CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
COUNTY-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
(CMAA)
TIME SURVEY REQUEST FORM

SUBMIT ONE FORM PER CLAIMING UNIT AT LEAST 30 DAYS PRIOR TO THE REQUESTED TIME SURVEY MONTH.

Local Governmental Agency (LGA)

Claiming Unit Name (as it appears in the Claiming Plan)

Address

City            State          Zip

The LGA identified above, requests approval from the Department of Health Care Services (DHCS) to conduct a time survey for County-Based Medi-Cal Administrative Activities as follows:

Fiscal Year ________________ during the month of _________________.

MONTH                         YEAR

We understand that the process of this time survey must meet the same criteria as the time survey period designated by the DHCS. Results from this time survey shall be in effect from the first day of the calendar quarter in which the time survey is conducted, and shall remain in effect until superseded by an additional approved subsequent time survey or by the mandatory time survey in the next fiscal year.

Contact Person (print)    Telephone Number

Signature                  Date

DHCS USE ONLY

Approved by DHCS

Denied by DHCS

Signature                  Date

Revised 1-08