

## Parts of the Invoice

Invoices are divided into three parts:

1. Part A – Summarization of all the services and total amount billed
2. Part B – Itemized listing of all services provided during the month, by defendant/offender
3. Support Documentation:

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)

## Part A – Summary

Revised 06/25/2006 Page \_\_\_ of \_\_\_

DATE: 10/3/2007 ATTACHMENT J-B  
PAGE \_\_\_ OF \_\_\_

ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS  
TREATMENT SERVICES INVOICE

BOC: 2526

(PART A)

1. Judicial District: \_\_\_\_\_ 3. B.P.A.#: \_\_\_\_\_

2. Vendor: \_\_\_\_\_ 4. Service Delivery: \_\_\_\_\_

a. Address: \_\_\_\_\_ 5. Total # Individuals Served: \_\_\_\_\_

b. Telephone: \_\_\_\_\_

Vendor 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 any 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.

6. PROJECT CODE	7. QUANTITY	8. UNIT PRICE	9. TOTAL PRICE
0010			
0012			
1001			
1200			
1301			
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# INTRODUCTION

## *Invoice Template*

- ▶ 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 10<sup>th</sup> of each month, following the month in which services were performed.
- ▶ For Example:
  - ▶ January's invoices are to be received by the 10<sup>th</sup> of February
  - ▶ July's invoices are to be received by the 10<sup>th</sup> of August

# INTRODUCTION

## Program Plans



## PROB 45 – Program Plan

- ▶ 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.

Attachment 1.2

Prob. Form 45 Today's Date:

**Client Identifying Information**

Client:	PACIS#:	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*

- ▶ 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

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PROBATION OFFICE

**ROBERT A. RAMIREZ**  
Chief U.S. Probation Officer

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

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

**REPLY TO:**

(Headquarters)  
501 "T" 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*

- ▶ 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*

- ▶ 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*

- ▶ 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*

- ▶ 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 10<sup>th</sup> 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

- ▶ For your convenience, attached is a Quick Reference guide you may download.
- ▶ Click on the attachments tool within Adobe to open the document.



### 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 10<sup>th</sup> of each following month
- Preferred Method:
  - U.S. Courts Service Provider Communications System (SPCS)
- Other Methods:
  - U.S. Courts Electronic Reporting System (ERS)
  - U.S. Postal Service or another Common Carrier
  - Email



# 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

- ▶ 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									
PROGRAM NAME: Substance Abuse		PROVIDER NAME: Vendor's Name		DATE OF CURRENT IN PLAN (ATTACH REVISIONS): 10/1/2018					
CLIENT NAME: Last Name 1, First Name, MI		FACTS NO. 012345		PERIOD COVERING: January, 2019					
PHASE NO. 1 Phase III		TIME TO PHASE: 4 months		PRETRIAL CLIENT: <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No		CLIENT EMPLOYED: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other			
CONTACTS SINCE LAST REPORT									
a. Date	b. Service (Name & No.)	c. Length of Contact		d. Comments (No Shows, Tardiness, Absence Addressed)					e. Cost (insert amount)
1/13/19	2010 - Indiv. Counseling	1 hr.							N/A
URINE TESTING RECORD									
DATE COLLECTED	Schedule	Sample Not Tested	Drug Use Admitted	COLLECTOR	SPECIAL TESTS	TEST RESULTS	Cost (insert amount)		
1/10/19	X		X		Collector's Name	Spec. Gravity	1.014 (Neg.)	\$25.00	
COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS									
a. Describe the treatment goals addressed this month ( <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met): <b>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>									
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: <b>Co-payment - Amount, Outstanding \$45.00.</b>									
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.**



