

## **SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT**

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## **General Information and Requirements for Children's Medical Services (CMS) Quarterly Administrative Expenditure Invoices**

- I. The quarterly administrative expenditure invoice forms contain the same five line items used in the budgets.
- II. Counties/cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices. However, justification worksheets and/or documentation of how expenditure amounts were derived must be maintained at the county/city level for audit purposes.
- III. Quarterly expenditure invoices for salaries and wages must be supported by time studies or attendance documentation maintained at the county/city level for audit purposes. Documentation for staff who qualify for enhanced federal funding and/or who work on more than one program must include quarterly time studies at a minimum, prepared for each budgeted position using the same representative month each quarter. (See Section 9).
- IV. Tools for using time study information to allocate personnel services and benefits expenses are included in References, Section 10.
- V. Overhead costs submitted on the quarterly invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller (OASC) 10 federal guidelines. External overhead costs invoiced for reimbursement must be based on the plan approved by the State Controller's Office (A-87 approval letter). Documentation must be maintained by the county/city for audit purposes.
- VI. Invoices must list **actual** expenditures made during the quarter for items approved in the budget justification worksheet, with the following exceptions:
  - A. Indirect costs are approved estimates for invoicing purposes based on federal OASC-10 cost allocation methods.
  - B. Staff benefits may be invoiced at an estimated rate for three quarters but must be adjusted to actual costs on the fourth quarter invoice.
  - C. Counties may not invoice for goods (e.g., equipment, printing, videos, etc.) until after they have actually been received. Budgeted goods that are supported by a purchase order, issued in the budget and for which funds are encumbered may not be received until the following fiscal year. These costs may be included on the fourth quarter invoice or submitted on a supplemental invoice for the fiscal year in which they were encumbered.
- VII. For questions concerning the appropriate line item usage for an expense, refer to Section 6 for the definitions of the five line item categories listed on the quarterly invoice or contact the regional administrative consultant/analyst.
- VIII. Round all figures to the nearest whole dollar; 50 cents or more is rounded up, and 49 cents and less is rounded down.

- IX. Quarterly invoices for expenditures authorized in CMS budgets shall be submitted no later than 60 days after the end of each quarter.
- A. First quarter invoice (time period of July 1 through September 30) is due by November 30.
  - B. Second quarter invoice (time period of October 1 through December 31) is due by February 28.
  - C. Third quarter invoice (time period of January 1 through March 31) is due by May 31.
  - D. Fourth quarter invoice (time period of April 1 through June 30) is due by August 31.
  - E. Supplemental invoices will only be accepted up to six months after the close of the fiscal year for which they apply. The fiscal year ends June 30; therefore December 31 would be the last day to submit supplemental invoices for any given fiscal year.
- X. Headings on invoices must contain the identification items identified below. Additional information as identified in the specific and separate California Children's Services (CCS) or Child Health and Disability Prevention (CHDP) instructions must also be provided:
- A. Program name (i.e., CCS, CHDP)
  - B. Name of county or city
  - C. Fiscal year of invoicing period
  - D. Quarter ending date
    - Quarter 1 ends September 30;
    - Quarter 2 ends December 31;
    - Quarter 3 ends March 31; and
    - Quarter 4 ends June 30.
- XI. **Signature/Certification blocks** must contain at a minimum the following, with additional information as identified in the specific and separate CCS or CHDP instructions:
- A. Contact person name and telephone number.
  - B. Signatures of authorized officials certifying the accuracy of the expenditures reported.
  - C. Date signed.

**NOTE:** Invoices submitted without signatures will be returned for authorized signatures before being processed for payment. Original signatures are required. Signature stamps are not acceptable.

- XII. Invoices that exceed budgeted funding sources or do not compute will be returned to the appropriate county for corrections.
- XIII. Agencies are responsible for federal audit exceptions and must identify the State in the event any exceptions are found.
- XIV. Numbered Letter 01-0106, California Children's Services (CCS) Expenditure Reporting to the California Department of Finance (DOF) for the purpose of Calculation of Realignment Caseload Growth, provided information on the development of the annual realignment caseload growth schedule by the California Department of Finance for programs covered by the State Local Program Realignment Initiative of 1993 which participates in caseload growth funding from the Caseload Sub-Account of the Sales Tax Growth Account of the Local Revenue Fund.

Starting with the 2006 reporting cycle, for the purpose of reporting county CCS program expenditures to DOF for calculation of Realignment Caseload Growth, a cut-off date has been established for receipt of quarterly county CCS program diagnosis, treatment, and therapy expenditure reports that will be included in the calculation of CCS services costs included in the caseload growth expenditures that will be reported to DOF for the reporting period.

For fiscal year (FY) 2005-06 expenditures which will be reported to DOF for the FY 2006-07 Realignment Caseload Growth calculations, the cut-off for receiving the diagnosis, treatment, and therapy expenditure reports will be December 31, 2006. The FY 2005-06 county expenditures reported after that date will not be reported to DOF. The Children's Medical Services Branch will continue to receive and reconcile CCS overdue expenditure reports for purposes of State/County share of cost determination after the cut-off, but this late data will not be reported to DOF and will not be included in DOF's caseload growth calculation for the reporting period.

## CHDP Quarterly Administrative Expenditure Invoice Instructions

The CHDP Quarterly Administrative Expenditure Invoice (No County/City Match) form is on Section 8, page 11. The CHDP Quarterly Administrative Expenditure invoice (County/City Match) form is on Section 8, page 12. All invoices must be prepared in accordance with these instructions in order to receive reimbursement for county/city administrative expenditures.

I. Instructions for Preparation of CHDP Quarterly Administrative Expenditure Invoices (No County/City Match)

CHPD administrative expenditures are reimbursed according to the individual county/city percentages of the Medi-Cal and non-Medi-Cal portions of the approved program's budget.

An exception to the application of the non-Medi-Cal percentage is for an expense qualifying as 100 percent Medi-Cal funded, i.e., costs of services exclusively for Medi-Cal eligibles. A county/city program having a category or line item that includes expenses designated as 100 percent Medi-Cal must asterisk (\*) the category, footnote the specific amount and have supporting documentation on file. All other expenses must have the non-Medi-Cal percentage rate of the individual county/city approved budget applied to distribute the Medi-Cal and non-Medi-Cal share of the expenses.

Column 1 will always be the sum of Column 2 and Column 3 for each category/line item. Column 3 will always be the sum of Column 4 and Column 5 for each applicable category/line item.

A. Category/Line Item

1. (I.) Total Personnel Expenses

Enter the total amount for "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total of non-Medi-Cal personnel services claimed in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the percentage of the non-Medi-Cal share on the approved budget.

Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

Enter the total amount of Medi-Cal personnel services claimed for enhanced funds in Column 4 and the total amount claimed for non-enhanced funds in Column 5. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1 on this line, the total of all operating expenses.

Enter the non-Medi-Cal amount claimed of operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for operating expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 4 and enter the non-enhanced operating expenses claimed in Column 5.

**NOTE:** Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. (III) Total Capital Expenses

Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found on Page 8-70.

Enter in Column 2, the amount of non-Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for capital expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for Capital Expenses.

Enter the Capital Expenses amount from Column 3 into Column 5, non-enhanced.

4. (IV) Total Indirect Expenses

Enter in Column 1, the total of all Indirect Expenses.

Enter the amount of non-Medi-Cal indirect expenses in Column 2. This amount is derived by multiplying the total indirect expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for indirect expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for the indirect expenses.

Enter the indirect expenses amount from Column 3 in Column 5, non-enhanced.

5. (V) Total Other Expenses

Enter the total of all other expenses on this line in Column 1.

Enter in Column 2, the non-Medi-Cal other expenses. This amount is derived by multiplying the total Other Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount claimed for other expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount in Column 1 for Other Expenses.

Enter the amount claimed for Other Expenses from Column 3 into Column 5, non-enhanced.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds

1. State

Enter the amount for State in Column 2. This amount is the same as the Expenditure Grand Total amount for TOTAL CHDP Non Medi-Cal.

2. Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal and Column 5, State/Federal.

a. Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 4, Enhanced by 25 percent and enter this amount on the State Funds line in Column 4.

Subtract the amount of State Funds for Column 4, Enhanced from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

b. Non-Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 5, Non-Enhanced by 50 percent and enter this amount on the State Funds line for Column 5.

Subtract the amount of State Funds for Column 5, Non-Enhanced from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

c. Total Medi-Cal Funds

Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

Enter in Column 3 on the Federal (Title XIX) Funds line the total of Column 4 and Column 5, Federal (Title XIX) Funds.

3. Total Funds

Enter in Column 1, Total Funds for the State Funds (non-Medi-Cal) line, the same amount as entered in Column 2, Total CHDP Funds.

Add Columns 4 and 5 together for the State Funds line under Medi-Cal Funds and enter the total in Column 3, total Medi-Cal and Column 1, Total Funds.

Add Columns 4 and 5 together for the Federal (Title XIX) Funds line and enter the total in Column 3, Total Medi-Cal Funds, and Column 1, Total Funds.

**NOTE:** The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the "Expenditure Grand Total" line.

C. Certification and Signatures

Provide a contact name and telephone number for county or city staff responsible for compiling the expenditure invoice.

Certify the accuracy and policy compliance of the reported expenditures by signing and dating the completed invoice form. Original signatures are required. Signature stamps are not acceptable.

II. Instructions for Preparation of the CHDP Quarterly Administrative Expenditure Invoice Form (County/City Match)

The county/city match invoice for expanded services for Medi-Cal recipients is 100 percent county/city funds with federal fund match. No State funds are included on this invoice.

A. Category/Line Item

1. (I) Total Personnel Expenses

Enter the total amount of "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time

study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total amount of personnel expenses invoiced in Column 2 for enhanced funding and the total amount invoiced in Column 3 for non-enhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1, the total of all operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 2 and enter the non-enhanced operating expenses claimed in Column 3.

**NOTE:** Only travel and training expenses may qualify as operating expenses for enhanced funding, and only when claimed by an SPMP following specific FFP guidelines (See Section 9).

3. (III) Total Capital Expenses

Enter the total Capital Expenses on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Page Section 8, page 88.

4. (IV) Total Indirect Expenses

Enter the total Indirect Expenses on this line in Column 1 and Column 3.

5. (V) Total Other Expenses

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds.

1. County/City Funds

County/city expenditures must meet the Federal Title XIX funding match requirements to obtain this reimbursement but county/city matching funds are not reimbursed. Therefore, a county/city fund line is not completed on the invoice form.

2. Federal (Title XIX) Funds

a. Enhanced Funds

Multiply the Enhanced "Expenditure Grand Total" amount (Column 2) by 75 percent. Enter the amount on the "Federal (Title XIX) Funds" line, Enhanced, in the "Source of Funds" section.

b. Nonenhanced Funds

Multiply the non-enhanced "Expenditure Grand Total" amount (Column 3) by 50 percent. Enter this amount on the "Federal (Title XIX) Funds" line, non-enhanced, in "Source of Funds" section.

c. Total Funds

Add Columns 2 and 3 together for the Federal (Title XIX) Funds line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Provide the contact name and telephone number of the county/city staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

Type or print the name and title of the official who signed the invoice.

