

**STATE OF CALIFORNIA - Health and Human Services Agency
Drug Medi-Cal Organized Delivery System (DMC-ODS) Services**

Instructions for Completing DMC-ODS Services Quarterly Claim for Reimbursement of State General Fund eligible expenditures (Form DHCS 5136).

General Instructions

Complete one claim form for each quarter, and complete one claim form to cover the total State General Fund eligible expenses for the Fiscal Year. The deadline for submitting the completed claim form is within 60 calendar days after the end of the quarter.

Counties may choose not to be reimbursed for DMC-ODS-ODS State General Fund eligible expenditures throughout the year, but instead to be reimbursed only once through the cost report settlement process. In that case, counties may forego submitting quarterly claims for reimbursement of DMC-ODS State General Fund expenditures. However, the county is still required to complete one claim form to cover the total DMC-ODS State General Fund reimbursement for the Fiscal Year.

Heading Instructions

Enter the date the claim form is submitted, the county code, the county name, and the fiscal year in which the State General Fund eligible expenditures were incurred. Mark either the box to indicate the quarter in which the eligible expenditures were incurred or the box to indicate the Total Fiscal Year DMC-ODS State General Fund reimbursement.

If after a quarterly report is submitted, the county determines that State General Fund eligible expenditures changed for that prior quarter, submit a revised quarterly report and mark the Yes box to the right of the box labeled "Is this a revision of a prior quarter's claim form?"

Line-Item Instructions

The county data entry required on this form is found on lines 1, 3, 4 and 5. Lines 2 and 6 are formula generated.

Line 1: Enter the Drug Medi-Cal-ODS direct service treatment expenses eligible for State General Fund reimbursement on Line 1, Column A. Enter the direct service treatment expenses not eligible for State General Fund on Line 1, Columns B and C, respectively. These columns must be entered directly due to differences in federal match for individual aid codes.

Line 1, Column D is formula driven with no data-entry required by the county.

The direct service expenses are based on the direct-service treatment expenses reported on the "Drug Medi-Cal Certification for Federal Reimbursement" (i.e., CPE) form.

For example, DMC-ODS services other than Narcotic Treatment Program expenses, counties bill DMC-ODS services at the lower of customary charge, allowable cost, or reimbursement rates (22 CCR Sec 51516.1(a)).

Line 2 is formula driven with no data-entry required by the county.

Line 3: Enter the desired amount of State General Fund requested. This amount cannot exceed the lower of a) Line 1, Column A plus Line 2 or b) Line 6.

Line 4: Enter the State General Fund eligible expenditures reimbursed in prior quarters of the same Fiscal Year.

Lines 5: Enter the maximum available reimbursement for State General Fund eligible for the applicable fiscal year, as published by the most recent DHCS Information Notice.

Line 6 is formula driven with no data-entry required by the county.

Certifications

Each claim form must include the signed certification of the County Alcohol and Other Drug Programs Administrator and either the County Auditor-Controller, Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer.

Transmittal to DHCS (two methods)

1. Scan the completed, signed form and email as attachment to sudfmab@dhcs.ca.gov
or
2. Mail completed form to:
Department of Health Care Services
SUD Program, Policy and Fiscal Division
Fiscal Management and Accountability Branch
1500 Capitol Avenue, MS 2624
PO Box 997413
Sacramento, CA 95899-7413