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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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** | | |
| Case  No. | | First & Last Initial | MI or  DD | MA Yes or  No | | Start Date | | End Date | Total Units | | Start Date | End Date | Total  Units | Start Date | End Date | Total  Units | | | Start Date | End Date | | Total  Units | All  Units | @ Rate  for 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** | | | | | | | | | | | |