**NOTE:** An original signature is required. Signature stamps are not acceptable.

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE  
 (No County / City Match)  
 FISCAL YEAR \_\_\_\_\_

MONTH/DATE/YEAR

CATEGORY/LINE ITEM	TOTAL EXPENDITURES ( COLUMNS 2 + 3)	TOTAL CHDP <i>Non Medi-Cal</i>	TOTAL MEDI-CAL (COLUMNS 4 + 5)	ENHANCED STATE/FEDERAL 25/75	NONENHANCED STATE/FEDERAL 50/50
COLUMN	1	2	3	4	5
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURE GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL	NONENHANCED STATE/FEDERAL
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					

Prepared By \_\_\_\_\_

Date \_\_\_\_\_ Telephone Number \_\_\_\_\_

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director \_\_\_\_\_

Date \_\_\_\_\_

Revision Date: November 2003

State of California - Health & Human Services Agency  
 \_\_\_\_\_ COUNTY/CITY

Department of Health Services - Children's Medical Services  
 QUARTER ENDING: \_\_\_\_\_

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE  
 (County / City Match)  
 FISCAL YEAR \_\_\_\_\_

MONTH/DATE/YEAR

CATEGORY/LINE ITEM	TOTAL EXPENDITURES ( COLUMNS 2 + 3)	ENHANCED COUNTY/FEDERAL 25/75	NONENHANCED COUNTY/FEDERAL 50/50
COLUMN	1	2	3
I. TOTAL PERSONNEL EXPENSES			
II. TOTAL OPERATING EXPENSES			
III. TOTAL CAPITAL EXPENSES			
IV. TOTAL INDIRECT EXPENSES			
V. TOTAL OTHER EXPENSES			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL	NONENHANCED COUNTY/FEDERAL
COLUMN	1	2	3
FEDERAL (TITLE XIX)			

Prepared By \_\_\_\_\_

Date \_\_\_\_\_ Telephone Number \_\_\_\_\_

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director \_\_\_\_\_

Date \_\_\_\_\_

Revision Date: November 2003

## **HCPCFC Quarterly Administrative Expenditure Invoice Instructions**

In order to receive reimbursement for Health Care Program for Children in Foster Care (HCPCFC) expenditures, the Quarterly HCPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HCPCFC Quarterly Administrative Expenditure Invoice form is found on Section 8, page 15.

The HCPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the invoice form. Local county and city Child Health and Disability Prevention (CHDP) programs administering the HCPCFC are reimbursed for the actual administrative costs according to the amount of State General Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is on Section 8, page 2.

### **A. Category/Line Item**

1. Total Personnel Expenses (see I. Total Personnel Expenses on the invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This is the total expenditure for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of state and federal funds at the enhanced percentage in Column 2.

Enter the total amount of state and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages are calculated using completed time study documents and other applicable documentation.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form)

Enter the total amount of state and federal funds for the quarter in Column 1.

Enter the total amount of enhanced travel and training expenses in Column 2.

Enter the non-enhanced travel and training expenses in Column 3.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

**NOTE:** Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see the shaded area III. Total Capital Expenses on the invoice form.)

Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Indirect expenses are non-enhanced; they may not be claimed at the enhanced rate.

Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

The Total Invoiced amount in Column 1 is the same as the amount in Column 3.

5. Total Other Expenses (see the shaded area V. Total Other Expenses on the invoice form).

Total Other Expenses are not allowed on the HCPCFC Administrative Budget.

6. Expenditure Grand Total (see Expenditure Grand Total on the Invoice form).

Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the invoice form.

B. Source of Funds

1. State

Enter the amount of state general funds expended for this quarter in Column 1.

The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Federal

Enter the amount of federal funds (Title XIX) expended for this quarter in Column 1.

The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

- a. Enhanced State/Federal (Column 2, Source of Funds)

Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

b. Non-Enhanced State/Federal (Column 3, Source of Funds)

Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

c. Expenditure Grand Total (Column 1, Source of Funds)

Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

**NOTE:** The totals of funding amount entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

**NOTE:** An original signature is required. Signature stamps are not acceptable.

Quarter ending: \_\_\_\_\_  
month/date/year

**HPCFC Quarterly Administrative Expenditure Invoice**

Fiscal Year \_\_\_\_\_

County/City Name: \_\_\_\_\_

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
<b>Expenditure Grand Total</b>	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
<b>State Funds</b>	\$0	\$0	\$0
<b>Federal Funds (Title XIX)</b>	\$0	\$0	\$0
<b>Expenditure Grand Total</b>	\$0	\$0	\$0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

CHDP Director or Deputy Director \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Signature)

## **Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster Care Quarterly Administrative Expenditure Invoice**

In order to receive reimbursement for the CHDP Program Foster Care expenditure, the Quarterly Foster Care Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The Foster Care Quarterly Administrative Expenditure Invoice form is on Section 8, page 20.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) Instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city CHDP Programs administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the Invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is on Section 8, page 2, Plan and Fiscal Guidelines Manual.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with federal funds (Title XIX) for this budget. No state general funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure Invoice form.

### **A. Category/Line Item**

1. Total Personnel Expenses (see I. Total Personnel Expenses on the Invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This amount is the total amount for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other application documentation.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form).

Enter the total amount of operating expenses for the quarter in Column 1.

Enter the total amount of enhanced operating expenses in Column 2.

Enter the non-enhanced operating expenses in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by a Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see III. Total Capital Expenses on the Invoice form).

Enter the total amount capital expenses for the quarter on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Section 8, page 88.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Enter the total amount of indirect expenses for the quarter on this line in Column 1 and Column 3.

5. Total Other Expenses (see V. Total Other Expenses on the Invoice form).

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Enter the sum of the Total Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses and Other Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds

1. County/City Funds

County/city expenditures must meet the federal funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

2. Federal Funds (Title XIX)

- a. Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the federal funds (Title XIX) line, Enhanced, in the Source of Funds section.

- b. Non-Enhanced Funds

Multiply the non-enhanced Expenditure Grand Total amount, Column 3, by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, non-enhanced in Source of Funds section.

c. Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the Foster Care Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

**NOTE:** An original signature is required. Signature stamps are not acceptable.

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Quarter ending: \_\_\_\_\_  
month/date/year

**CHDP Foster Care Quarterly Administrative Expenditure Invoice**

Fiscal Year \_\_\_\_\_  
County/City Name: \_\_\_\_\_

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
County-City Funds	\$0	\$0	\$0
Federal Funds (Title XIX)	\$0	\$0	\$0
Expenditure Grand Total	\$0	\$0	\$0

Source City-County Funds:

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

CHDP Director or Deputy Director \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Signature)

## CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS

### INITIAL INVOICE

### INSTRUCTIONS FOR COMPLETION

Beginning in fiscal year (FY) 2006-07, the terminology for caseload is changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2006-07 will now be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

A CMS Net report is being developed to request "eligible month" information. **The eligible month information will need to be processed monthly.** The eligible month information may be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months

**TOTAL                      465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

The Initial Invoice is the first invoice prepared for a quarter that is submitted to the Children's Medical Services (CMS) Branch for reimbursement. This means that no other invoice had been previously submitted to the CMS Branch for this particular quarter.

The following are instructions for the completion of the California Children's Services (CCS) Program Administrative Expenditure Invoice – Initial, which are prepared on a quarterly basis.

**Fiscal Year**

- 11) Enter the state fiscal year (FY) for which this invoice applies.

**County**

- 12) Enter the name of the county for which this invoice applies.

**Quarter**

- 13) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x  
Quarter 2: October 1, 200x – December 31, 200x  
Quarter 3: January 1, 200x+1 – March 31, 200x+1  
Quarter 4: April 1, 200x+1 – June 30, 200x+1

**CCS CASELOAD**

**Column B – Actual Caseload**

**Medi-Cal Cases**

- 14) Enter the Average Total Cases of Open (Active) Medi-Cal Children.

Calculate the average total cases by adding the total cases of open (active) Medi-Cal Children for each month in the quarter and dividing by 3.

- 15) Enter the number of Potential Cases of Medi-Cal Children.

- 16) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

**Non-Medi-Cal Cases: Healthy Families**

- 17) Enter the Average Total Cases of Open (Active) Healthy Families (HF) Children.

Calculate the average total cases by adding the total cases of open (active) HF Children for each month in the quarter and dividing by 3.

- 18) Enter the number of Potential Cases of HF Children.

- 19) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

### **Non-Medi-Cal Cases: Straight CCS**

- 20) Enter the Average Total Cases of Open (Active) Straight CCS Children.
- Calculate the average total cases by adding the total cases of open (active) Straight CCS Children for each month in the quarter and dividing by 3.
- 21) Enter the number of Potential Cases of Straight CCS Children.
- 22) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

### **Total Non-Medi-Cal Cases**

- 23) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

### **Total Caseload**

- 24) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

### **Column C – Percent of Grand Total**

#### **Medi-Cal Percentages**

- 25) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 26) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 27) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

#### **Non-Medi-Cal Percentages: Healthy Families**

- 28) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 29) Enter the percentage for Potential Cases of HF Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 30) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

### **Non-Medi-Cal Percentages: Straight CCS**

- 31) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 32) Enter the percentage for Potential Cases of Straight CCS Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 33) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

### **Total Non-Medi-Cal Cases Percentage**

- 34) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

### **Total Caseload Percentage**

- 35) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

## **ADMINISTRATIVE EXPENDITURES**

### **County**

- 36) Enter the name of the county for which this invoice applies.

### **Quarter**

- 37) Enter the dates of the quarter for which the invoice applies.

### **Column C, Total Expenditures**

- 28) Enter the total of all expenditures charged during the quarter to each category/line item listed in Column B.
- 29) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the total of respective amounts in Columns D and G.

### **Column D, Total Non-Medi-Cal**

- 30) Enter the amount of Total Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Total Non-Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Non-Medi-Cal Cases as calculated in step 24 for CCS Caseload.

The percentage for Total Non-Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Non-Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to non-Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses} \\
 - \quad \underline{\text{All M\&T Expenditures}} \\
 = \quad \text{Remaining Balance} \\
 \times \quad \underline{\text{Total Non-Medi-Cal Cases \%}} \\
 = \quad \text{Share of Total Other Expenses for Total Non-Medi-Cal Cases} \\
 + \quad \underline{\text{M\&T Expenditures for Non-Medi-Cal Clients}} \\
 = \quad \text{Amount of Total Other Expenses for Total Non-Medi-Cal Cases}
 \end{array}$$

- 31) Enter the Total Expenditures for Total Non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the total of respective amounts in Columns E and F.

### Column E, Straight CCS

- 32) Enter the amount of Straight CCS expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Straight CCS expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total Straight CCS Cases as calculated in step 23 for CCS Caseload.

- 33) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

### Column F, Healthy Families (HF)

- 34) Enter the amount of HF expenditures charged during the quarter to each category/line item listed in Column B.

The amount of HF expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total HF Cases as calculated in step 20 for CCS Caseload.

- 35) Enter the Total Expenditures for HF by adding all entries in Column F.

**Column G, Total Medi-Cal**

- 36) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column G.

The amount of Total Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Medi-Cal Cases as calculated in Step17 for CCS Caseload.

The percentage for Total Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses} \\
 - \quad \underline{\text{All M\&T Expenditures}} \\
 = \quad \text{Remaining Balance} \\
 \times \quad \underline{\text{Total Medi-Cal Cases \%}} \\
 = \quad \text{Share of Total Other Expenses for Total Medi-Cal Cases} \\
 + \quad \underline{\text{M\&T Expenditures for Medi-Cal Clients}} \\
 = \quad \text{Amount of Total Other Expenses for Total Medi-Cal Cases}
 \end{array}$$

- 37) Enter the Total Expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the total of respective amounts in Columns H and I.

**Column H, Medi-Cal Enhanced**

- 38) Enter the amount of Medi-Cal Enhanced expenditures charged during the quarter to Total Personnel Expenses and Total Operating Expenses listed in Column B.

