COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FINANCIAL EXHIBIT B-5
DMH SPONSORED TRAINING SESSIONS - First 5 LA PCIT TRAINING REIMBURSEMENT REQUEST FORM
Fiscal Year 2013-2014

TYPE of FUNDS First 5 LA PCIT

Legal Entity Number :

Legal Entity Name :

Provider Number :

Billing Month:

PCIT Supervisor/Training Coordinator:

Contact Email Address:

BACK-UP DOCUMENTATION MUST BE ATTACHED TO THIS REIMBURSEMENT REQUEST FORM FOR PAYMENT.
PLEASE ATTACH BACK-UP DOCUMENTATION: CERTIFICATES OF ATTENDANCE AND/OR CERTIFICATES OF COMPLETION AND SIGN-IN-SHEETS.

Name of Staff (First and Last Name)	Licensure Type	Training Description	Date of Training	ACTUAL TRAINING HOURS	Hourly Rate $36.33/hr
				Total Reimbursement:	

All claims shall be submitted by contractor to DMH within sixty (60) days of the event.

AGENCY VERIFICATION	
Signature	Date
Print Name	Title

Mail Request Form to:
County of Los Angeles Department of Mental Health Provider Reimbursement Section 550 S. Vermont Avenue, 8th Floor Los Angeles, CA 90020

DMH/PCIT APPROVAL
Approved by:
Date:
Total Funding: