COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FINANCIAL EXHIBIT B6
DMH SPONSORED TRAINING SESSIONS - First 5 LA PCIT TRAINING REIMBURSEMENT REQUEST FORM
Fiscal Year 2014-2015

TYPE of FUNDS	First 5 LA PCIT	**Billing Month:**	
Legal Entity Number :		**PCIT Supervisor/Training Coordinator:**	
Legal Entity Name :		**Contact Email Address:**	
Provider Number :			

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 month in which the event occurred.

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: