

PURCHASE OF SERVICE CLIENT INVOICE FORM

Instructions for Completion

A preprinted invoice will be mailed to the Contractor five (5) working days prior to the end of each month. After receiving the preprinted invoice, the Contractor fills in the appropriate information. The original preprint must be returned to the DHS Accounting Services Section, 500 Summer Street N.E., E-75, Salem, Oregon 97301 by the 10th of each month following services. The invoice must be returned prior to the end of the invoice service month. The Contractor must send a copy of the invoice TO the DHS branch having responsibility for the child, and should make a copy for their records. If you have not received a preprinted invoice, contact a local DHS Service Delivery Area having responsibility for the child. If a child does not appear on the existing invoice, call the branch for the proper case name, case number and person letter information and write it on the preprint prior to sending it to DHS.

The following definitions cover the column headings on the Supplemental Client Invoice Purchase of Service form (CF 284) to be filled in by the Contractor (see attached sample of form):

1. Service Date (Begin and End Dates):

The number of days for which payment will be made includes the first day of direct care in a facility of the Contractor (whether regarded as a trial placement or a continuing placement). But does not include the day the child leaves that form of care. If the child leaves care during the month, the date **prior** to the leaving shall be entered in the "END" column and a note shall be made on the reverse side of the invoice using the appropriate "**Line Number**" and a name to indicated the date the child left care. All absences from the Contractor's facility must be recorded on the reverse side of the form using the appropriate line number and name.

When more than one contracted service is being provided for a client, use the second set of service dates on the appropriate line number to identify the services.

2. Contracted Services ("Cont Serv")- Type of Service Code:

The contract document entitled SCHEDULE, in the section entitled "Consideration", instructs the Contractor on what code to use.

3. Bill Unit:

Individual time components for which DHS is being billed, such as Hourly (HR), or Daily (DA)

4. Number of Units:

Total number of units (daily or hourly) for which payment is to be made.

5. Absent Days:

Reflects the total number of days the child was absent from the Contractor's physical custody during the month- computed by counting the day the child leaves care, but not the day of return. This column **must** be filled out for every child. For those who were not absent, enter "0"

6. Remarks:

Explanatory information- to be made on reverse side of client invoice. Identify item by Line Number and Name.

7. Contractor Signature and Date

Contractor's "original" signature and date of signature. If you have questions, please call the DHS Accounting Services Section, Contract Payment Person at the following:

Contracts A - H 945-5708
 I - N 945-6858
 O - P 945-5709

EXPLANATION OF INVOICE EXAMPLES

The following example are explanations of the entries on the sample shown on the back of the Supplemental Client Invoice Purchase of Service form (CF284)

- Line 01 Full month placement for Rose Petal in one residential care placement (RS 1).
- Line 02 Lucy Jones terminated from professional group home placement (PG 1) after 16 days.
- Line 03 Following 11 days of residential care (RS 1), John Brown was placed in transition services (TS 2) for the remaining 20 days of the month.
- Line 04 Suzy Reiner was placed in shelter care (AS 1) for 2 days before running. The DHS caseworker sent SYSM- authorization message to the DHS Accounting Services Section, Contract Payment person, approving absence of 14 days from the private facility. When apprehended, Suzy was again placed in shelter (AS 1) for the remaining 12 days of the month.
- Line 05 Star Bright's residential placement (RS 1) was interrupted by a hospitalization or home visit. Hospitalization, home visit, etc.- SYSM authorization message sent by local Service Delivery Area caseworker to the DHS Accounting Services Section, Contract Payment person, Central Office.

The following entries are to be made on the reverse side of the client invoice using the following format:

- | | | |
|---------|--------------|---|
| Line 02 | JONES, Lucy | Left care 1-17-82 |
| Line 03 | BROWN, John | Left residential care 1-13-82; entered transition 1-13-82 |
| Line 04 | REINER, Suzy | Ran following 2-day placement, additional 14 days claimed as per SYSM authorization |
| Line 05 | BRIGHT, Star | Placed in hospital 1-7-82 to 1-13-82 |

*SYSM to be sent when a child is absent more than four (4) days.

Note: If the authorized DHS representative has agreed with the Contractor that credit may be granted for empty bed space being reserved by the Contractor for a child prior to placement, a special form CF918, must be completed by the Contractor. This form may be ordered by calling your local DHS/Service Delivery Area. The form must be returned to the DHS Accounting Services Section, 500 Summer Street N.E., E-75, Salem, Oregon 97301

SUPPLEMENTAL CLIENT INVOICE- PURCHASE OF SERVICE

Invoice Number: _____
Month: _____ Year: _____
Provider Number: _____

See Back For Example

Provider Name: _____

| Line # | Client Name | Case # | P/L | Br* | Service Dates | | Cont Serv | Bill Unit | # of Units | Service Dates | | Cont Serv | Bill Unit | # of Units | Absent Days |
|-----------|-------------|--------|-------|-------|---------------|-----|--------------|--------------|---------------|---------------|-----|--------------|--------------|---------------|----------------|
| | | | | | Begin | End | | | | Begin | End | | | | |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | / / | / / | _____ | _____ | _____ | _____ |

*Br= DHS Branch responsible for placing child in custody

I certify that the service described on this invoice was rendered to the persons named herein according to Oregon Law and the Rules and regulations of the Department of Human Services. That payment, therefore, has not been received except as noted.

Signature-Agency Director or Provider

Date

Number of Days Program in Operation (Day Treatment Only): _____

EXAMPLE

This example illustrates the completion instructions which are attached.

Instructions for CF284 Supplemental Client Invoice- Purchase of Service

| Line # | Client Name | Case # | p/l | Br* | ① | ② | ③ | ④ | ⑤ | | | Cont Serv | Bill Unit | # of Units | Absent Days |
|--------|--------------|---------|-----|--------|------------------------------|-----------|-----------|------------|------------------------------|-----------|-----------|-----------|-----------|------------|-------------|
| | | | | | Service Dates Begin - End | Cont Serv | Bill Unit | # of Units | Service Dates Begin - End | Cont Serv | Bill Unit | | | | |
| 1 | Petal, Rose | UVW6789 | N | Mult. | 01/01/94-01/31/94 | RS1 | da | 31 | / / / / | | | | | | 0 |
| 2 | Jones, Lucy | TOE0234 | X | Clack. | 01/01/89-01/16/89 | PG1 | da | 15 | / / / / | | | | | | 0 |
| 3 | Brown, John | QPX5431 | Y | Mult. | 01/01/89-01/12/89 | RS1 | da | 11 | 01/13/89-01/31/89 | TS2 | da | 20 | | | 0 |
| 4 | Reiner, Suzy | XPY1434 | Z | Clat. | 01/01/89-01/16/89 | AS1 | da | 15 | 01/20/89-01/31/89 | TS2 | da | 12 | | | 14 |
| 5 | Bright, Star | EYT9865 | T | Clack. | 01/01/89-01/31/89 | RS1 | da | 31 | / / / / | | | | | | 7 |

⑥ Write any explanation on back of form:

Examples for sample above (lines 4 & 5)

#4 -Detention 1/14/89 through 1/27/89

#5- Runaway 1/1/89 through 1/7/89

⑦

Signature-Agency Director or Provider

Date