

Monthly Invoicing

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**SUBMITTAL INSTRUCTIONS FOR U.S.
PROBATION**

Monthly Processing of Invoices

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- Invoices are to be received before the 10th of each month. For example, October's invoices are to be received by November 10th. Tardiness may be noted on Audit reports and may also delay payment processing.
- Make sure all forms are complete before submittal. Missing documents, signatures, and initials may cause services to be deducted and/or payment to be delayed.

Submit the following each month:

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- **Part A—with a “wet” signature**
- **Part B**
- **Monthly Treatment Report**
- **Daily Log(s) for each client receiving services**
- **Copies of any reports/polygraphs claimed on Part B**
- **Receipts for any medication, transportation, emergency funds, and/or postage for sweat patches being claimed.**
- **Incomplete forms and/or missing documents may cause services to be deducted and/or payment to be delayed.**

Part B: Correct



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- RESIDENTIAL EXAMPLE**

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ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS TREATMENT SERVICES INVOICE

Client's Pacts # is listed here (you can find this number on the client's Program Plan). Please do not list Social Security numbers (for security reasons) nor your internal client numbers since this may result in billing delays/revisions/deductions.

(PART B)

1. CLIENT NAME	2. CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST
T. Cat	12345	10/1-2/2015	2002	2	\$100.00	\$200.00
		10/5-31/2015	2002	27	\$100.00	\$2,700.00
H. Hedgehog	23456	10/1-10/31/2015	6002	30.5	\$250.00	\$7,625.00

As residential clients are seen for multiple days in a row, service dates may be grouped together.

Please make sure you list the service code provided on the client's program plan. Services billed under the wrong code will be deducted and you will be asked to submit supplemental billing.



Part B: Check it twice

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RESIDENTIAL EXAMPLE

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST
T. Cat	12345	10/1-2/2015	2002	2	\$100.00	\$200.00
		10/5-31/2015	2002	27	\$100.00	\$2,700.00
		10/31/2015	1501			\$145.00
H. Hedgehog	23456	10/1-31/2015	6002	30.5	\$250.00	\$7,625.00
		10/31/2015	1501			\$381.25

1501 may only be claimed for co-payments the client has made.

PROGRAM PLAN: PROB 45

Residential Examples

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Client's PACTS number used for billing is found here

Probation clients are always "Post Conviction". Please do not include services for Pretrial clients on Probation invoices--they will be deducted.

Prob. Form 45 Today's Date:

Client Identifying Information

Client: CAT, TOM PACTS#: 12345
 Address: 123 Litterbox Lane, 90210
 Officer: MICHAELSKERS, QUE...
 Officer Phone: 415-436-7540
 Pretrial/Post Conviction: POST CONVICTION
 Client Phone: 555-555-5551
 DOB: 12/31/2002



Prob. Form 45 Today's Date:

Client Identifying Information

Client: HEDGEHOG, HENRY PACTS#: 23456
 Address: 238 Woods Lane, 90210
 Officer: RANGER, PARK
 Officer Phone: 415-436-7540
 Pretrial/Post Conviction: POST CONVICTION
 Client Phone: 555-555-3552
 DOB: 01/01/2010



Contact the person listed here should you have questions about a client's program plan

Provider Information

Provider: Treatment USA Procurement No: 0971-2016-32RD
 Provider Location: TUSA Effective Date: 09/30/2015
 Attn: John Doe Termination Date:
 Location Address: 124, 90222
 Phone: 555-525-5555
 Fax: 555-581-5555

Provider Information

Provider: Treatment USA Procurement No: 0971-2016-32RD
 Provider Location: TUSA Effective Date: 10/05/2015
 Attn: John Doe Termination Date: 10/30/2015
 Location Address: 124, 90222
 Phone: 555-525-5555
 Fax: 555-581-5555

Authorized Services
 Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Authorized Services
 Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
2002	Long-Term Residential Treatment		31	monthly	\$500
1501	Administrative Fee				

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
6001	Short-Term Residential for Co-occurring Disorders		31	Monthly	

If a co-pay is listed on a program plan 1501 should also be listed

Please make sure the code listed on a client's program plan matches services being billed on your invoice--if they do not match services may be deducted.

