Golden Gate Regional Center
875 Stevenson Street, Sixth Floor
San Francisco, CA 94103

Vendor Sign-In Sheet

(Therapists, Specialists, Instructors, Interpreters, or Individual Contractors)

Vendor: **Vendor #/Service Code:**

Consumer: **UCI#:**

Instructions: Use a separate form for each month. Complete the form and return it to the regional center. ***The vendor must sign on the vendor certification statement and the family member/parent must sign for each date of service to verify the services provided*.** You may furnish a copy of this sheet to the family upon their request for their recordkeeping.

Date	Total Hours	Verification by Family Member/Parent* *Signature*

VENDOR CERTIFICATION STATEMENT

1. I agree and certify that all claims for services provided to regional center consumers have been provided to the consumer.
2. I acknowledge that the services were provided in accordance with the consumer's Person-Centered Individual Program Plan (PCIPP) or addendum.
3. I certify that all information submitted to the regional center is accurate and complete.
4. I understand that I can bill for services that are actually provided to the consumer and were authorized by the regional center. I understand that payment of these claims will be from federal and/or state funds, and any falsification or concealment of material fact may be prosecuted under federal/or state laws.
5. I understand that I must keep, for a minimum of five years from the date of service, in written or printed form, all records that are necessary to disclose fully the extent of services furnished to the consumer. Records must specify the date, actual service time, location, nature of services performed, and units of service provided pursuant to Section 54326(a)(3)(B), Title 17, California Code of Regulations.
6. I agree to furnish the records mentioned in item 5 above, including any information regarding payments claimed for providing the services, on request, to the California Department of Health Services; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representative(s).
7. I agree that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

Vendor:
Under penalty of perjury, I certify that all services provided as recorded on this form are correct. I further certify that I have read and fully complied with the requirements of this program, and the terms and conditions stated above.

Vendor Signature: _____

Date: _____

If the number of service dates exceeds the amount of space please submit additional copies of this form as needed.