The amount of expenditures charged to Personnel Expenses is based on time studies for:

- a. Skilled Professional Medical Personnel (SPMP) who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and
- b. Clerical staff who directly support and are supervised by the SPMP.

Only training and travel costs for SPMP are allowed as expenditures for Operating Expenses.

Medi-Cal Enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

### **Column I, Medi-Cal Non-Enhanced**

- 39) Enter the amount of Medi-Cal non-enhanced expenditures charged during the quarter to each category/line item listed in Column B.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; ancillary staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

The amount of Medi-Cal Non-Enhanced expenditures for each category/line item listed in Column B is determined by subtracting the entries in Column H from the corresponding entries in Column G.

### **Maintenance & Transportation (M&T)**

- 40) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, Straight CCS, HF, and Total Medi-Cal for M&T.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

### **SOURCE OF FUNDS**

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

### **Column M, Straight CCS**

- 41) Enter the amount of state and county funds that were used to pay straight CCS expenditures.

The funding distribution for straight CCS expenditures is 50 percent state funds and 50 percent county funds.

The amount of state funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

- 42) Enter Total Source of Funds by adding all entries in Column M.

### **Column N, Healthy Families**

- 43) Enter the amount of federal, state, and county funds that were used to pay HF expenditures.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent state funds, and 17.5 percent county funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

- 44) Enter Total source of Funds by adding all entries in Column N.

### **Column L, Total Non-Medi-Cal**

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the total of respective amounts in Columns M and N.

### **Column P, Medi-Cal Enhanced**

- 47) Enter the amount of State and Federal funds that were used to pay Medi-Cal enhanced expenditures.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent state funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

- 48) Enter Total Source of Funds by adding all entries in Column P.

### **Column Q, Medi-Cal Non-Enhanced**

- 49) Enter the amount of state and federal funds that were used to pay Medi-Cal non-enhanced expenditures.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

- 50) Enter Total Source of Funds by adding all entries in Column Q.

### **Column O, Total Medi-Cal**

- 51) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 52) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the total of respective amounts in Columns P and Q.

### **Column K, Total Expenditures**

- 53) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

- 54) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.

- 55) Enter the amounts for straight CCS state and county funds from Column M to Column K.

### Total Source of Funds

- 56) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

### CERTIFICATION

- 57) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices. Original signature is required. Signature stamps are not acceptable.
- 58) Type or print the name of the authorized official.
- 59) Enter the date that the signature was affixed.
- 60) Type or print the name of the contact person for the expenditure invoice.
- 61) Enter the telephone number for the contact person.

### SUBMISSION

- 62) Submit the invoice with original signature. Signature stamps are not acceptable.

No additional copies are required.

- 63) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

Department of Health Services  
Children's Medical Services Branch  
MS 8104  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Attention: Program Support Section

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

<u>Quarter</u>	<u>Due Date</u>
1 <sup>st</sup>	November 30, 200x
2 <sup>nd</sup>	February 28, 200x+1
3 <sup>rd</sup>	May 31, 200x+1
4 <sup>th</sup>	August 31, 200x+1

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency

Department of Health Services - Children's Medical Services Branch

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM**  
**FISCAL YEAR \_\_\_\_\_**  
**CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

**COUNTY \_\_\_\_\_**  
**QUARTER \_\_\_\_\_**

<b>CCS CASELOAD</b>	<b>ACTUAL CASELOAD</b>	<b>PERCENT OF GRAND TOTAL</b>
<i>A</i>	<i>B</i>	<i>C</i>
<b>MEDI-CAL CASES</b>		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
<b>TOTAL MEDI-CAL CASES</b>		
<b>NON-MEDI-CAL CASES</b>		
<b>HEALTHY FAMILIES (HF)</b>		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
<b>TOTAL HEALTHY FAMILIES CASES</b>		
<b>STRAIGHT CCS</b>		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
<b>TOTAL STRAIGHT CCS CASES</b>		
<b>TOTAL NON-MEDI-CAL CASES</b>		
<b>TOTAL CASELOAD</b>		

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency Department of Health Services - Children's Medical Services Branch

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

COUNTY: \_\_\_\_\_ QUARTER: \_\_\_\_\_

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL	ENHANCED	NON-ENHANCED
				CCS	FAMILIES			
		50/50		65/17.5/17.5	State/Federal		State/Federal	
		State/County		Fed/State/Co			State/Federal	
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	<b>TOTAL EXPENDITURES</b>							
	Maintenance & Transportation	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
	<b>SOURCE OF FUNDS</b>							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	<b>MEDI-CAL</b>							
	State Funds							
	Federal Funds (Title XIX)							
	<b>HEALTHY FAMILIES</b>							
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
	<b>STRAIGHT CCS</b>							
	State Funds							
	County Funds							
	<b>TOTAL SOURCE OF FUNDS</b>							

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official \_\_\_\_\_ Date \_\_\_\_\_ Type or Print Name of Contact Person \_\_\_\_\_  
 ( ) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency

Department of Health Services - Children's Medical Services Branch

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM**  
**FISCAL YEAR 2004-2005**  
**CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

**COUNTY ANYWHERE**  
**QUARTER July 1, 2004 - September 30, 2004**

<b>CCS CASELOAD</b>	<b>ACTUAL CASELOAD</b>	<b>PERCENT OF GRANT TOTAL</b>
<i>A</i>	<i>B</i>	<i>C</i>
<b>MEDI-CAL CASES</b>		
Average Total Cases of Open (Active) Medi-Cal Children	1,736	62.65%
Potential Cases of Medi-Cal Children	218	7.87%
<b>TOTAL MEDI-CAL CASES</b>	<b>1,954</b>	<b>70.52%</b>
<b>NON-MEDI-CAL CASES</b>		
<b>HEALTHY FAMILIES (HF)</b>		
Average Total Cases of Open (Active) HF Children	0	0.00%
Potential Cases of HF Children	0	0.00%
<b>TOTAL HEALTHY FAMILIES CASES</b>	<b>0</b>	<b>0.00%</b>
<b>STRAIGHT CCS</b>		
Average Total Cases of Open (Active) Straight CCS Children	631	22.77%
Potential Cases of Straight CCS Children	186	6.71%
<b>TOTAL STRAIGHT CCS CASES</b>	<b>817</b>	<b>29.48%</b>
<b>TOTAL NON-MEDI-CAL CASES</b>	<b>817</b>	<b>29.48%</b>
<b>TOTAL CASELOAD</b>	<b>2,771</b>	<b>100.00%</b>

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency Department of Health Services - Children's Medical Services Branch

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

COUNTY: ANYWHERE QUARTER: July 1, 2004 - September 30, 2004

A	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
				CCS 50/50 State/County	FAMILIES 65/17.5/17.5 Fed/State/Co			
B	C=D+G	D=E+F	E	F	G=H+I	H	I	
I.	Total Personnel Expenses	197,512	58,227	58,227	0	139,285	98,436	40,849
II.	Total Operating Expenses	49,207	14,506	14,506	0	34,701	26,507	8,194
III.	Total Capital Expenses	0	0	0	0	0		0
IV.	Total Indirect Expenses	23,611	6,961	6,961	0	16,650		16,650
V.	Total Other Expenses	8,053	1,000	1,000	0	7,053		7,053
	<b>TOTAL EXPENDITURES</b>	<b>278,383</b>	<b>80,693</b>	<b>80,693</b>	<b>0</b>	<b>197,690</b>	<b>124,943</b>	<b>72,747</b>
	Maintenance & Transportation	\$ 4,500	\$ 750	\$ 250	\$ 500	\$ 3,750		
	<b>SOURCE OF FUNDS</b>							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	<b>MEDI-CAL</b>							
	State Funds	67,609				67,609	31,236	36,373
	Federal Funds (Title XIX)	130,081				130,081	93,707	36,373
	<b>HEALTHY FAMILIES</b>							
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
	<b>STRAIGHT CCS</b>							
	State Funds	40,347	40,347	40,347				
	County Funds	40,347	40,347	40,347				
	<b>TOTAL SOURCE OF FUNDS</b>	<b>278,383</b>	<b>80,693</b>	<b>80,693</b>	<b>0</b>	<b>197,690</b>	<b>124,943</b>	<b>72,747</b>

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

					<b>Jane Doe</b>	
Signature of Authorized Official					Type or Print Name of Contact Person	
<b>Mary Smith</b>		<b>11/15/04</b>			<b>(123) 456-7890</b>	
Type or Print Name of Authorized Official		Date			Telephone Number	

## **CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL A)**

### **INSTRUCTIONS FOR COMPLETION**

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the initial invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the Children's Medical Services (CMS) Branch, and any changes that update the information previously reported on the Initial Invoice.

Example: The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1<sup>st</sup> Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1<sup>st</sup> Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1<sup>st</sup> Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1<sup>st</sup> Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part A) Invoice for the CCS Program Administrative Expenditure Invoice.

#### **Fiscal Year**

- 1) Enter the state fiscal year (FY) for which this invoice applies.

## County

- 2) Enter the name of the county for which this invoice applies.

## No.

- 3) Enter the number in the sequence of supplemental invoices submitted to the CMS Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

## Quarter

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

## CCS CASELOAD

Beginning in fiscal year (FY) 2006-07, the terminology for caseload is changed to “eligible months”. **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2006-07 will now be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

A CMS Net report is being developed to request “eligible month” information. **The eligible month information will need to be processed monthly.** At the end of the three month period the total number of “eligible months” from the three combined reports would need to be divided by three to achieve the “average caseload” number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month three = 167 eligible months

**TOTAL                      465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

## **Column B – Correct Caseload**

### **Medi-Cal Cases**

- 5) Enter the Average Total Cases of Open (Active) Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 6) Enter the number of Potential Cases of Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

### **Non-Medi-Cal Cases: Healthy Families (HF)**

- 8) Enter the Average Total Cases of Open (Active) HF Children that was previously reported on the Initial Invoice and any changes to this figure.
- 9) Enter the number of Potential Cases of HF Children that was previously reported on the Initial Invoice and any changes to this figure.
- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

### **Non-Medi-Cal Cases: Straight CCS**

- 11) Enter the Average Total Cases of Open (Active) Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 12) Enter the number of Potential Cases of Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

### **Total Non-Medi-Cal Cases**

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

### **Total Caseload**

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

### **Column C – Percent of Grand Total**

#### **Medi-Cal Percentages**

- 16) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 17) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 18) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

#### **Non-Medi-Cal Percentages: Healthy Families**

- 19) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 20) Enter the percentage for Potential Cases of HF Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 21) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

#### **Non-Medi-Cal Percentages: Straight CCS**

- 22) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 23) Enter the percentage for Potential Cases of Straight CCS Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 24) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

### **Total Non-Medi-Cal Cases Percentage**

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

### **Total Caseload Percentage**

- 26) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

## **ADMINISTRATIVE EXPENDITURES**

### **County**

- 27) Enter the name of the county for which this invoice applies.

### **No.**

- 28) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

### **Quarter**

- 29) Enter the dates of the quarter for which the invoice applies.

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

### **Column C, Total Expenditures**

- 30) Enter the amounts of Total Expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

- 31) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

### **Column D, Total Non-Medi-Cal**

- 32) Enter the amounts of total non-Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how maintenance and transportation (M&T) costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the Initial Invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Non-Medi-Cal from the Supplemental (Part) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to non-Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses (amounts previously reported and any changes)} \\
 - \quad \text{All M\&T Expenditures (amounts previously reported and any changes)} \\
 \hline
 = \quad \text{Remaining Balance (amounts previously reported and any changes)} \\
 \times \quad \text{Total Non-Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} \\
 \hline
 = \quad \text{Correct Share of Total Other Expenses for Total Non-Medi-Cal Cases} \\
 + \quad \text{Correct M\&T Expenditures for Non-Medi-Cal Clients} \\
 \hline
 = \quad \text{Correct Amount of Total Other Expenses for Total Non-Medi-Cal Cases}
 \end{array}$$

- 33) Enter the total expenditures for total non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

**Column E, Straight CCS**

- 34) Enter the amounts of straight CCS expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 35) Enter the total expenditures for straight CCS by adding all entries in Column E.

**Column F, Healthy Families (HF)**

- 36) Enter the amounts of HF expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 37) Enter the total expenditures for HF by adding all entries in Column F.

### Column G, Total Medi-Cal

- 38) Enter the amounts of total Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how M&T costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the initial invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Medi-Cal from the Supplemental (Correct) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses (amounts previously reported and any changes)} \\
 - \quad \text{All M\&T Expenditures (amounts previously reported and any changes)} \\
 \hline
 = \quad \text{Remaining Balance (amounts previously reported and any changes)} \\
 \times \quad \text{Total Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} \\
 \hline
 = \quad \text{Correct Share of Total Other Expenses for Total Medi-Cal Cases} \\
 + \quad \text{Correct M\&T Expenditures for Medi-Cal Clients} \\
 \hline
 = \quad \text{Correct Amount of Total Other Expenses for Total Medi-Cal Cases}
 \end{array}$$

- 39) Enter the total expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

### Column H, Medi-Cal Enhanced

- 40) Enter the amounts of Medi-Cal enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

Only personnel expenses and operating expenses (i.e., training and travel costs) for SPMP are allowed as expenditures for Medi-Cal Enhanced.

Medi-Cal enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

### **Column I, Medi-Cal Non-Enhanced**

- 41) Enter the amounts of Medi-Cal non-enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; associate staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

### **Maintenance & Transportation (M&T)**

- 42) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal for M&T that were previously reported on the Initial Invoice and any changes to these amounts.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

### **SOURCE OF FUNDS**

Complete the non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

### **Column M, Straight CCS**

- 43) Enter the amounts of state and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for straight CCS expenditures is 50 percent State funds and 50 percent County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

### **Column N, Healthy Families**

- 44) Enter the amounts of federal, state, and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent State funds, and 17.5 percent County funds.

The amount of federal funds is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

### **Column L, Total Non-Medi-Cal**

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

### **Column P, Medi-Cal Enhanced**

- 47) Enter the amounts of state and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal Enhanced expenditures is 25 percent State funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column H by 75 percent.

### **Column Q, Medi-Cal Non-Enhanced**

- 48) Enter the amounts of state and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

### **Column O, Total Medi-Cal**

49) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

50) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

### **Column K, Total Expenditures**

51) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

52) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.

53) Enter the amounts for straight CCS state and county funds from Column M to Column K.

### **Total Source of Funds**

54) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

### **CERTIFICATION**

55) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). An original signature is required. Signature stamps are not acceptable.

56) Type or print the name of the authorized official.

57) Enter the date that the signature was affixed.

- 58) Type or print the name of the contact person for the expenditure invoice.
- 59) Enter the telephone number for the contact person.

**SUBMISSION**

- 60) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature.

No additional copies are required.

- 61) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Services  
Children's Medical Services Branch  
MS 8104  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Attention: Program Support Section

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2005-06 ends June 30, 2006. Supplemental Invoices (Parts A and B) for FY 2005-06 are due December 31, 2006.

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM**

FISCAL YEAR \_\_\_\_\_

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)**

COUNTY \_\_\_\_\_

NO.: \_\_\_\_\_

QUARTER \_\_\_\_\_

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
<b>MEDI-CAL CASES</b>		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
<b>TOTAL MEDI-CAL CASES</b>		
<b>NON-MEDI-CAL CASES</b>		
<b>HEALTHY FAMILIES (HF)</b>		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
<b>TOTAL HEALTHY FAMILIES CASES</b>		
<b>STRAIGHT CCS</b>		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
<b>TOTAL STRAIGHT CCS CASES</b>		
<b>TOTAL NON-MEDI-CAL CASES</b>		
<b>TOTAL CASELOAD</b>		

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)**

COUNTY: \_\_\_\_\_ NO.: \_\_\_\_\_ QUARTER: \_\_\_\_\_

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	<b>TOTAL EXPENDITURES</b>							
	Maintenance & Transportation	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
	<b>SOURCE OF FUNDS</b>							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	<b>MEDI-CAL</b>							
	State Funds							
	Federal Funds (Title XIX)							
	<b>HEALTHY FAMILIES</b>							
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
	<b>STRAIGHT CCS</b>							
	State Funds							
	County Funds							
	<b>TOTAL SOURCE OF FUNDS</b>							

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official		Type or Print Name of Contact Person	( )
Type or Print Name of Authorized Official	Date	Telephone Number	

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM**  
**FISCAL YEAR 2004-2005**  
**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)**

COUNTY ANYWHERE NO.: 1  
 QUARTER July 1, 2004 - September 30, 2004

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
<b>MEDI-CAL CASES</b>		
Average Total Cases of Open (Active) Medi-Cal Children	1,736	62.65%
Potential Cases of Medi-Cal Children	218	7.87%
<b>TOTAL MEDI-CAL CASES</b>	<b>1,954</b>	<b>70.52%</b>
<b>NON-MEDI-CAL CASES</b>		
<b>HEALTHY FAMILIES (HF)</b>		
Average Total Cases of Open (Active) HF Children	95	3.43%
Potential Cases of HF Children	37	1.34%
<b>TOTAL HEALTHY FAMILIES CASES</b>	<b>132</b>	<b>4.76%</b>
<b>STRAIGHT CCS</b>		
Average Total Cases of Open (Active) Straight CCS Children	536	19.34%
Potential Cases of Straight CCS Children	149	5.38%
<b>TOTAL STRAIGHT CCS CASES</b>	<b>685</b>	<b>24.72%</b>
<b>TOTAL NON-MEDI-CAL CASES</b>	<b>817</b>	<b>29.48%</b>
<b>TOTAL CASELOAD</b>	<b>2,771</b>	<b>100.00%</b>

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)**

COUNTY: ANYWHERE NO.: 1 QUARTER: July 1, 2004 - September 30, 2004

A	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		I	
			TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL	ENHANCED		NON-ENHANCED
				CCS	FAMILIES				
			50/50	65/17.5/17.5		25/75	50/50		
			State/County	Fed/State/Co		State/Federal	State/Federal		
B	C=D+G	D=E+F	E	F	G=H+I	H	I		
I.	Total Personnel Expenses	197,512	58,227	48,825	9,402	139,285	98,436	40,849	
II.	Total Operating Expenses	49,207	14,506	12,164	2,342	34,701	26,507	8,194	
III.	Total Capital Expenses	0	0	0	0	0		0	
IV.	Total Indirect Expenses	23,611	6,961	5,837	1,124	16,650		16,650	
V.	Total Other Expenses	8,053	1,000	1,000	0	7,053		7,053	
	<b>TOTAL EXPENDITURES</b>	<b>278,383</b>	<b>80,693</b>	<b>67,826</b>	<b>12,868</b>	<b>197,690</b>	<b>124,943</b>	<b>72,747</b>	
	Maintenance & Transportation	\$ 4,500	\$ 750	\$ 250	\$ 500	\$ 3,750			
<b>SOURCE OF FUNDS</b>									
J	K=L+O	L	M	N	O=P+Q	P	Q		
<b>MEDI-CAL</b>									
	State Funds	67,609				67,609	31,236	36,373	
	Federal Funds (Title XIX)	130,081				130,081	93,707	36,373	
<b>HEALTHY FAMILIES</b>									
	State Funds	2,252	2,252		2,252				
	County Funds	2,252	2,252		2,252				
	Federal Funds (Title XXI)	8,364	8,364		8,364				
<b>STRAIGHT CCS</b>									
	State Funds	33,913	33,913	33,913					
	County Funds	33,913	33,913	33,913					
	<b>TOTAL SOURCE OF FUNDS</b>	<b>278,383</b>	<b>80,693</b>	<b>67,826</b>	<b>12,868</b>	<b>197,690</b>	<b>124,943</b>	<b>72,747</b>	

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed

Signature of Authorized Official		Jane Doe
Mary Smith	12/01/04	(123) 456-7890
Type or Print Name of Authorized Official	Date	Telephone Number

## CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL B)

### INSTRUCTIONS for COMPLETION

Beginning in fiscal year (FY) 2006-07, the terminology for caseload is changed to “eligible months”. **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2006-07 will now be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

A CMSNet report is being developed to request “eligible month” information. **The eligible month information will need to be processed monthly.** At the end of the three month period the total number of “eligible months” from the three combined reports would need to be divided by three to achieve the “average caseload” number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month three = 167 eligible months

**TOTAL                      465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the CMS Branch, and any changes that update the information previously reported on the Initial Invoice.

**Example:** The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1<sup>st</sup> Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1<sup>st</sup> Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1<sup>st</sup> Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

**Example:** When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1<sup>st</sup> Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part B) Invoice for the CCS Program Administrative Expenditure Invoice.

### **Fiscal Year**

- 1) Enter the state fiscal year (FY) for which this invoice applies.

### **County**

- 2) Enter the name of the county for which this invoice applies.

### **No.**

- 3) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

### **Quarter**

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

## **CCS CASELOAD**

### **Column B – Difference in Caseload**

#### **Medi-Cal Cases**

- 5) Enter the difference for Average Total Cases of Open (Active) Medi-Cal Children by subtracting the Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 6) Enter the difference for Potential Cases of Medi-Cal Children by subtracting the number of Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

#### **Non-Medi-Cal Cases: HF**

- 8) Enter the difference for Average Total Cases of Open (Active) Healthy Families (HF) Children by subtracting the Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) HF Children on the Supplemental (Part A) Invoice.
- 9) Enter the difference for Potential Cases of HF Children by subtracting the number of Potential Cases of HF Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

#### **Non-Medi-Cal Cases: Straight CCS**

- 11) Enter the difference by subtracting the Average Total Cases of Open (Active) Straight CCS Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Straight CCS Children on the Supplemental (Part A) Invoice.
- 12) Enter the difference by subtracting the number of Potential Cases of Straight CCS Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Straight CCS Children on the Supplemental (Part A) Invoice.

- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

**Total Non-Medi-Cal Cases**

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

**Total Caseload**

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

**Column E – Percent of Grant Total**

**Medi-Cal Cases Percentages**

- 16) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 17) Enter the difference by subtracting the percentage for Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 18) Enter the percentage for Total Medi-Cal Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

**Non-Medi-Cal Percentages: HF**

- 19) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.
- 20) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 21) Enter the percentage for Total HF Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

**Non-Medi-Cal Percentages: Straight CCS**

- 22) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.

- 23) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 24) Enter the percentage for Total Straight CCS Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

**Total Non-Medi-Cal Cases Percentage**

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

**Total Caseload Percentage**

- 26) Enter the percentage for Total Caseload by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

The Total Caseload Percentage must equal zero percent (0%).

**ADMINISTRATIVE EXPENDITURES**

**County**

- 27) Enter the name of the county for which this invoice applies.

**No.**

- 28) Enter the number in the sequence of supplemental invoices submitted to the CMS Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

**Quarter**

- 29) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x  
Quarter 2: October 1, 200x – December 31, 200x  
Quarter 3: January 1, 200x+1 – March 31, 200x+1  
Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

### **Column C, Total Expenditures**

- 30) Enter the difference for each category/line item listed in Column B by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.
- 31) Enter the difference for Total Expenditures by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

### **Column D, Total Non-Medi-Cal**

- 32) Enter the difference for each category/line item listed in Column B by subtracting the Total Non-Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 33) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Non-Medi-Cal that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

### **Column E, Straight CCS**

- 34) Enter the difference for each category/line item listed in Column B by subtracting the Straight CCS expenditures that were previously reported on the Initial Invoice from the correct Straight CCS expenditures reported on the Supplemental (Part A) Invoice.
- 35) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Straight CCS that were previously reported on the Initial Invoice from the correct Total Expenditures for Straight CCS reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column E.

### **Column F, Healthy Families (HF)**

- 36) Enter the difference for each category/line item listed in Column B by subtracting the HF expenditures that were previously reported on the Initial Invoice from the correct HF expenditures reported on the Supplemental (Part A) Invoice.
- 37) Enter the difference for Total Expenditures by subtracting the Total Expenditures for HF that were previously reported on the Initial Invoice from the correct Total Expenditures for HF reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column F.

### **Column G, Total Medi-Cal**

- 38) Enter the difference for each category/line item listed in Column B by subtracting between the Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 39) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

### **Column H, Medi-Cal Enhanced**

- 40) Enter the difference for Total Personnel Expenses and Total Operating Expenses listed in Column B by subtracting the Medi-Cal Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Enhanced expenditures reported on the Supplemental (Part A) Invoice.
- 41) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column H.

### **Column I, Medi-Cal Non-Enhanced**

- 42) Enter the difference for each category/line item listed in Column B by subtracting the Medi-Cal Non-Enhanced expenditures that were previously reported on the Initial Invoice

from the correct Medi-Cal Non-Enhanced expenditures reported on the Supplemental (Part A) Invoice.

- 43) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Non-Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Non-Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column I.

### **Maintenance & Transportation (M&T)**

- 44) Enter the differences for Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal by subtracting the Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts that were previously reported on the Initial Invoice from the correct Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts reported on the Supplemental (Part A) Invoice.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

### **SOURCE OF FUNDS**

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

#### **Column M, Straight CCS**

- 45) Enter the difference for each source of funds listed in Column J by subtracting the state and county funds that were previously reported on the Initial Invoice from the correct state and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for straight CCS expenditures is 50 percent state funds and 50 percent county funds.

The amount of state funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

- 46) Enter the Total Source of Funds by adding all entries in Column M.

### **Column N, HF**

- 47) Enter the difference for each source of funds listed in Column J by subtracting the federal, state, and county funds that were previously reported on the Initial Invoice from the correct federal, state, and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent state funds, and 17.5 percent county funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

- 48) Enter the Total Source of Funds by adding all entries in Column N.

### **Column L, Total Non-Medi-Cal**

- 49) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 50) Enter Total Source of Fund by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

### **Column P, Medi-Cal Enhanced**

- 51) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct state and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent state funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

- 52) Enter the Total Source of Funds by adding all entries in Column P.

### **Column Q, Medi-Cal Non-Enhanced**

- 53) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct state and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

- 54) Enter the Total Source of Funds by adding all entries in Column Q.

### **Column O, Total Medi-Cal**

- 55) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 56) Enter Total Source of Fund by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

### **Column K, Total Expenditures**

- 57) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

- 58) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.

- 59) Enter the amounts for straight CCS state and county funds from Column M to Column K.

### **Total Source of Funds**

- 60) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the sum of Columns M and N.

The entry in Column O must equal the sum of Columns P and Q.

The entry in Column K must equal the sum of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

### **CERTIFICATION**

- 61) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). Original signatures are required. Signature stamps are not allowed.
- 62) Type or print the name of the authorized official.
- 63) Enter the date that the signature was affixed.
- 64) Type or print the name of the contact person for the expenditure invoice.
- 65) Enter the telephone number for the contact person.

### **SUBMISSION**

- 66) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature.  
  
No additional copies are required.
- 67) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Services  
Children's Medical Services Branch  
MS 8104  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Attention: Program Support Section

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of each fiscal year.

Example: FY 2005-06 ends June 30, 2006. Supplemental Invoices (Parts A and B) for FY 2005-06 are due December 31, 2006.

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM**  
**FISCAL YEAR \_\_\_\_\_**  
**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)**

COUNTY \_\_\_\_\_ NO.: \_\_\_\_\_  
 QUARTER \_\_\_\_\_

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>

MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
<b>TOTAL MEDI-CAL CASES</b>		

NON-MEDI-CAL CASES		
<b>HEALTHY FAMILIES (HF)</b>		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
<b>TOTAL HEALTHY FAMILIES CASES</b>		
<b>STRAIGHT CCS</b>		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
<b>TOTAL STRAIGHT CCS CASES</b>		
<b>TOTAL NON-MEDI-CAL CASES</b>		

<b>TOTAL CASELOAD</b>		
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Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency

Department of Health Services - Children's Medical Services Branch

**CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)**

COUNTY: \_\_\_\_\_

NO.: \_\_\_\_\_

QUARTER: \_\_\_\_\_

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	<b>TOTAL EXPENDITURES</b>							

Maintenance & Transportation \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
<b>MEDI-CAL</b>									
	State Funds								
	Federal Funds (Title XIX)								
<b>HEALTHY FAMILIES</b>									
	State Funds								
	County Funds								
	Federal Funds (Title XXI)								
<b>STRAIGHT CCS</b>									
	State Funds								
	County Funds								
<b>TOTAL SOURCE OF FUNDS</b>									

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
Type or Print Name of Contact Person

\_\_\_\_\_  
Type or Print Name of Authorized Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

State of California - Health and Human Resources Agency		Department of Health Services - Children's Medical Services Branch	
<b>CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM</b>			
FISCAL YEAR <u>2004-2005</u>			
<b>CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)</b>			
COUNTY <u>ANYWHERE</u>		NO.: <u>1</u>	
QUARTER <u>July 1, 2004 - September 30, 2004</u>			
<b>CCS CASELOAD</b>		<b>DIFFERENCE IN CASELOAD</b>	<b>PERCENT OF GRAND TOTAL</b>
A		B	C
<b>MEDI-CAL CASES</b>			
Average Total Cases of Open (Active) Medi-Cal Children		0	
Potential Cases of Medi-Cal Children		0	
<b>TOTAL MEDI-CAL CASES</b>		0	
<b>NON-MEDI-CAL CASES</b>			
<b>HEALTHY FAMILIES (HF)</b>			
Average Total Cases of Open (Active) HF Children		95	3.43%
Potential Cases of HF Children		37	1.33%
<b>TOTAL HEALTHY FAMILIES CASES</b>		132	4.76%
<b>STRAIGHT CCS</b>			
Average Total Cases of Open (Active) Straight CCS Children		-95	-3.43%
Potential Cases of Straight CCS Children		-37	-1.33%
<b>TOTAL STRAIGHT CCS CASES</b>		-132	-4.76%
<b>TOTAL NON-MEDI-CAL CASES</b>		0	0.00%
<b>TOTAL CASELOAD</b>		0	0.00%

## CCS Quarterly Medical Therapy Program (MTP) Claims Preparation Invoice Instructions

The CCS Quarterly MTP Claims Preparation Invoice form is found on Section 8, page 69. All invoices must be prepared in accordance with these instructions in order to receive reimbursement.

Beginning in fiscal year (FY) 2006-07, the terminology for caseload is changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2006-07 will now be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

A CMS Net report is being developed to request "eligible month" information. **The eligible month information will need to be processed monthly.** At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month three = 167 eligible months

**TOTAL                      465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

### I. Instructions for preparation of the CCS Quarterly MTP Claims Preparation Invoice

CCS county programs are reimbursed for expenditures incurred in the preparation of Medi-Cal and non-Medi-Cal claims submitted to the Department of Health Services (DHS) fiscal intermediary for MTP services provided to CCS clients at a

Medical Therapy Unit (MTU)/Certified Rehabilitation Unit. Reimbursement is according to the ration of Medi-Cal caseload to non-Medi-Cal caseload.

The Medi-Cal caseload ratio is applied to the expenditures and is reimbursed at 50 percent. The non-Medi-Cal ratio is applied to the expenditures and is reimbursed at 100 percent.

A. Caseload Procedures for Reporting Caseload

1. Enter the total number of MTP clients for the quarter in the caseload data box located at the top left portion of the invoice.
2. Enter the number and percentage of Medi-Cal clients of the total MTP clients in the spaces provided.
3. Enter the number and percentage of non-Medi-Cal clients in the appropriate spaces.

B. Category/Line Items

1. (I) Total Personnel Expenses

The amounts invoiced for all employees must be supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the actual expenditures for salaries and wages of staff invoiced in Column 1.

Enter in Column 2 the amount claimed at 100 percent state reimbursement. This amount is derived by multiplying the amount in Column 1 by the percentage of non-Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

2. (II) Total Operating Expenses

Enter the actual expenditures for operating expenses in Column 1. **Do not invoice any travel and training costs on this invoice.**

Enter in Column 2, the amount of expenditures claimed at 100 percent state funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non-Medi-Cal clients.

Enter in Column 3, the amount of expenditures claims at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

3. (III) Total Capital Expenses

The definitions of equipment and guidelines for reimbursement of equipment are found on Section 8, page 84.

Enter the total Capital Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent state funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non-Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

4. (IV) Total Indirect Expenses

Enter the total of all indirect expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent state Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non-Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

5. (V) Total Other Expenses

Enter the Total Other Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent state funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non-Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

6. Expenditure Grand Total

Add Totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses, and enter the amount on this line.

C. Source of Funds

1. State General Funds

Enter in Column 2 on the State General Funds line, the amount from Column 2 of the Expenditure Grand Total.

Multiply the Expenditure Grand Total in Column 3 by 50 percent and enter this amount in Column 3 on the State General Funds line.

Add Columns 2 and 3 together and enter the sum in Column 1 on the State General Funds line.

2. County Funds

Subtract the State General Funds amount in Column 3 from the Expenditure Grand Total line in Column 3, and enter this amount on the County Funds line in Column 3 and Column 1.

D. Certification and Signatures

Provide the contact name and telephone number of the county staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

COUNTY \_\_\_\_\_

QUARTER ENDING \_\_\_\_\_

Month/Day/Year

Medical Therapy Program (MTP) CASELOAD		
	Number	%
Straight CCS		
Healthy Families		
Medi-Cal		
<b>TOTAL</b>		

**CCS QUARTERLY MEDICAL THERAPY PROGRAM**

**CLAIMS PREPARATION EXPENDITURE INVOICE**

FISCAL YEAR \_\_\_\_\_

CATEGORY/LINE ITEM	TOTAL EXPENDITURES 1	Non-M/C 100% State 2	M/C 50%State/50%County 3
<b>I. TOTAL PERSONNEL EXPENSE</b>			
<b>II. TOTAL OPERATING EXPENSE</b>			
<b>III. TOTAL CAPITAL EXPENSE</b>			
<b>IV. TOTAL INDIRECT EXPENSE</b>			
<b>V. TOTAL OTHER EXPENSE</b>			
<b>EXPENDITURE GRAND TOTAL</b>			

SOURCE OF FUNDS			
State General Funds			
County Funds			

**CERTIFICATION:**

I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

**AUTHORIZED OFFICIAL**

**CONTACT PERSON (Type or Print Name)**

**Signature**

**Date**

( ) **AUTHORIZED OFFICIAL**

**TELEPHONE NUMBER**

**(Type or Print Name)**

Revision Date: November 2003

## Instructions and Invoice Forms

### (Diagnostic, Treatment, and Therapy Expenditure Reporting)

#### PART I. SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

Open the Excel file and go to the worksheet tab labeled 'Part I Dx Trtmnt' (yellow tab if you have Microsoft Excel 2003).

