

**County of Los Angeles Department of Mental Health Provider Reimbursement & Support Services Division
 Monthly Claim for Cost Reimbursement¹
 DISASTER RECOVERY PROGRAMS
 DURING FISCAL YEAR 20xx-20xx**

Funding Source Name: _____ Financial Exhibit Number: _____

Legal Entity Name: _____

Legal Entity Mailing Address: _____

Billing Month(s): _____ Contract/Amendment Number: _____

Provider Number(s): _____

1. Expenditures	
1.1 Salaries and Employee Benefits ²	_____ (1.1)
1.2 Operating Expenses	_____ (1.2)
1.3 Equipment	_____ (1.3)
1.4 Advertising, Printing, etc.	_____ (1.4)
1.5 Other (provide details)	_____ (1.5)
2. Total Expenditures (add lines 1.1 thru 1.5)	_____ (2)
3. Less: Client & Third Party Revenues	
3.1 Client Fees	_____ (3.1)
3.2 Client Insurance	_____ (3.2)
3.3 Medicare	_____ (3.3)
3.4 Other: _____	_____ (3.4)
4. Total Revenues (add lines 3.1 thru 3.4)	_____ (4)
5. Expenditures less revenues (subtract line 4 from line 2)	_____ (5)
6. Total Net Costs	_____ (6)
7. Total Payment Requested	_____ (7)

Comments: _____

I hereby certify, to the best of my knowledge and belief, that this claim and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that all disbursements have been made in accordance with the FEMA grant agreement; that all persons for whom labor records have been submitted for reimbursement have worked in compliance with the Fair Labor Standards Act (FLSA §778.101 § 778.103); and that payments received under this contract have not been used for supplanted positions (CFR § 206.228 (a)(4)).

Signature _____

Phone _____

Title _____

Date _____

¹ Please complete a "Monthly Claim for Reimbursement" for each funding source per financial exhibit.

² Complete the enclosed Labor Record to support Salaries & Employee Benefits and submit with this claim form.