Instructions to Provider Regarding Client Needs and Goals of Treatment

Officer:  Referral Agent:  Client: _____

Instructions to Provider Regarding Client Needs and Goals of Treatment

Officer:  Referral Agent:  Client: _____

Part B: Correct



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• SA/DAC EXAMPLE

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ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS TREATMENT SERVICES INVOICE

(PART B)

Remember that units for counseling sessions are 30 min. So if a client is seen for a full hour 2 units should be charged. If a client arrives late or is only seen for 30 min you may only bill for one unit.

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST
H. Hedgehog	23456	10/2/2015	1012	1	\$20.00	\$20.00
		10/4/2015	2020	3	\$35.00	\$105.00
		10/4/2015	1202			\$25.00
		10/4/2015	1201			\$1.25
		10/6/2015	2010	2	\$40.00	\$80.00
		10/15/2015	2010	1	\$40.00	\$40.00
		10/20/2015	1010	1	\$20.00	\$20.00
		10/21/2015	2020	3	\$35.00	\$105.00
		10/21/2015	CPAY			(\$15.00)
		10/21/2015	1501			\$0.75
		10/30/2015	2011	1	\$550.00	\$550.00
		10/31/2015	1010	NO TEST		

Check your BPA, if the unit for the service is a Report—you may not bill by the hour for this service; you bill only for the report and you include a copy of the report with the invoice you submit.

Remember: co-payments are always deducted

Urinalysis sometimes cannot be performed on a specimen for a variety of reasons—instances such as these are classified as “No Test” and will not be paid by Probation. Probation along with your UA contact will be notified of No Tests. “No Test” 1010 services will be deducted if charged.



Part B: Check it twice

• SA/DAC EXAMPLE

Testing is usually only done once a day, so if more than one unit is charged supporting documentation will be checked to verify the number charged is correct.

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	
H.Hedgehog Transportation, Medication, Co-pays, and Emergency Funds all have fees associated with them. If you forget to claim these fees on an invoice you may not be notified of your error.	23456	10/2/2015	1012	3	\$20.00	\$60.00	
		10/4/2015	2020	3	\$25.00	\$75.00	
		10/4/2015	1202				\$25.00
		10/6/2015	2010	2	\$40.00	\$80.00	
		10/15/2015	2010	1	\$40.00	\$40.00	
		10/20/2015	1010	1	\$20.00	\$20.00	
		10/21/2015	2020	3	\$35.00	\$105.00	
		10/21/2015	CPAY				\$15.00
		10/21/2015	1501				\$0.75
		10/30/2011	2011	3	\$550.00	\$1,650.00	
10/22/2015	6010	2	\$60.00	\$120.00			
		10/17/2015	4010			\$381.25	

Please check your BPA and enter the correct unit price for each service. Listing an incorrect price may result in deductions or you may be asked to submit supplemental billing for the amount under-billed.

Probation will deduct any co-payments not deducted from the total or mistakenly added to the total amount of an invoice.

Due to Probation's accounting system, mental health services may not be charged on the same invoice as SA/DAC services. Any MH services listed on a DAC invoice will be deducted and you will be asked to submit supplemental MH invoices for these services.

Services which list their unit price by Report should be charged by the Report and not by units of time. Check your BPA for unit types. Extra units will be deducted.

Program Plan: PROB 45 DAC/MH Example

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Client's PACTS number can be found here please use this number on invoices

Prob. Form 45 Today's Date:

Client Identifying Information

Client: HEDGE HOG, HENRY	PACTS#: 23456	
Address: 238 Woods Lane 90210	Pretrial/Post Conviction: POST CONVICTION	
Officer: RANGER, PARY	Client Phone: 555-555-5552	
Officer Phone: 415-436-7540	DOB: 01/01/2010	

Client's Probation Officer is listed here

Provider Information

Provider: TREATMENT USA
 Provider Location: MENDOCINO
 Attn: John Smith
 Location Address: 124 _____
 90222
 Phone: 555-525-5555
 Fax: 555-581-5555

Procurement No: 0971-2010-40P
 Effective Date: 10/03/2015
 Termination Date:

This is the date services should start. If you provide services before this date you may not be paid for those services. Also, if a Termination Date is listed and services are provided after the termination date, you may not be paid for these services.

Authorized Services
 Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
1012	Sweat Patch		4	Monthly	
1010	Urine Collection		4	Monthly	
2020	Group Counseling		3	Bi-Weekly	\$35.00
6010	Individual Counseling		2	Weekly	
4010	Physical Exam & Report		1	Per-Plan	
1501	Administrative Fee				

Be mindful of the interval: services may be listed as Monthly, Bi-Weekly, Weekly, or Per-Plan. If you provide more services than what is asked for on the plan, you may not be paid for the extra services.