- Fill in the name of your county on the line at the top left corner.
- Fill in the 'from' and 'to' date on the 'Expenditures from:' line at the top right corner of the form.

#### 1. DIAGNOSTIC Expenditures

- Enter on line **a** the total amount of Diagnostic expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports**. (If the amount is negative, enter as a negative.)
- Enter on line **b** the total of **County paid diagnostic** expenditures for the quarter. (Please note, an entry on this line should only be made if the county has prior approval from the Children's Medical Services (CMS) Branch or the transition to the fiscal intermediary (FI) provider payment processing occurred within the last 18 months of the quarter being claimed.)
- Enter on line **c** the total amount of approved diagnostic expenditure **Adjustments** (the approved adjustment documentation must be attached). The amount entered must be entered as a **positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.
- Enter on line **d** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes deposits made within the county for returned warrants and provider refunds, enter amount as a positive.)
- Lines **e** and **f** are formula driven and will calculate based on the data entered in the lines a, b, c, and d.
- Enter on line **g** the amount of **Emergency Relief Funding (100% State)**. Per H&SC Section 123945, a board of supervisors signed request is required and must be on file with CMS. The amount entered must be entered as a **positive**. (Please note: an entry on this line should only be made provided the county has prior approval and has coordinated with state personnel the correct amount.)

## 2. TREATMENT Expenditures

- Enter on line **a** the total amount of treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports** that are applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b** the sum of the three **MR-O-163(M) Monthly CCS Financial Reports**, CCS Funded totals, (AidCode 9K), Net Paid Amount. **(If the amount is negative, enter as a negative.)**
- Enter on line **c** the total of **County Paid Treatment** expenditures for the quarter (this includes county paid dental). *(Please note; an entry on this line should only be made if the county has prior approval or the transition to FI provider payment processing occurred within the last 18 months of the quarter being claimed.)*
- Enter on line **d** the total amount of approved treatment expenditure **Adjustments**, this amount also includes Delta Dental *(the approved adjustment documentation must be attached)*. The amount entered must be entered as a **positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.**
- Enter on line **e** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes returned warrants and provider refunds, enter amount as a positive.)
- Lines **f** and **g** are formula driven and will calculate based on the data entered in the lines a, b, c, d, and e.
- Enter on line **h** the amount of **Emergency Relief Funding (100% State)**. Per H&SC Section 123945, a board of supervisors signed request required and must be on file with CMS. The amount entered must be entered as a **positive**. *(Please note: an entry on this line should only be made if the county has prior approval and has coordinated with state personnel the correct amount.)*

## 3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES

Lines **a** and **b** are formula driven and will calculate from the data entered in the lines above. Line **a** represents the total reportable expenditures, and line **b** represents a gross total which is used in determining the amount of reimbursement due to the state or due to the county.

## 4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures

This line calculates the **total county share** of the CCS diagnostic and treatment expenditures for the quarter. *This amount is the total reportable county cost of the non-Medi-Cal and non-Healthy Families CCS diagnostic and treatment expenditures for the quarter. This amount does not necessarily equal the amount of the Claim for Reimbursement which is determined by a number of different variables.*

5. **ASSESSMENT FEES**

Enter in field 'a' the amount of the year to date outstanding assessment fees and enter in field 'b' the amount collected for the quarter.

6. **ENROLLMENT FEES**

Enter in field 'a' the amount of the year to date outstanding enrollment fees and enter in field 'b' the amount collected for the quarter.

**(The remaining lines on this worksheet are formula driven.)**

7. **TOTAL FEES COLLECTED**

This line calculates from the entries in lines 5 and 6.

8. **GROSS Diagnostic and Treatment Expenditures, and FEES collected**

This line will calculate from the data in the fields '3.b.' and '7'.

9. **50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED**

This field will calculate from the field on line 8.

10. **AMOUNT DUE STATE (positive) or DUE COUNTY ( negative )**

This field will pull the same amount as line 9 , and is displayed only for summary purposes.

**PART II. SUMMARY REPORT OF THERAPY EXPENDITURES**

**Open the Excel file and go to the worksheet tab labeled 'Part II Therapy' (blue tab if you have Microsoft Excel 2003).**

The format of this worksheet was previously updated to accommodate for claiming the 100 percent state reimbursable therapy services expenditures per requirements of AB-3632 (Chapter 26.5 Government Code) interagency regulations. In addition, a change in reporting and offsetting reimbursements received for Medical Therapy Program (MTP) claims submitted to Electronic Data System (EDS), County Organized Health Systems (COHS), or other plans for Medi-Cal reimbursement has been incorporated in this form. No other claiming requirements or allowable services for the MTP were changed.

Information pertaining to the expenditures claimed for the MTP can be found in the Numbered Letters 33-1293 and 35-0994. Additionally, County programs can find specific detail on the types of equipment and supplies that can be purchased and claimed through their California Children Services (CCS) MTP in the numbered letter N.L.: 13-0701, Index: Medical Therapy Program, 'Revised Interagency Agreement...'

**Header section:** Fill in the caseload fields, the county name and the 'Expenditures from' and 'to' dates of the quarter.

**SECTION I. COUNTY EMPLOYED MEDICAL THERAPY UNIT (MTU) STAFF**

The fields (columns/lines) 1 through 9, as applicable, are to be **completely** filled in by the county, *(if more space is needed an attachment with the same data requirements must be attached).*

**Column Entries:**

1. Name(s) of county employed staff.
2. Classification of the staff (corresponding to each name).
3. Monthly salary of each staff listed.
4. Full Time Equivalent (FTE) Percent

Enter in decimals the percent of staff time spent on the therapy program; an employee who is also budgeted on the administrative budget cannot have a total combined FTE percent that exceeds 100 percent.

5. Expenditures Paid for the Quarter

Multiply the monthly salary (Column 3) for each employee by three (for the three months in the quarter). Multiply the resulting amount by the FTE percent (Column 4) and enter the total in Column 5.

**Line Entries:**

6. Total Personal Services

Enter all expenditures identified in Column 5.

7. Staff Benefits

Enter the percentage paid by the county for staff benefits for county employed therapy personnel in the space provided and calculate the benefits amount by multiplying the Staff Benefit percentage by the Total Personal Services amount from Line 6 and enter the total on Line 7.

8. Other

Enter an amount **only** if your county pays an area differential for recruitment purposes. Enter the total amount of the differential paid in the reporting quarter. **DO NOT INCLUDE STAFF BENEFITS IN THIS AMOUNT. Attach a listing to the claim showing the differential paid for the quarter by classification.**

9. Travel Expenses

Enter the total amount of travel expenses for all therapy staff incurred during the reporting quarter. (See *Numbered Letters for specific allowable costs.*)

10. Total County Staff Expenditures

This line will calculate the totals for 'Section I' and 'State Share Due County'.

**SECTION II. CONTRACT THERAPISTS**

Columns 1 through 5 are to be ***completely*** filled in by the county if the county contracts for therapy (*if more space is needed, an attachment with the same data requirements must be attached*).

**Column Entries:**

1. Name(s) of contract staff/company name.
2. Job title of contract staff/number of therapists billed.
3. Hourly rate paid for each staff listed.
4. Number of hours worked for the quarter.
5. Expenditures Paid for the Quarter

Multiply the hourly rate (Column 3) by the corresponding number of hours for each contractor (Column 4) and enter the **total** in Column 5.

**Line Entry:**

6. Total Contract Staff Services

Enter on line 6.a. the total of the expenditures from Column 5. The 'State Share Due County' will calculate one half (1/2) of the amount on Line 6.a.

**SECTION III. MTP COORDINATION WITH SELPA/LEA-LIAISON ACTIVITIES AND IEP ATTENDANCE BY MTP STAFF**

Section III on this claim is specific to the MTP requirements outlined in the Interagency Regulations. The staffing levels are allocated by the state. The personal service expenditures of the staff in this section are reimbursed 100 percent by the state. This section is to be filled out using the same guidelines used in SECTION I. COUNTY EMPLOYED MEDICAL THERAPY UNIT (MTU) STAFF for data fields 1 through 9. Line 10 contains formulas to total the lines 6 through 9 and enters the amount 'State Share Due County' 100 percent.

## **SECTION IV. OTHER EXPENDITURES**

### **Lines 1, 2, and 3**

Enter on the appropriate type of expenditure claimed. **In addition, attach an itemized listing of the expenditures being claimed. (See the Numbered Letters and interagency regulations for the types of expenditures allowed.)**

### **Line 4 Total Other Expenditures**

This line contains formulas to calculate the total and the 'State Share due County'.

## **SECTION V. SUBTOTAL**

This section contains formulas and calculates accordingly.

## **SECTION VI. EDS PAID CLAIMS and ADJUSTMENTS**

### **Column Entries:**

### **Total MR-0-940 (Includes adjustments)**

Enter the sum from **MR-0-940 Monthly Expenditure Reports** of therapy expenditure totals of the three months for the quarter in the space provided. Also include the total amount of approved therapy expenditure **Adjustments** (*the approved adjustment documentation must be attached*). The cell (b.) offset to state share due county will calculate.

## **SECTION VII, VIII, and IX**

These fields contain formulas and calculate the 'State Share due County' or 'County Share Due State'; and the 'State Share due County 100%'.

## **SECTION X. TOTAL THERAPY EXPENDITURES**

Formula calculates the total therapy expenditures from the county incurred expenditures and the MR-0-940 therapy expenditures, excluding the 100 percent state reimbursed county expenditures. This amount is for display and posting purposes only.

## **SECTION XI. MTU MEDI-CAL / COHS PAID THERAPY**

Enter the total amount of reimbursements received from EDS for claims billed to Medi-Cal and from COHS or other plans. The total County Share Due State will calculate. Total will post to Claim for Reimbursement summary.

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## **INSTRUCTIONS FOR CCS CLAIM FOR REIMBURSEMENT**

### **Diagnostic / Treatment / Therapy**

**Open the Excel file and go to the worksheet tab labeled: "Claim for Reimb" (green tab if you have Microsoft Excel 2003).**

This worksheet was developed to calculate the amount of reimbursement due to the state or due to the county from the two separate worksheets, 'Part I DX Trtmnt' (yellow tab) and 'Part II Therapy' (blue tab). The only entries the county will make are as follows:

#### **Heading**

The county will enter the county 'name', the 'fiscal year', and the 'from' and 'to' dates for the quarter being claimed.

No other data, or field entries are required before printing, however, the date fields and telephone number fields may be entered before printing the form.

Print out the worksheets, review for completeness, and have them signed by the appropriate staff. Signature stamps are not acceptable. Send the original signed copy of the 'Claim for Reimbursement' and Parts I and II, including the required attachments, to:

**Children's Medical Services Branch**

**Program Support Section, Fiscal Unit**

**MS 8104**

**P.O. Box 997413**

**Sacramento, CA 95899-7413**

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## INSTRUCTIONS FOR CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

The worksheet is labeled 'CCS HF' (orange tab if you have Microsoft Excel 2003). Open the Excel file and go to the applicable worksheet tab for HF.

Fill in the 'fiscal year', county 'name', and the 'Expenditures from' and 'to' dates for the quarter being reported.

