



California Access to Recovery Effort

(CARE)

Form 9

INVOICE COVER SHEET

(This cover sheet must accompany all invoices submitted for payment)

As the authorized representative* for _____,
(provider name)

I certify that the CARE services billed during the month(s) of _____, 200_____, shown on the attached invoice(s) for payment, were rendered in accordance with the *CARE Policies and Procedures* and are documented in the client's file(s) as specified in the *Policies and Procedures* (documentation must include completion of the *Client Services Summary* form).

I understand that services billed are subject to audit by the State Department of Alcohol and Drug Programs and/or the State Controller's Office, and noncompliance with policies and procedures will result in sanctions, including, but not limited to, withholding payment until compliance is attained, disallowance of unauthorized billings, repayment of fraudulent billings, fiscal audits, forfeiture of CARE participation, and criminal prosecution, pursuant to the *CARE Policies and Procedures*, Sections XIX and XX.

Authorized Representative Signature*

Date

Printed Name/Title

Phone Number

Email address

* This form must be signed by a person authorized to represent the provider organization or entity. If the provider is a sole proprietor, the proprietor must sign. If the provider is a partnership, each partner must sign. If the provider is a firm, association, corporation, or governmental entity, the chief executive officer or the individual legally responsible for representing the firm, association, corporation or governmental entity must sign. If the authorized representative chooses to designate his/her signature authority, that designation must be submitted to ADP in writing from the authorized representative.