If a copay amount is listed, 1501 should also be listed on the plan.

Instructions to Provider Regarding Client Needs and Goals of Treatment
 Please sweat patch client once a week. If patch falls off please UA test client.

Officer will list important notes/instructions here.

Officer:  Referral Agent:  Client: _____

Part B: Correct



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- MH EXAMPLE

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**ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE**

(PART B)

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	
H. Hedgehog	23456	10/2/2015	6010	1	\$60.00	\$60.00	
		10/4/2015	6051	1	\$180.00	\$180.00	
		10/4/2015	CPAY				(\$25.00)
		10/4/2015	1501				\$1.25
		10/6/2015	6010		2	\$60.00	\$120.00
		10/15/2015	6040				\$1,000.00
		10/20/2015	6041				\$50.00
		10/25/2015	4020			\$200.00	
T. Cat	12345	10/4/2015	6036	2	\$35.00	\$70.00	
		10/10/2015	6010	2	\$60.00	\$120.00	
		10/15/2015	5010	1		\$825.00	
		10/15/2015	1202				\$50.00
		10/15/2015	1201				\$2.50

Some services are charged per visit. Check your BPA

For services paid at "Actual Cost" please list the total amount only since the unit price will vary and include a receipt with the invoice.

Some services are charged per Report. Check your BPA



Part B: Check it twice

MH EXAMPLE

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	
H. Hedgehog Services are charged by month. You may not submit invoices listing services for multiple months. Services listed outside of the month listed on Part A will be deducted and you will be asked to submit supplemental invoices for each month a service was provided.	23456	10/2/2015	6010	3	\$60.00	\$180.00	
		10/4/2015	6051	2	\$180.00	\$360.00	
		10/4/2015	CPAY				(\$25.00)
		10/6/2015	6010	2	\$60.00	\$120.00	
		10/15/2015	6040				\$1,000.00
		9/2/2015	4020				\$200.00
T. Cat	12345	10/4/2015	6036	2	\$35.00	\$70.00	
		10/10/2015	6010	2	\$60.00	\$120.00	
		10/15/2015	5010	3	\$825.00	\$2,475.00	
		10/15/2015	1202			\$50.00	

Extra units will be deducted if supporting documentation does not support the charge and/or if the incorrect service units were used. Please check your BPA for unit measurements: 30 min increments, Report, Visit, Actual Cost, etc.

You may not be notified if you fail to charge for fees associated with Transportation, Medication, Emergency Funds, and/or co-pays.

Invoice Submittal: Services by : “Project Code”

**ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE**

(PART A)

1.	Judicial District	<u>NDCA</u>	3. B.P.A.#	<u>0971-2016-XXXX</u>
2.	Vendor	<u>Treatment Inc.</u>	4. Service Delivery:	<u>October 2015</u>
	a. Address:	<u>123 Mail Payment Here Rd. San Francisco, CA 94102</u>	5. Total # Individuals Served:	<u>5</u>
	b. Telephone:	<u>415-436-7540</u>		

Vendors Certification: I certify that all expenditures and requests for reimbursement in this voucher are accurate and correct to the best of my knowledge and include only charges for services actually rendered to clients under the terms of the agreement and for which no other compensation has been received from either the client or the United States District Court.

6. PROJECT CODE	7. QUANTITY	8. UNIT PRICE	9. TOTAL PRICE
4010			
4020			
5010			
5011			
5020			
5030			
6000			
6010			
6020			
6030			
6040			
6041			
6051			
1201			
1202			
1301			
1302			
1401			
1402			
CPAY			
1501			
Total:			0.00

MH
Services

**ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE**

(PART A)

1.	Judicial District	<u>NDCA</u>	3. B.P.A.#	<u>0971-2016-XXXX</u>
2.	Vendor	<u>Treatment Inc.</u>	4. Service Delivery:	<u>October 2015</u>
	a. Address:	<u>123 Mail Payment Here Rd. San Francisco, CA 94102</u>	5. Total # Individuals Served:	<u>5</u>
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Vendors Certification: I certify that all expenditures and requests for reimbursement in this voucher are accurate and correct to the best of my knowledge and include only charges for services actually rendered to clients under the terms of the agreement and for which no other compensation has been received from either the client or the United States District Court.

