COUNTY OF YOLO

Health and Human Services Agency

Karleen Jakowski,
Mental Health
Director

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Quarterly Service Verification Summary Form

Program Name: ____

Dates Verified:________________ to: ________________

Verification Completed by: ________________________ Date Verification Completed: ____________

# of Client Services Provided	# of Client Surveys Completed	# of Surveys Verified	# of Surveys with Discrepancies (Client survey does not match claim data)

Was the Yolo County Behavioral Health Compliance Officer notified via ***encrypted*** email at HHSA.BHCompliance@yolocounty.org if fraudulent claims were discovered?

__ Yes __ N/A

Were claim errors processed for deletion/voids?

__ Yes __ N/A

Network providers only:

I attest that ______________________________ completed the mandatory service verification and that the
(Program Name)
above information is accurate to the best of my knowledge.

Program Director (or Designee) Printed Name	Signature	Date

Revised: June 2023