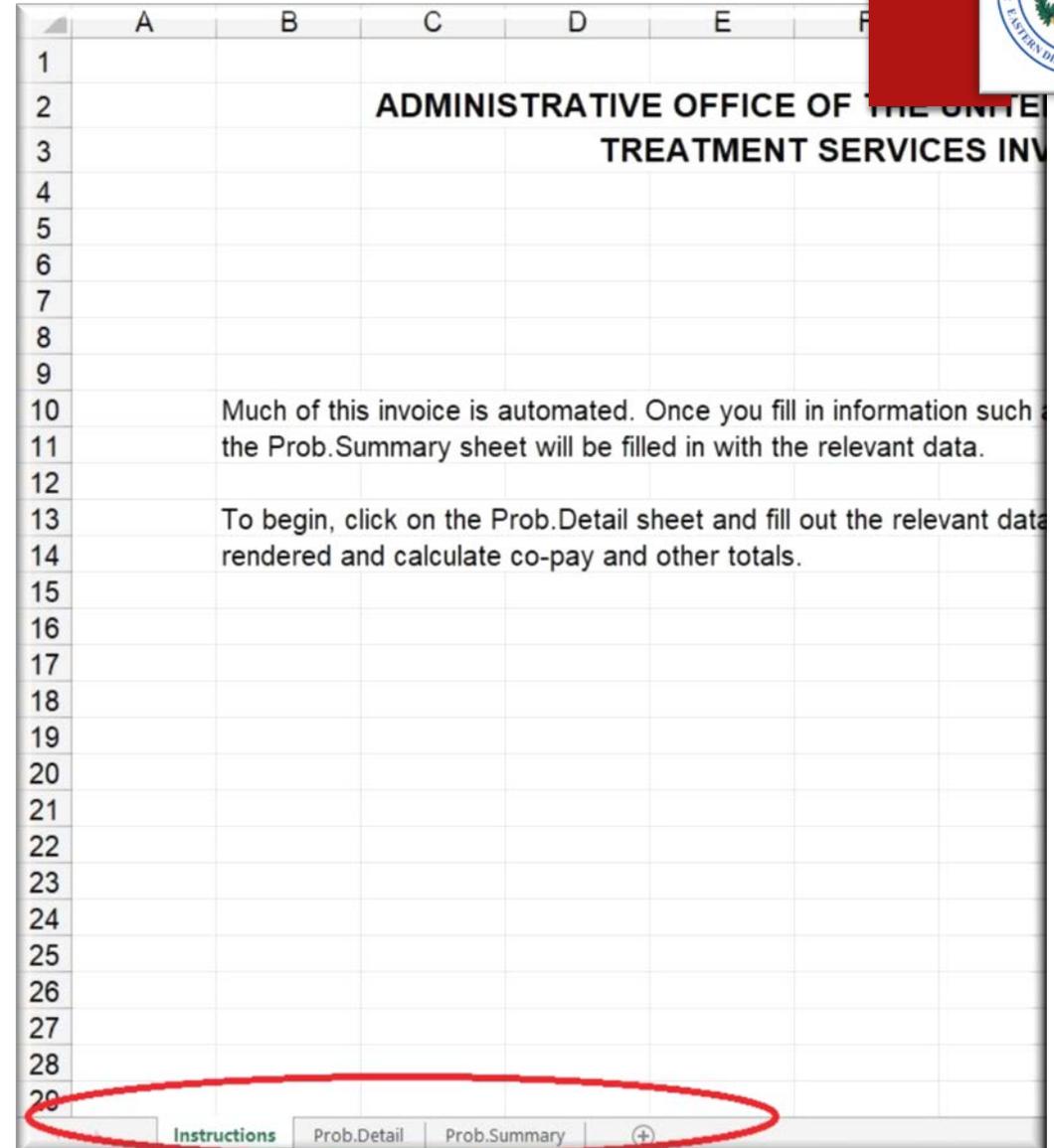
# PREPARE YOUR INVOICE

STEP 2

# PREPARE YOUR INVOICE

## Step 2 – Spreadsheet Navigation

- ▶ 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:
  - ▶ 1<sup>st</sup> Tab – Instructions
  - ▶ 2<sup>nd</sup> Tab – Part B, Invoice Detail
  - ▶ 3<sup>rd</sup> Tab – Part A, Invoice Summary





