**Sanilac County Community Mental Health Authority Invoice for Comprehensive Community Support Services (CCSS)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Period** |  | **Location:** |  |  | **Provider:** |  |
| **From** |  |  | **Address:** |  |  | **Address:** |  |
| **To** |  |  | **City/State:** |  |  | **City/State:** |  |
|  |  |  |  |  |
| **Complete One:** | **Provider Federal ID#** |  | **Provider Social Security#** |
|  |  |  |  |
| **Consumer Information** | **Week 1** | **Week 2** | **Week 3** | **Week 4** | **Total Billing** |
| CaseNo. | First & Last Initial | MI orDD | MA Yes orNo | Start Date | End Date | Total Units | Start Date | End Date | TotalUnits | Start Date | End Date | TotalUnits | Start Date | End Date | TotalUnits | AllUnits | @ Ratefor CCSS | Amount Billed |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Total Units** |  |  |  |  |  |  |  |  | **Total Billed** |  |
| ***Agency Use Only* CMH Adjustments** |  |  |  |  |  |  |  |  |  |  |
| ***Comments/Explanations: - Comments***  |
| **CERTIFICATION AND SIGNATURE** |
| *I hereby certify the above represents the true number of consumers and units of service provided for the period stated.*  | *The information contained on this form is true to the best of my knowledge* |
| **Provider Signature Date** | **Care Manager Signature Date** |