6. PROJECT CODE	7. QUANTITY	8. UNIT PRICE	9. TOTAL PRICE
1010			
1012			
1504			
2000			
2011			
2022			
2010			
2020			
2030			
1201			
1202			
1301			
1302			
1401			
1402			
CPAY			
1501			
Total:			0.00

DAC
Services

Part B: Correct



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- SO EXAMPLE

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ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS TREATMENT SERVICES INVOICE

If a service is charged in 30 min increments and the client is seen for an hour and a half, 3 units should be charged.

(PART B)

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST
H. Hedgehog	23456	10/2/2015	6012	1	\$60.00	\$60.00
		10/4/2015	6022	3	\$35.00	\$105.00
		10/4/2015	CPAY	2		(\$100.00)
		10/4/2015	1501			\$5.00
		10/6/2015	6012	2	\$60.00	\$120.00
		10/15/2015	6022	3	\$35.00	\$105.00
		10/20/2015	5012	1	\$1,200.00	\$1,200.00
T. Cat	12345	10/4/2015	6022	2	\$35.00	\$70.00
		10/10/2015	6012	2	\$60.00	\$120.00
		10/15/2015	6022	3	\$35.00	\$105.00
		10/17/2015	5023	1	\$500.00	\$500.00

Some services are charged by the Report/Polygraph; check your BPA. Copies of the Report/Polygraph will be included with the invoice.



Part B: Check it twice

SO EXAMPLE

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST
H.Hedgehog	23456	10/2/2015	6012	1	\$60.00	\$60.00
		10/4/2015	6022	3	\$35.00	\$105.00
		10/4/2015	1202			\$25.00
		10/4/2015	CPAY			(\$100.00)
		10/6/2015	6012	3	\$40.00	\$120.00
		10/15/2015	6022	3	\$20.00	\$60.00
		10/20/2015	5012	4	\$1,200.00	\$4,800.00
T. Cat	12345	10/4/2015	6022	2	\$35.00	\$70.00
		10/10/2015	6012	2	\$60.00	\$120.00
		10/15/2015	6022	3	\$35.00	\$105.00
		10/17/2015	5023	2	\$500.00	\$1,000.00
		10/17/2015	1202			\$25.00
		10/17/2015	1201			\$1.25

You may not be notified if you fail to claim fees for any Transportation, Emergency Funds, or co-pays.

Make sure to list the correct unit price for each service and also check your totals to make sure they are correct. Probation is not allowed to pay more than the total listed on the invoice you submit. If you under-bill you will need to submit either a revised invoice or supplemental billing to claim the correct total amount due.

Services charged by the Report/Polygraph completed may not be billed by time. Extra units will be deducted and only the correct amount of Reports/Polygraphs will be paid for as long as copies are provided with the invoice submitted.

Monthly Treatment Report: PROB 46

PROB 46 (Rev. 06/10)				MONTHLY TREATMENT REPORT				This form must be completed and submitted with each monthly billing. Additional sheets may be used.			
1. PROGRAM NAME: Treatment USA				1a. PROVIDER NAME: Dr. No				2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS): 10/5/2015 18			
3. CLIENT NAME: Hedgehog, Henry				3a. PACTS NO. 23456				4. FOR PERIOD COVERING: October 2015			
5. PHASE NO. 1		5a. TIME IN PHASE: 30 days		6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				7. CLIENT EMPLOYED: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Student <input type="checkbox"/> Other			
8. CONTACTS SINCE LAST REPORT											
a. Date	b. Service (Name & No.)			c. Length of Contact			d. Comments (No Shows, Tardiness, Issues Addressed)			e. Copay (amount collected)	
10/04/2015	2011			60 min			Intake				
10/12/2015	2010			60 min			build rapport, go over tx plan				
10/15/2015	2020			120 min			schemas				
10/20/2015	2010			60 min			work on goal #1, steps to get there				
10/22/2014	2020			120 min			thought records				
10/25/2015	2010			30 min			Client 20 min late, issues w/ roommate				
9. URINE TESTING RECORD											
DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)	
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)					
10/06/2015	✓				✓		J.R.		negative	✓	
10/17/2015		✓		✓	✓		T.P.				
10/22/2015	✓				✓		J.R.	sweat patch	negative		
10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS											
a. Describe the treatment goals addressed this month (<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met):											
Build rapport with client. Worked on treatment plan with client and came up with 3 goals with the client. Currently working on steps to reach goals											
b. Describe any steps taken by the client this month toward these goals (<input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative):											
Client outlined steps to reach Goal #1 and has started step 1											
c. Describe any obstacles or setbacks the client encountered this month:											
Client had conflict with a roommate and we have been working on conflict resolution and listening techniques											
d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:											
Client is unsure what he needs to disclose to those around him and PO can go over these requirements with the client											
e. If continued treatment is recommended, discuss the plan for next month (<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended):											
Will work with client on steps for goals #2 & #3 and progress on steps for goal #1											
f. Discuss your observations of the client's behavior and commitment to treatment (<input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative):											
Client is engaged in sessions and contributes to group sessions											
g. Comments:											
please see p.2 for more information											
h. Overall Progress: <input checked="" type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable											
SIGNATURE OF COUNSELOR								DATE 11/01/2015			

Please do not use another form or even modify this form. If you need to add more information you may attach a 2nd page.

P.2

I am attaching a second page because I want to add more information to this client's program plan

10/4/2015: jfksajflkdjsljsljdks
ajfsfjslasjfkdsjfkldsjsk

Sjlfjdsajfksljsk

10/12/2015: Sjlfjdsajfksljsk

Alsfdksajfksljsljsljsk

Jslfjdsajfksljsljsk

10/15/2015: Ajskfjdsajfksljsljsk

Fjsdksajfksljsljsk jfksajfksljsk jfdksal

10/20/2015: Ajfkajfksljsk jfdksajfksljsk

jfksajfksljsk

Jskfjksa jfksajfksljsk jfksajfksljsk

10/22/2015: Jakfsdajfksljsk jfksajfksljsk

Jfdksajfksljsk jfksajfksljsk jfksajfksljsk

10/25/2015: Akfsa;jfksajfksljsk jfksajfksljsk

jfksajfksljsk

Ajfkajfksljsk jfksajfksljsk jfksajfksljsk

SWEAT PATCH TESTING LOG

SWEAT PATCH TESTING LOG

COMPLETE ONE FORM PER CLIENT PER MONTH
COMPLETE THE FIRST FIVE COLUMNS UPON APPLICATION, AND THE LAST FOUR UPON REMOVAL

Client Name HEDGEHOG, H. PACTS # 23456 Month/Year OCTOBER 2015

Application Date	Client's Signature/Initials	Chain of Custody Bar Code Number	Medications Taken	Collector's Initials	Removal Date	Client's Initials	Collector's Initials	Test Results/Date	Co-Pay Collected
9/27	H.H.	76502789	—	JT	10/2	HH	KR	POS. 10/9	—
10/2	H.H.	76502798	—	KR	10/7		J.T.	NEG 10/10	\$15 ⁰⁰
10/7		76502801	—		10/9			FEU OFF	—
10/9	H.H.	76502815	CODEINE	TJ	10/15	HH		NEG 10/19	—
10/15	H.H.	76502820	—		10/21	H.H.	TJ	POS 10/23	—
10/21	H.H.	76502825	—	KR	10/27	H.H.	KR	NEG 10/30	—
10/27	H.H.	76502832	—	TJ					

Make sure to record any co-pays **collected**

Remember that sweat patches are billed on the date they are **removed** only.

Comments (please note any unusual occurrences):

Services may be deducted and you may be asked to submit supplemental billing if any information is missing so please be sure all forms are complete before submitting.

BREATHALYZER LOG

BREATHALYZER LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

Client Name CAT, T. PACTS # 12345 Month/Year OCTOBER 2015

Client's Signature/Initials	Collector's Initials	Reason Tested	Test Results	Refusal
T.C.	J.T		0.02	
	KR		0.03	

Comments (please note any unusual occurrences):

Services may be deducted and you may be asked to submit supplemental billing if any information is missing so please be sure all forms are complete before submitting.

CONTACT INFORMATION FOR BILLING

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- **Mail all invoices to:**

U.S. Probation Office
Attn: Treatment
450 Golden Gate Ave. Ste 17-6884
P.O. Box 36057
San Francisco, CA 94102-3487

- **Treatment Phone number: 415-436-7568**
- **Treatment Fax number: 415-581-7401**
- **Officer-in-Charge USPO Jennifer James**