# PREPARE YOUR INVOICE

## Step 2 – Part B, Invoice *Navigation*

- ▶ 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-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: <b>Substance Abuse</b>		1a. PROVIDER NAME: <b>Vendor's Name</b>		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): <b>10/1/2018</b>	
3. CLIENT NAME: <b>Last Name 1, First Name, MI</b>		3a. FACTS NO. <b>012345</b>		4. FOR PERIOD COVERING: <b>January, 2019</b>	
5. PHASE NO. <b>Phase III</b>	5a. TIME IN PHASE: <b>4 months</b>	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. Copy (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)	Copy (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	\$ 0.50	\$ 0.50	\$ 10.00	\$ 10.00
		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 – 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: <b>Substance Abuse</b>		1a. PROVIDER NAME: <b>Vendor's Name</b>	2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): <b>10/1/2018</b>	
3. CLIENT NAME: <b>Last Name 1, First Name, MI</b>		3a. PACTS No. <b>012345</b>	4. FOR PERIOD COVERING: <b>January, 2019</b>	
5. PHASE NO. <b>Phase III</b>	5a. TIME IN PHASE: <b>4 months</b>	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. Copy (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)	Copy (amount collected)
	Yes	No	Uninf. 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-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: <b>Substance Abuse</b>		1a. PROVIDER NAME: <b>Vendor's Name</b>	2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): <b>10/1/2018</b>
3. CLIENT NAME: <b>Last Name 1, First Name, MI</b>		3a. FACTS NO. <b>012345</b>	4. FOR PERIOD COVERING: <b>January, 2019</b>
5. PHASE NO. <b>Phase III</b>	5a. TIME IN PHASE: <b>4 months</b>	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. Copy (amount collected)
1/11/19	2019 - 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)	Copy (amount collected)
	Yes	No	Uninf. 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

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. FACTS 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. Copy (amount collected)
1/11/19	2010 - Adv. 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)	Copy (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	\$ -	\$ -
		1/5/2019	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 – Length of Contact and/or Number of UAs

Part B – Quantity (Units)

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. FACTS 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, Fairness, Issues Addressed)	e. Copy (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)	Units (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	1/2/2019	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

- ▶ 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

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: <b>Substance Abuse</b>		1a. PROVIDER NAME: <b>Vendor's Name</b>		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): <b>10/1/2018</b>	
3. CLIENT NAME: <b>Last Name 1, First Name, MI</b>		3a. FACTS NO. <b>012345</b>		4. FOR PERIOD COVERING: <b>January, 2019</b>	
5. PHASE NO. <b>Phase III</b>	5a. TIME IN PHASE: <b>4 months</b>	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	Insf. Qty.	Stall	No	Yes (specify drug)				
1/10/19	X				X		Collector's Name	Spec. Gravity	1.014 (Neg.)	50

**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	2014	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	1410	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	\$ -	\$ -
		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, Manual Entries

- ▶ 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*

- ▶ 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.
- ▶ Electronic signatures are acceptable.
- ▶ Unsigned invoices will be returned unpaid.

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

---

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

- ▶ 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

- ▶ Invoices may be submitted several different ways:
  - ▶ Preferred Method:
    - ▶ Service Provider Communications System (SPCS) – Parts A & B of the invoice, and all supporting documents may be submitted through SPCS
  - ▶ Other Methods:
    - ▶ Electronic Reporting System (ERS) – Parts A & B only. Supporting documents must be mailed or hand-carried
    - ▶ Email
    - ▶ U.S. Postal Service or other common carrier
    - ▶ Hand Carried

