EXHIBIT 4
DMH Policy #804.01

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

CLINIC RECEIPTS TRANSMITTAL

DEPOSIT DATE_____

CONTROL UNIT NUMBER_____

CLINIC NAME_____ **STATE PROVIDER NUMBER**_____

Enclosed are Departmental Receipts numbered_____through_____ and:

Check(s)/money orders totaling $_____

Cash totaling $_____

for a grand total of $_____

REVENUE BY CATEGORY:

	Short-Doyle	Federal Medi-Cal
Client Payments	$_____	
Medicare Payments	_____	
Med-cal w/share of Cost		$_____
Insurance Payments	_____	_____
Other	_____	
Grand Total Collections	$_____	$_____

Revenue was collected _____through_____(dates).

PREPARED BY: **VERIFIED BY:**

Signature _____ _____

Title_____ _____

Telephone Number_____ _____

Revised 4/88