KERN REGIONAL CENTER

3200 N. SILLECT AVE.
BAKERSFIELD, CALIFORNIA 93308
(661 327-8531

VENDOR NO

BILLING DATE

NAME
ADDRESS

INVOICE NUMBER

SERVICE CODE

SUB CODE

PHONE NO.

ACCT CODE

LINE NO. CLIENT ID CLIENT NAME AUTH NO	BILLED SERVICES MO.	SUB CODE	GROSS BILLING UNITS	 COST/UNIT	TOTAL	RECEIVED REVENUES	REV CODE	NET BILLING
BILLS RECEIVED AFTER THE DUE DATE MAY NOT BE PROCESSED UNTIL THE FOLLOWING MONTH.				TOTAL		NET CLAIM		

CERTIFICATION STATEMENT

(1) The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the provider. (2) The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. (3) The Provider shall also certify that all information submitted to the regional center is accurate and complete. (4) The Provider understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. (5) The Provider agrees to keep for a minimum period of five years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. (6) The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the MediCal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representative. (7) The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

REMINDER:
1. Enter number of days the bill covers if different from authorized amount.
2. Provide unit or monthly cost of service.
3. Enter total claimed.
4. Provide your signature and date.
5. Attach Attendance Record

PLEASE MAKE COPY FOR YOUR RECORDS

I certify that the client(s) listed above were provided the service as authorized for the stated periods, and that no additional charges were made to other parties.

VENDOR SIGNATURE TITLE DATE