ORIGINAL

COUNTY OF SHASTA
OFFICE OF AUDITOR-CONTROLLER
REPORT OF CLAIMS REQUIRING BOARD ACTION IN ORDER TO
AUTHORIZE PAYMENT BY AUDITOR-CONTROLLER
11/7/2017

FUND/DEPT/ACCT	DEPARTMENT	PAYEE	DESCRIPTION	Amount	REASON	DEPARTMENT'S EXPLANATION
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 30.93	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 29.21	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 30.18	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 29.00	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 26.55	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 15.10	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 20.38	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 27.95	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
50100-034310	SOCIAL SERVICES	PROFESSIONAL MEDICAL COPY	MEDICAL COPIES	$ 26.23	Per Admin Policy 2-201 and Gov Code sections 910 and 911.2 invoices older than one year require Board approval.	SEE ATTACHED MEMO FROM DEPARTMENT
	TOTAL			**$ 235.53**		

Auditor's Certification:
I certify that the foregoing is a true list of claims properly and regularly coming before the Shasta County Board of Supervisors, and that the computations are correct.

Date: 10/25/17 Signature:

Approval of Claims:
These claims were allowed and the Claims List was approved as correct, by vote of the Board of Supervisors on this date.

Date:

Chairman

Health and Human Services Agency

Donnell Ewert, MPH, Director

Business and Support Services

Tracy Tedder, Branch Director

1810 Market Street
Redding, CA 96001-1930
P.O. Box 496005
Redding, CA 96049-6005
Phone: (530) 229-8419
Fax: (530) 225-5555
CA Relay Service: (800) 735-2922

Inter-Office Memorandum

To: Brian Muir, Auditor-Controller

From: Tracy Tedder, HHSA Branch Director

Date: October 9, 2017

Re: Board Claim for Professional Medical Copy

Professional Medical Copy (PMC) provides medical record copy services for Shasta County. A Health and Human Services Agency staff person requested copies of medical records for a client. The employee responsible for approving and routing the invoices for services rendered departed unexpectedly. The invoices were pending on the employee's desk and not followed up on in a timely manner to confirm that the services were received. The services have been confirmed and the department is requesting payment. A new process has been developed that incorporates these invoices being tracked by an analyst to ensure timely processing. The invoices listed below are now over one year old and must be approved by the Board of Supervisors for payment, per Admin Policy 2-101 Government Code 910 and 911.2.

PMC049379-01-01	07/31/2015	$30.93
PMC413714-01-01	11/05/2015	$30.18
PMC413585-01-01	11/09/2015	$29.21
PMC414929-01-01	12/10/2015	$29.00
PMC416871-01-01	01/26/2016	$26.55
PMC424151-01-03	06/21/2016	$20.38
PMC424532-01-01	06/30/2016	$15.10
PMC424581-01-03	06/30/2016	$27.95
PMC424441-01-01	07/05/2016	$26.23
	TOTAL:	$235.53

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	July 31, 2015	PMC409379-01-01

Bill To:
Marci Oller, Senior Social Worker, Children Services
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Marci Oller, Senior Social Worker, Childre
Shasta County Children & Family Service
1313 Yuba Street
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-
File No:

Facility Name: **Rolling Hills Clinic- Red Bluff**
Doctor Name: **Dr. Benton**
Recipient Name: **Shasta County Children & Family Services**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By U.S. Postal Service			2.55
Handling			4.00
Records (PHI)	29.00	.10	2.90
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Rolling Hills Clinic- Red Bluff to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Rolling Hills Clinic- Red Bluff.		SUB-TOTAL	28.95
		SALES TAX 7.5	1.98
		PREPAYMENT	
		TOTAL DUE	$ 30.93

- NOTAX

PAST DUE

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	July 31, 2015	PMC409379-01-01

OH652620
ENTERED
OCT 16 2017

TOTAL DUE: $ 30.93

Remit To:

Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC409379-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval_____

CASE NAME (first initial, last name): See Attached **SW:** Mitchell

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC409379-01-01

Reviewed by (**Supervisor**): M. Mitchell SPSW Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 30.93

Signature/Payee

Professional Medical Copy: VENDO04887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION:** I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By (**PM**): _____ **Date:** 8/8/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/7/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	November 09, 2015	PMC413585-01-01