# SUBMIT YOUR INVOICE – OPTION 1 (Preferred Method) *Step 4 – Service Provider Communication System (SPCS)*

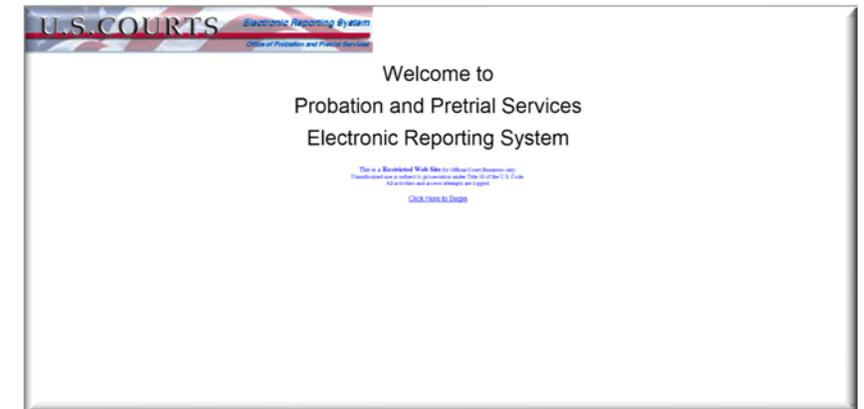
- ▶ To submit your invoice electronically, visit the U.S. Courts Service Provider Communications System
- ▶ Website:  
[https://serviceproviders.uscourts.gov/svc\\_providerweb/logon.aspx](https://serviceproviders.uscourts.gov/svc_providerweb/logon.aspx)
- ▶ Instructions may be found in the “How to Use SPCS” presentation.
- ▶ **IMPORTANT:** You must be registered in order to use this service. To receive an invitation, contact our office.

The screenshot shows the login page for the Electronic Reporting System (ERS) for Treatment Providers. The page has a blue header with the "UNITED STATES COURTS" logo on the left and the "ERS ELECTRONIC REPORTING SYSTEM TREATMENT PROVIDERS" logo on the right. The main content area is white with a yellow box containing the login form. The form is titled "Service Provider Communication" and is divided into two sections: "Probation and Pretrial Services Electronic Reporting System" and "ACCOUNT LOGIN". The "ACCOUNT LOGIN" section includes fields for "User ID:" and "Password:", both with "Forgot your User ID?" and "Forgot your Password?" links. A "Login" button is located below the password field. Below the login form, there is a note: "This site is best viewed at resolutions of 1280x800 or higher." The footer of the page is blue and contains a "Contact Us" link, the text "Administrative Office of the United States Courts", and a small circular logo on the right.

# SUBMIT YOUR INVOICE – OPTION 2

## Step 4 – Electronic Reporting System (ERS)

- ▶ To submit your invoice electronically, visit the U.S. Courts Electronic Reporting System (ERS)
- ▶ Website: <http://ers.uscourts.gov/>
- ▶ Follow the online instructions
- ▶ Remember to send all supporting documents through email or mail





# SUBMIT YOUR INVOICE – OPTION 2

## Step 4 – Electronic Reporting System (ERS)

- ▶ 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](mailto:dena_larkin@caep.uscourts.gov)
    - ▶ U.S. Pretrial Services Office – Amanda Underwood [amanda\\_underwood@caept.uscourts.gov](mailto:amanda_underwood@caept.uscourts.gov)
  - ▶ Select the Agency
  - ▶ Click “Next”



# SUBMIT YOUR INVOICE – OPTION 2

## Step 4 – Electronic Reporting System (ERS)

- ▶ 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 – OTHER OPTIONS

## Step 4 – Sending the Support Documentation

- ▶ Other options for submitting your invoice include:
  - ▶ The U.S. Postal Service, or common carrier
  - ▶ Hand delivery, or
  - ▶ Email



# SUBMIT YOUR INVOICE

## Step 4 – Support Documentation

- ▶ When sending the support documentation Include the following 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

- ▶ 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 & CONTACTS



# QUESTIONS & CONTACTS

- ▶ 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](mailto:michael_smith@caep.uscourts.gov)
  - ▶ U.S. Probation Office:
    - ▶ Dena Larkin, Procurement Administrator
    - ▶ (916) 930-4339
    - ▶ [dena\\_larkin@caep.uscourts.gov](mailto:dena_larkin@caep.uscourts.gov)
  - ▶ U.S. Pretrial Services Office:
    - ▶ Amanda Underwood, Procurement Administrator
    - ▶ (916) 930-4363
    - ▶ [amanda\\_underwood@caept.uscourts.gov](mailto:amanda_underwood@caept.uscourts.gov)

Thank  
You

