SHORT-DOYLE/MEDI-CAL MONTHLY CLAIM FOR REIMBURSEMENT -- QUALITY ASSURANCE
MH 1982 C (10/00)

(see instructions on reverse)

Fiscal Year

Claim For **MO/YR**

Date	County Code	County
Name	Position #	
Classification	Form # of	

* SPMP - Skilled Professional Medical Personnel	A SPMP*	B OTHER
1. Salary		
2. Benefits		
3. Training		
4. Travel		
5. General Expense		
6. Communication		
7. Facility Operation		
8. TOTAL (1 thru 7)		
9. Percent of Time on UR		
10. Percent UR for Medi-Cal		
11. Claimable Amount (8) x (9) x (10)		
12. Federal - 75% Amount (11A) x (0.75)		
13. Federal - 50% Amount (11B) x (0.50)		
14. County Match to FFP (11A minus 12A) and (11B minus 13B)		
TOTAL AMOUNT CLAIMABLE (12A + 13B)		

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. The County agrees and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the County. The services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan. The County shall also certify that all information submitted to the Department is accurate and complete. The county understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. The County agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; Calfornia Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The County also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

Date: _____ Signature: _____
Local Mental Heatlh Director

Executed at _____ ,California

I CERTIFY under penalty of perjury that I am duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts. I further certify that claimant wil provide the State's share of payment for Short-Doyle/Medi-Cal covered services included in this claim in order to satisfy matching requirements for federal financial participation pursuant to Title XIX of the Social Security Act.

Date: _____ Signature: _____

Title: _____ Executed at _____ ,California
(County Auditor-Controller, City Finance Officer, or Local Mental Heatlh Accounting Officer)

FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

County Claim for Reimbursement $ _____

Signature: _____ Date: _____
Accounting Office

Schedule No. _____

COMPLETION INSTRUCTIONS FOR MH 1982 C

Enter the name, claim month, and fiscal year. If you are using this form for individual staff documentation in lieu of SB 910 time study, complete the name classification, form number, and position number boxes.

Lines 1-7 indicate amounts expended for staff as skilled medical professionals and direct support staff under Column A. Column B is used for non-medical professionals and non-enhanced (50 percent FFP) clerical staff.

Line 8 Column A summarizes expenditures to be reimbursed at the enhanced FFP rate (75 percent).

Line 8 Column B summarizes expenditures to be reimbursed at the non-enhanced FFP rate (50 percent).

Line 10 indicates the amount of time staff spends on quality assurance activities.

Line 11 indicates the amount spent on Medi-Cal quality assurance. If your county only provides quality assurance activities for Medi-Cal patients, then this percentage is 100 percent. If your county provides quality assurance activities for all patients, then the percentage of Medi-Cal patients to total patients will be used here.

Lines 12, 13, and 14 are self-explanatory.

The bottom of the form summarizes the amounts claimable and not claimable.

Sent the completed MH 1982 C to:

Department of Mental Health
County Financial Program Support
1600 9th Street, Room 120
Sacramento, CA 95814

Attention: Medi-Cal Liaison