Bill To:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:	Facility Name: **Lassen Medical Group**
DOB:	Doctor Name: **- Custodian of Records**
SSN: **XXX-XX-**	Recipient Name: **Shasta County Children & Family Services**
File No:	

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By U.S. Postal Service			2.55
Handling			4.00
Records (PHI)	**13.00**	**.10**	1.30
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Lassen Medical Group to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Lassen Medical Group.		**SUB-TOTAL**	27.35
		SALES TAX 7.5	1.86
		PREPAYMENT	
		TOTAL DUE	**$ 29.21**

- No Tax

PAST DUE

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

OH 652623
ENTERED
OCT 16 2017

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	November 09, 2015	PMC413585-01-01

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: **$ 29.21**

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC413585-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Barber

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC413585-01-01

Reviewed by **(Supervisor):** N. Thielet SPMV Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 29.21

Signature/Payee

Professional Medical Copy: VEND004887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM)**: _____ **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/8/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	November 05, 2015	PMC413714-01-01

Bill To:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:	Facility Name: **Lassen Medical Group**
DOB:	Doctor Name: **- Custodian of Records**
SSN: **XXX-XX-**	Recipient Name: **Shasta County Children & Family Services**
File No:	

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By U.S. Postal Service			2.55
Handling			4.00
Records (PHI)	22.00	.10	2.20
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Lassen Medical Group to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Lassen Medical Group.		**SUB-TOTAL**	28.25
		SALES TAX 7.6	1.93 ✓
		PREPAYMENT	
		TOTAL DUE	**$ 30.18**

- NO TAX

PAST DUE

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	November 05, 2015	PMC413714-01-01

OH652622
ENTERED
OCT 16 2017

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: **$ 30.18**

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC413714-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Kissinger

INSTRUCTIONS

Note: **This is not a referral form**. SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC413714-01-01

Reviewed by (**Supervisor**): N. Ghilarducci SPM Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 30.18

Signature/Payee

Professional Medical Copy: VEND004887
PRINT NAME

_____
Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099
Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By (**PM**): _____ **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/8/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	December 10, 2015	PMC414929-01-01

Bill To:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-
File No:

Facility Name: **Lassen Medical Group**
Doctor Name: **- Custodian of Records**
Recipient Name: **Shasta County Children & Family Services**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By U.S. Postal Service			2.55
Handling			4.00
Records (PHI)	11.00	.10	1.10
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Lassen Medical Group to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Lassen Medical Group.		**SUB-TOTAL**	27.15
		SALES TAX 7.6	1.85 ✓
		PREPAYMENT	
		TOTAL DUE	**$ 29.00**

No Tax

PAST DUE

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	December 10, 2015	PMC414929-01-01

OH 652 626
ENTERED
OCT 16 2017

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: **$ 29.00**

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC414929-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Kissinger

INSTRUCTIONS

Note: **This is not a referral form**. SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC414929-01-01

Reviewed by **(Supervisor)**: [signature] Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 29.00

Signature/Payee

Professional Medical Copy: VEND004887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM)**: [signature] **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: [signature] **Date:** 8/8/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V 4887

professional MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	January 26, 2016	PMC416871-01-01

Bill To:
Jamie Jacobs, PHN
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Jamie Jacobs, PHN
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-
File No:

Facility Name: **Lassen Medical Group**
Doctor Name: **- Custodian of Records**
Recipient Name: **Shasta County Children & Family Services**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By Facsimile			4.00
Records (PHI)	12.00	.10	1.20
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
		SUB-TOTAL	24.70
		SALES TAX 7.5	1.85 ✓
		PREPAYMENT	
		TOTAL DUE	$ 26.55

PAST DUE

This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Lassen Medical Group to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Lassen Medical Group.

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	January 26, 2016	PMC416871-01-01

DH652627
ENTERED
OCT 16 2017

Remit To:

Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: $ 26.55

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC416871-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Thomas

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information): Medical Copies for youth in CWS case. Invoice # PMC416871-01-01

Reviewed by **(Supervisor):** H. Thurlet SHW Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 26.55

Signature/Payee

Professional Medical Copy: VEND004887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM):** L a. Stu **Date:** 8/7/17

Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/8/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 22, 2016	PMC424532-01-01

Bill To:
Accounts Payable
Shasta County Health and Human Services Agency
PO Box 496005
Redding, CA 96049

Ordered By:
Accounts Payable
Shasta County Health and Human Service
PO Box 496005
Redding, CA 96049

Patient:		Facility Name:	North State Orthopedics
DOB:		Doctor Name:	
SSN:	XXX-XX-	Recipient Name:	Malia Xiong, MSC
File No:			

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Sheet Charge (1-20) 50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**		PAST DUE	14.05
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom North State Orthopedics to Malia Xiong, MSC by you or your representative. It is not for treatment or office visits to North State Orthopedics.		SUB-TOTAL	14.05
		SALES TAX 7.5	1.05 ✓
		PREPAYMENT	
		TOTAL DUE	$ 15.10

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

OH652630
ENTERED
OCT 16 2017

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 22, 2016	PMC424532-01-01

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: $ 15.10

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC424532-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Mitchell

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC424532-01-01

Reviewed by **(Supervisor):** M. Shiver SPSA Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 15.10

Signature/Payee

Professional Medical Copy: VEND004887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM):** _____ **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/7/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 21, 2016	PMC424151-01-03

Bill To:
Accounts Payable
Shasta County Health and Human Services Agency
PO Box 496005
Redding, CA 96049

Ordered By:
Leann Scott
(Use Account CCOSHAHS) Shasta County
2640 Breslauer Way
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-0099
File No:

Facility Name: **Anderson Medical Associates**
Doctor Name:
Recipient Name: **Shasta County Mental Health**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
*Service Fee/Clerical Fee			15.00
*Records (PHI)	20.00	.25	5.00
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
		SUB-TOTAL	20.00
		SALES TAX 7.5	.38 ✓
		PREPAYMENT	
		TOTAL DUE	$ 20.38

- NOT M

PAST DUE :

This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Anderson Medical Associates to Shasta County Mental Health by you or your representative. It is not for treatment or office visits to Anderson Medical Associates.

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

OH 652628
ENTERED
OCT 16 2017

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 21, 2016	PMC424151-01-03

Remit To:

Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: $ 20.38

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC424151-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Mitchell

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC424151-01-03

Reviewed by **(Supervisor)**: N. Mitchell SPVS Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 20.38

Signature/Payee

Professional Medical Copy: VENDO04887

PRINT NAME

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM)**: J. Hall **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/7/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

U4887

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 30, 2016	PMC424581-01-03

professional MEDICAL COPY

Bill To:
Starla Kissinger, MSC
Shasta County Health and Human Services Agency
PO Box 496005
Redding, CA 96049

Ordered By:
Starla Kissinger MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-
File No:

Facility Name: **North State Orthopedics**
Doctor Name:
Recipient Name: **Shasta County Children & Family Services**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By Facsimile			4.00
Records (PHI)	25.00	.10	2.50
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES RES. 2004-118		PAST DUE	
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom North State Orthopedics to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to North State Orthopedics.		SUB-TOTAL	26.00
		SALES TAX 7.5	1.95 ✓
		PREPAYMENT	
		TOTAL DUE	$ 27.95

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSS	June 30, 2016	PMC424581-01-03

OH 652631
ENTERED
OCT 16 2017

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: $ 27.95

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC424581-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Brooks

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information):
Medical Copies for youth in CWS case. Invoice # PMC424581-01-03

Reviewed by **(Supervisor):** M. Shiflet SPHN Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:** _____ TOTAL COST:$ 27.95

Signature/Payee

Professional Medical Copy: VEND004887

PRINT NAME

_____

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature _____ **Date** _____

Payment Authorized By **(PM):** _____ **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/7/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst

V4887

professional
MEDICAL COPY

Invoice

Federal Tax I.D. No. 68-0037053

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	July 05, 2016	PMC424441-01-01

Bill To:
Malia Xiong, MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Ordered By:
Malia Xiong, MSC
Shasta County Children & Family Services
1313 Yuba Street
Redding, CA 96001

Patient:
DOB:
SSN: XXX-XX-
File No:

Facility Name: **Lassen Medical Group**
Doctor Name: -
Recipient Name: **Shasta County Children & Family Services**

LOCATION AND DESCRIPTION OF SERVICES RENDERED	QUANTITY	UNIT PRICE	AMOUNT
Delivery By Facsimile			4.00
Records (PHI)	9.00	.10	.90
Service Fee/Clerical Fee			19.50
50100--034500 WL1CFS--WL3000 MEDICAL COPIES **RES. 2004-118**			
This invoice has been generated as a result of a request on your behalf to transfer your medical records or health informationfrom Lassen Medical Group to Shasta County Children & Family Services by you or your representative. It is not for treatment or office visits to Lassen Medical Group.		**SUB-TOTAL**	24.40
		SALES TAX 7.5	1.83
		PREPAYMENT	
		TOTAL DUE	**$ 26.23**

PAST DUE

Thank you for choosing Professional Medical Copy!
For billing inquiries, please contact our Accounting Department at (530) 953-2872.

FOR PROPER CREDIT DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

Remittance Copy

ACCOUNT NO:	INVOICE DATE:	INVOICE NO:
SCDOSSCFS	July 05, 2016	PMC424441-01-01

OH 652632
ENTERED
OCT 16 2017

Remit To:
Professional Medical Copy
P.O. Box 991522
Redding, CA 96099

TOTAL DUE: $ 26.23

1. PLEASE INCLUDE INVOICE NUMBER ON PAYMENT.
2. MAKE CHECKS PAYABLE TO **Professional Medical Copy.**

VISA MasterCard DISCOVER

Order#:PMC424441-01/CINV

REQUEST/CLAIM FOR ADMINISTRATIVE FUNDS

Emergency Request (Date Check Needed): _____ PM Approval _____

CASE NAME (first initial, last name): See Attached **SW**: Anderson

INSTRUCTIONS

Note: **This is not a referral form.** SWs arranging services for a client must complete the appropriate referral form and have it reviewed and approved by your program manager.

This form is used for all purchases made for clients in CWS cases including:

1. Non-Contracted Services (i.e. mental health, anger management)
2. CalCard Reconciliation- (items purchased for clients)
3. Direct reimbursements to staff, clients, and care providers (for items purchased for clients)
4. Requests for monthly RABA bus passes
5. Respite payments (see backside of form)

***Include an original itemized receipt. Do NOT tape or highlight on printed information on receipt.**

Justification for Payment or Item(s) (be concise, do NOT include case specific or confidential information): Medical Copies for youth in CWS case. Invoice # PMC424441-01-01

Reviewed by **(Supervisor):** M. Shirley SPHN Date: 8/7/17

CLAIM AND PAYMENT INSTRUCTIONS:

Submit this form at the completion of service. **Be sure to sign and date.** Submit form and appropriate billing information to: Shasta County HHSA/Children's Services, Attn: Analyst, 1313 Yuba St, Redding, CA 96001

The undersigned, under penalty of perjury, states that the above claim and the items as therein set out are true and correct; that no part thereof has heretofore been paid, and that the amount herein is justly due this claimant, and that the same is presented within one year after the last item thereof has accrued. Furthermore, if I am a county or district employee, I also certify that I have deducted the value of any personal gain I may have received including, but not limited to, cash back earned on a personal credit card, frequent flier miles, and room-stay rewards.

_____ **Date:**_____ TOTAL COST:$ 26.23

Signature/Payee

Professional Medical Copy: VENDOO4887

PRINT NAME

_____

Social Security Number (when applicable) OR Worker ID Number (staff reimbursements /CALCard Reconciliation)

P.O. Box 991522, Redding, CA 96099

Mailing Address (Street, City, State, ZIP) **(or CWS Email for staff reimbursement)**

IV. **CLIENT/FOSTER PARENT VALIDATION**: I have received the respite services as shown and certify that this is a true statement.

Signature_____ **Date**_____

Payment Authorized By **(PM):** J. Stuart **Date:** 8/7/17
Must be signed BEFORE being forwarded to Analyst

Analyst Review: _____ **Date:** 8/8/17

Budget Code: 50100/034500/ WL1CFS, WL3000

BUDGET CODES: To be completed by Children's Services Analyst