NLCMH-Rev.5/2014

NORTHERN LAKES COMMUNITY MENTAL HEALTH

SPECIALIZED RESIDENTIAL SERVICES

MONTHLY RESIDENTIAL OCCUPANCY REPORT AND INVOICE

AUTHORITY: Information provided on this form is protected health information under Federal & State privacy / confidentiality laws.

CONTRACT TYPE

__ DD

__ MI

SECTION I PROVIDER INFORMATION

TO: NORTHERN LAKES CMH AUTHORITY

FROM: Facility Name

TO: Street Name City State Zip

Provider / Corporation Name

SECTION II MONTHLY DIRECT STAFFING HOURS

Specific Specialized Res. Staff Hours	
Non-Specialized Res. Staff or AFC or CFC Hours	
Total Monthly Staff Hrs	

SECTION III PROVIDER TAX IDENTIFICATION NUMBER

TAX ID. # ____ Federal I.D. ____ or Social Security # ____

DATE OF SERVICE: MONTH _____ YR _____

SECTION IV SPECIFIC CONSUMER BILLING INFORMATION

NLCMH CASE NUMBER	CONSUMER NAME LAST, FIRST NAME	MEDICAID IDENTIFICATION Number	Occupancy Information: DAYS IN RES.	DAYS ABSENT	TOTAL DAYS	NLCMH DAILY RATE ($)	Total Mthly Residential Cost ($)
	TOTALS						

SECTION V SERVICE CODE & DAILY ATTENDANCE INFORMATION

NOTE: Place an "X" each day consumer is present; "O" when is absent; an "H" when hospitalized or Blank before Admitted or after Discharge.

NLCMH Case #	SERVICE CODES PC Code / CLS Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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SECTION VI ATTESTATION AND SIGNATURE

By signing this document, under penalty of law, the Provider duly authorized agent represents and warrants that all information provided in or under this form, and associated request for reimbursement cover only preauthorized care, services, supports and staffing, complies with federal and State laws, and constitutes a "Clean Claim" as defined by MCL 440.111i.

(NL Office Use Only)

NLCMH PROVIDER CODE

RESIDENTIAL CONTRACTOR	Date

NLCMH Manager / Supervisor Signature (Required) Signature Date