### 1. HF TREATMENT

- Enter on line **a** the total amount of HF Treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports applicable**. (If the amount is negative, enter as a negative.)
- Enter on line **b** the sum of the three **MR-O-163(M) Monthly CCS Financial Reports, CCS HF (9H) FUNDED TOTALS, (Aid Code 9K), Net Paid Amount**. (If the amount is negative, enter as a negative.)
- Enter on line **c** the total amount of approved HF Treatment expenditure **Adjustments (only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached)**. The amount entered must be entered as a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.
- Enter the amount of county paid HF treatment expenditures on line **d** (this includes county paid dental, also). (**Pre-approval by CMS must be attached or on file in the CMS Fiscal Unit**).
- Line **e** will calculate the total HF Treatment expenditures.

### 2. HF THERAPY

'HF Therapy' expenditures are payments to vendors, and are provided in lieu of the County MTP for HF. HF therapy expenditures should only be coded and paid from this fund source when services have been provided to HF clients.

- Enter on line **a** the total amount of HF therapy expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. (If the amount is negative, enter as a negative.)
- Enter on line **b** the total amount of approved HF therapy expenditure **adjustments (only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached)**. The amount entered must be entered as a

**positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.**

- Enter on line **c** the amount of County Paid HF Therapy expenditures (***pre-approval by CMS must be attached or on file in the CMS Fiscal Unit***).
- Line **d** calculates the total HF Therapy expenditures.

**3. TOTAL HEALTHY FAMILIES EXPENDITURES**

Formula will calculate from the entries made in HF Treatment and HF Therapy. This amount is rounded to the nearest dollar.

**4. FUNDING SOURCES**

The funding sources for **a** Total HF expenditures and adjustments; **b** Total County Paid; and **c** Total HF Expenditure Funding Sources are formula driven.

**5. AMOUNT DUE**

Amount due is formula driven and calculates the **Amount due State or Amount due County**

No other data, or field entries are required before printing, however, the date fields and phone number field may be entered before printing the form.

Print out the worksheet, review for completeness, and have it signed by the appropriate staff. Signature stamps are not acceptable. Send the original signed copy of the 'CCS HEALTHY FAMILIES QUARTERLY REPORT OF EXPENDITURES' including required attachments, to:

**Children's Medical Services Branch**

**Program Support Section, Fiscal Unit**

**MS 8104**

**P.O. Box 997413**

**Sacramento, CA 95899-7413**

State of California - Health and Human Services Agency

Department of Health Services

**CCS CLAIM FOR REIMBURSEMENT**  
**DIAGNOSTIC/TREATMENT/THERAPY**

To: STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES

CLAIM OF: \_\_\_\_\_ COUNTY

FISCAL YEAR: \_\_\_\_\_

FOR EXPENDITURES INCURRED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

(PURSUANT TO SECTIONS 123800-123995 OF THE HEALTH AND SAFETY CODE, AND RELATED LEGISLATION)

<b>PART I</b>	<b>DIAGNOSTIC AND TREATMENT</b> ( <i>amount from Lines</i> are from the CCS QUARTERLY REPORT OF EXPENDITURES, PART I)	<b>Positive amount = due State; negative (-) amount = due County. Except line 11&amp;12 display as a positive, the amount due County (line 11) or due</b>
1.	DIAGNOSTIC - ( <i>amount from Line 1. f.</i> )	[ ] \$0
	<b>1.a. County Share (50% of line 1. above or adjusted for relief)</b>	[ ] \$0
2.	TREATMENT - ( <i>amount from Line 2. f.</i> )	[ ] \$0
	<b>2.a. County Share (50% of line 2. above or adjusted for relief)</b>	[ ] \$0
3.	Subtotal COUNTY SHARE Diagnostic & Treatment (line 1.a.+ line 2.a.) <i>positive amount = amount due State, negative (-) amount = amount due County</i>	[ ] \$0
4.	TOTAL Fees Collected	[ ] \$0
	<b>4.a. County Share (50% of line 4. above)</b>	[ ] \$0
5.	<b>TOTAL PART I (line 3. + line 4.a.)</b> <i>positive amount = amount due State, negative (-) amount = amount due County</i>	[ ] \$0
<b>PART II</b>	<b>MEDICAL THERAPY PROGRAM</b> (amounts are from CCS QUARTERLY REPORT OF EXPENDITURES, PART II)	
6.	Total County Share ( <i>amount from Section VII or Section VIII</i> )	[ ] \$0
7.	Total 100% Reimbursable to County ( <i>from Section IX, as applicable</i> )	[ ] \$0
8.	Total Medi-Cal /COHS due State ( <i>amount from Section XI</i> )	[ ] \$0
9.	<b>TOTAL PART II (sum of lines 6, 7, &amp; 8)</b>	[ ] \$0
<b>PART III</b>	<b>TOTAL CLAIM FOR REIMBURSEMENT</b>	
10.	<b>TOTAL OF PART I and PART II (Line 5 + Line 9)</b>	[ ] \$0
11.	<b>AMOUNT DUE COUNTY</b>	[ ] \$0
	<b>or</b>	
12.	<b>AMOUNT DUE STATE</b>	[ ] \$0

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: \_\_\_\_\_ Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

CCS QUARTERLY REPORT OF EXPENDITURES

DIAGNOSTIC AND TREATMENT

\_\_\_\_\_ COUNTY Expenditures from: \_\_\_\_\_ to: \_\_\_\_\_  
(Per H&S Code, Sections 123800-123996 and related legislation)

**PART I SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES**

**1. DIAGNOSTIC Expenditures**

- a. MR-0-940 \$ \_\_\_\_\_
- \* b. County paid diagnostic (*requires approval*) \_\_\_\_\_
- c. Adjustments (approval documentation must be attached) \_\_\_\_\_  
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.
- d. Misc. Revenue & Refunds \_\_\_\_\_
- e. Net Diagnostic Expenditures = a + b + c - d **\$0**  
the 'Net' amount represents total reportable expenditures less revenues & refunds
- f. Gross Diagnostic = a - b + c + d **\$0**  
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).
- g. Emergency Relief Funding (100% State) \$ \_\_\_\_\_  
H&S Code Section 123945, Bd of Supvs signed request required & on file
- \* *transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.*

**2. TREATMENT Expenditures**

- a. MR-0-940 \$ \_\_\_\_\_
- b. MR-0-163 (M) Delta Dental \_\_\_\_\_
- \* c. County paid treatment (*requires approval*) \_\_\_\_\_
- d. Adjustments (approval documentation must be attached) \_\_\_\_\_  
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.
- e. Misc. Revenue & Refunds \$ \_\_\_\_\_
- f. Net Treatment Expenditures = a + b + c + d - e **\$0**  
the 'Net' amount represents total reportable expenditures less revenues & refunds.
- g. Gross Treatment = a + b - c + d + e **\$0**  
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).
- h. Emergency Relief Funding (100% State) \$ \_\_\_\_\_  
H&S Code Section 123945, Bd of Supvs signed request required & on file.
- \* *transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.*

**3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES**

- a. Net Diagnostic and Treatment (1.e. + 2.e.) **\$0**
- b. Gross Diagnostic and Treatment (1.f. + 2.f.) **\$0**

**4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures**  
(amount reportable as actual County share of expenditures) **\$0**

- 5. ASSESSMENT FEES a. receivables \_\_\_\_\_ b.collected \_\_\_\_\_
- 6. ENROLLMENT FEES a. receivables \_\_\_\_\_ b.collected \_\_\_\_\_

**7. TOTAL FEES COLLECTED** **\$0**

**8. GROSS Diagnostic and Treatment Expenditures, and Fees collected** **\$0**  
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

**9. 50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED** **\$0**

**10. AMOUNT DUE STATE (positive) or DUE COUNTY (-)** **\$0**  
AMOUNT DUE may change if any State approved adjustments were entered by the State during processing.

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

County: \_\_\_\_\_

CCS QUARTERLY REPORT OF EXPENDITURES  
 MEDICAL THERAPY PROGRAM  
 Part II. Summary Report of Therapy Expenditures

Expenditures from \_\_\_\_\_ to: \_\_\_\_\_  
 per Health and Safety Code Sections 123800-123995

MTP Caseload	
non M-C:	
Medi-Cal:	
Total:	0

SECTION I. COUNTY EMPLOYED MTU STAFF (excluding staff designated as MTP liaison and for IEP attendance)

1. NAME	2. CLASSIFICATION	3. MONTHLY SALARY	4. FTE PERCENT	5. EXPENDITURES PAID FOR QUARTER

- 6. Total Personal Services \_\_\_\_\_
- 7. Staff Benefits-----%. \_\_\_\_\_
- 8. Other (attach documentation) \_\_\_\_\_
- 9. Travel Expenses \_\_\_\_\_
- 10. TOTAL COUNTY STAFF EXPENDITURES a. **\$0**

b. State Share Due County (50%) **\$0**

SECTION II. CONTRACT THERAPISTS

1. NAME	2. JOB TITLE	3. HOURLY RATE	4. NUMBER OF	5. EXPENDITURES PAID FOR QUARTE

*The county certifies that it invoices the State for reimbursement of contract physical therapists (PT) and occupational therapists (OT) at the same rate it pays county employed Ots and PTs, including benefits. The difference in the higher rate of pay for contract positions will be paid 100% from county funds, unless specifically preapproved and authorized as a area of critical need by the State Children's Medical Services Branch. Please notate on separate attachment for any costs that are not reimbursed by the State.*

- 6. TOTAL CONTRACT STAFF SERVICES a. \_\_\_\_\_

b. State Share Due County (50%) **\$0**

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

County: \_\_\_\_\_

**CCS QUARTERLY REPORT OF EXPENDITURES**  
**MEDICAL THERAPY PROGRAM**  
**Part II. Summary Report of Therapy Expenditures**

Expenditures from \_\_\_\_\_ to: \_\_\_\_\_  
 per Health and Safety Code Sections 123800-123995

**SECTION III. MTP COORDINATION with SELPA/LEA -LIAISON ACTIVITIES and IEP ATTENDANCE BY MTP STAFF**

1. NAME	2. CLASSIFICATION	3. MONTHLY SALARY	4. FTE PERCENT	5. EXPENDITURES PAID FOR QUARTE
6. Total Personal Services _____ 7. Staff Benefits @ _____% _____ 8. Other (attach documentation) _____ 9. Travel Expenses _____ 10. TOTAL COUNTY STAFF EXPENDITURES a. <b>\$0</b>				
			b. State Share Due County (100%)	<b>\$0</b>

**SECTION IV. OTHER EXPENDITURES (attach documentation)**

1. MTU Supply & Equipment Expenditures _____ 2. MTU Conference Expenditures _____ 3. Other (misc.) _____ 4. Total Other Expenditures a. <b>\$0</b>				
			b. State Share Due County (50%)	<b>\$0</b>

**SECTION V. SUBTOTAL -Add SECTIONS I, II, and IV**

a. <b>\$0</b>			b. TOTAL State Share Due County (50%)	<b>\$0</b>
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**SECTION VI. EDS PAID CLAIMS and ADJUSTMENTS**

Total MR-O-940 (Includes adjustments)				
a. <b>\$0</b>			b. Offset to State Share Due County (50%)	<b>\$0</b>

**SECTION VII. TOTAL STATE SHARE AT 50% DUE COUNTY**

If Section V is greater than Section VI, subtract Section VI from Section V.

State Share Due County **\$0**

**SECTION VIII. TOTAL COUNTY SHARE DUE STATE**

If Section VI is greater than Section V, subtract Section V from Section VI.

County Share Due State **\$0**

**SECTION IX. TOTAL STATE SHARE AT 100% DUE COUNTY from SECTION III**

State Share Due County (100%) **\$0**

**SECTION X. TOTAL THERAPY EXPENDITURES (excludes 100% State reimbursed)** **\$0**

**SECTION XI. MTU MEDI-CAL / COHS PAID THERAPY** 0.00

County Share Due State **\$0**

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: \_\_\_\_\_

\_\_\_\_\_ COUNTY Expenditures from: \_\_\_\_\_ to: \_\_\_\_\_  
(Per H&S Code, Sections 123800-123995 and related legislation)

**1. HF TREATMENT**

- a. MR-0-940 \$ \_\_\_\_\_
- b. MR-0-163 (M) Delta Dental \_\_\_\_\_
- \* c. Treatment Adjustments (fiscal intermediary related, MR-0-940 only) \_\_\_\_\_
- d. County Paid HF Treatment \_\_\_\_\_
- e. Total HF Treatment (a. + b. + c. + d.) \$0

\* Approval documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.

**2. HF THERAPY**

- a. MR-0-940 \$ \_\_\_\_\_
- \* b. Therapy Adjustments (fiscal intermediary related, MR-0-940 only) \_\_\_\_\_
- c. County Paid HF Therapy \_\_\_\_\_
- d. Total HF Therapy (a.+ b.+c.) \$0

\* Adjustments of FI paid claims only, documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.

**3. TOTAL HEALTHY FAMILIES EXPENDITURES (Total is rounded to nearest dollar)** \$0

**4. FUNDING SOURCES**

	Federal Title XXI	State	County
a. Total MR-0-940 and Adjustments	\$0	\$0	\$0
b. Total County Paid	\$0	\$0	\$0
c. Total HF Expenditure Funding Sources	\$0	\$0	\$0

**5. AMOUNT DUE (formula will calculate) :**

**Amount due STATE** \$0  
 or  
**Amount due COUNTY** \$0

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 10990 to 10996 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

## **Management of Equipment Purchased with State Funds**

### **I. County/City Guidelines for Equipment**

All equipment purchased with funds furnished in whole or in part by the State under the terms of this agreement shall be the property of the State and shall be subject to the following provisions.

- A. The county/city shall use its own procurement process when purchasing equipment. The cost of equipment includes the purchase price plus all costs to acquire, install, and prepare equipment for its intended use. Examples of items may include computers, printers, photocopiers, etc.
- B. All equipment purchased under this agreement shall be used only to conduct business related to programs funded by Children's Medical Services (CMS) Branch.
- C. The county/city shall maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of state property to assure its full availability and usefulness.
- D. The county/city shall forward to the CMS Branch regional office a list of all new equipment purchased on the "Contractor Equipment Purchased with DHS Funds" form (HAS 1203) <http://www.dhs.ca.gov/publications/forms/pdf/has1203.pdf> (see page 86). The regional office will forward the HAS 1203 to the Branch's Administration Unit, Program Support Section. The Administration Unit will contact the Department's Asset Management for identification tags. Asset Management is responsible for inventory and control of equipment. Asset Management staff will determine which type of tag should be applied to the pieces of equipment. Each piece of equipment will retain the same tag number for its duration. All equipment must have State identification tags affixed to the front left-hand corner. Identification tags will be forwarded to the contact person on the HAS 1203.
- E. Invoices for budgeted equipment purchases are to be submitted with their quarterly invoice only after the equipment is received.
- F. The county/city shall submit an annual inventory of state-purchased equipment on the form entitled "Inventory/Disposition of DHS-Funded Equipment" (HAS 1204) <http://www.dhs.ca.gov/publications/forms/pdf/has1204.pdf> (see page 88). This form has a dual purpose; it serves to provide an inventory to Asset Management of the Department's assets and to notify Asset Management when disposal of those assets is needed.
- G. Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report.

- H. Management of all county/city equipment purchased with State funds shall be coordinated through the CMS Administrative Consultant in accordance with the procedures described in Section II below.

## **II. Tagging and Disposal of State Purchased Equipment**

- A. Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602, as all equipment with a unit cost of \$5,000 or more and a life expectancy of more than four years that is used to conduct state business.
- B. In response to the HAS 1203 received from the county/city, the CMS Branch Administrative Consultant forwards state tag(s) to the county/city with an equipment identification tag transmittal letter.
- C. State-purchased equipment used by counties/cities in performance of CMS program obligations must be disposed of according to DHS procedures. Disposition occurs when funding is terminated; the useful life of the equipment is expended; the equipment is determined by the State to be obsolete for purpose for which it was intended; or any other reason deemed by the State to be in its own best interest.
  - 1. The county/city representative submits a written request to the CMS Branch Regional Administrative Consultant to dispose of equipment, or the CMS Branch Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.
  - 2. The CMS Branch Regional Administrative Consultant notifies the DHS Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Property Survey Report (STD 152) <http://www.osp.dgs.ca.gov/StandardForms/fill+and+Print+Standard+efor+ms.htm> (see Page 90).



**INSTRUCTIONS FOR HAS 1203  
(Please read carefully.)**

The information on this form will be used by the California Department of Health Services (DHS) Asset Management (AM) to track contract equipment and miscellaneous property (see definitions A, B, and C) which is purchased with DHS funds and is used to conduct state business under this contract. After the Standard Agreement has been approved and each time state/DHS equipment and/or miscellaneous property has been received, the DHS Program Contract Manager is responsible for obtaining the information from the Contractor and submitting this form to DHS AM. The DHS Program Contract Manager is responsible for ensuring the information is complete and accurate. (See *Health Administrative Manual (HAM)*, Section 2-1060 and Section 9-2310.)

Upon receipt of this form from the DHS Program Contract Manager, AM will fill in the assigned state/DHS property tag number, if applicable, for each item. AM will return the original form to the DHS Program Contract Manager, along with the appropriate property tags. The DHS Program Contract Manager will then forward the property tags and the original form to the Contractor and retain one copy until the termination of this contract. The Contractor should place property tags in plain sight and, to the extent possible, on the item's front left-hand corner. The manufacturer's brand name and model number are not to be covered by the property tags.

1. If the item was shipped via the DHS warehouse and was issued a state/DHS property tag by warehouse staff, fill in the assigned property tag. If the item was shipped directly to the Contractor, leave the first column blank.
2. Provide the quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of:
  - A. **Major Equipment:**
    - Tangible item having a base unit cost of \$5,000 or more and a life expectancy of one (1) year or more.
    - Intangible item having a base unit cost of \$5,000 or more and a life expectancy of one (1) year or more (e.g., software, video).**These items are issued green numbered state/DHS property tags.**
  - B. **Minor Equipment:** Tangible item having a base unit cost less than \$5,000 with a life expectancy of one (1) year or more and listed on DHS AM's "Minor Equipment List". (A "Minor Equipment List" can be printed from HAM Section 2-1030.) **These items are issued green numbered state/DHS property tags.**
  - C. **Miscellaneous Property:** Specific tangible items with a life expectancy of one (1) year or more that are purchased with DHS funds (furniture, cabinets, typewriters, desktop calculators, portable dictators, nondigital cameras.) **These items are issued green unnumbered "BLANK" state/DHS property tags.** NOTE: It is DHS policy not to tag modular furniture. (See your Federal rules, if applicable.)
3. Provide the DHS Purchase Order (STD 65) number if the items were purchased by DHS. (See HAM, Section 2-1050.1.)
4. If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHS Vehicle Services. (See HAM, Section 2-10050.)
5. If all items being reported do not fit on one form, make copies and write the number of pages being sent in the upper right-hand corner (e.g., "Page 1 of 3.") The DHS Program Contract Manager should retain one copy and send the original to: Department of Health Services, Asset Management, P.O. Box 997413, 1501 Capitol Avenue, Suite 71.2101, MS 1405, Sacramento, CA 95899-7413.
6. Property tags that have been lost or destroyed must be replaced. Replacement property tags can be obtained by contacting AM (916) 650-0124.
7. Use the version on the DHS Intranet forms site. The HAS 1203 consists of one page for completion and one page with information and instructions.

HAS 1203 (3/06)



**INSTRUCTIONS FOR HAS 1204**  
**(Please read carefully.)**

The information on this form will be used by the California Department of Health Services (DHS) Asset Management (AM) to: (a) conduct an inventory of DHS equipment and property (see definitions A, B, and C) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items' ages, per number 1 below, purchased with DHS funds and used to conduct state business under this contract. (See *Health Administrative Manual (HAM)*, Section 2-1060 and Section 9-2310.)

The DHS Program Contract Manager is responsible for obtaining information from the Contractor for this form. The DHS Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

**Inventory:** List all DHS tagged equipment and miscellaneous property on this form and submit it within 30 days prior to the three-year anniversary of the contract's effective date, if applicable. The inventory should be based on previously submitted HAS 1203s, "Contractor Equipment Purchased with DHS Funds." AM will contact the DHS Program Contract Manager if there are any discrepancies. (See HAM, Section 2-1040.1.)

**Disposal:** (*Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).*) The HAS 1204 should be completed, along with a "Property Survey Report" (STD. 152) or a "Property Transfer Report" (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the DHS Program Contract Manager to arrange for the appropriate disposal/transfer of the items. (See HAM, Section 2-1050.4.)

1. List the state/DHS property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;
  - A. Major Equipment: (These items were issued green numbered state/DHS property tags.)
    - Tangible item having a base unit cost of \$5,000 or more and a life expectancy of one (1) year or more.
    - Intangible item having a base unit cost of \$5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)
  - B. Minor Equipment: (These items were issued green numbered state/DHS property tags.)
    - Tangible item having a base unit cost less than \$5,000 with a life expectancy of one (1) year or more and listed on DHS AM's "Minor Equipment List". (A "Minor Equipment List" can be printed from HAM, Section 2-1030.)
  - C. Miscellaneous Property: (These items were issued green unnumbered "BLANK" state/DHS property tags.)
    - Specific tangible items with a life expectancy of one (1) year or more that are purchased with DHS funds (furniture, cabinets, typewriters, desktop calculators, pocket dictators, nondigital cameras.)
2. If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHS Vehicle Services. (See HAM, Section 2-10050.)
3. If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right-hand corner (e.g. "Page 1 of 3.")
4. The DHS Program Contract Manager should retain one copy and send the original to: Department of Health Services, Asset Management, P.O. Box 997413, 1501 Capitol Avenue, Suite 71.2101, MS 1405, Sacramento, CA 95899-7413.
5. Use the version on the DHS Intranet forms site. The HAS 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 650-0124.

HAS 1204 (3/06)

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2006-07

STATE OF CALIFORNIA  
**PROPERTY SURVEY REPORT**  
STD. 152 (REV. 9-2003)

*Record as of disposition data (lost, stolen or destroyed property—record as of the date such determination was made).*

Authority is requested to dispose of the following State property:

**Print**      **Clear**

RETURN TO: REPORTING DEPARTMENT/AGENCY      ATTENTION      DOCUMENT NUMBER

RETURN ADDRESS      INS CODE      DATE

CITY      ZIP CODE      REPLACEMENTS: SEE PURCHASE ESTIMATE NUMBER

FUND OWNED BY      CONTACT PERSON      TELEPHONE NUMBER

ATTACHED

ITEM--DESCRIPTION, MODEL NUMBER, SERIAL NUMBER, ETC.	STATE IDENT. NO. (1)	DATE PURCHASED	ORIGINAL COST	LOCATION (CITY)	PRESENT CONDITION	DISP. CODE*	PRICE OFFERED (2)	PRICE RECEIVED (3)	RECEIPT NUMBER
1.									
2.									
3.									
4.									
5.									
6.									
7.									

(1) PROPERTY TAG NUMBER OR NUMBER FOR VEHICLE      (2) DO NOT OBTAIN BIDS ON TRADE-INS. ESTIMATE PRICE OFFERED      (3) AMOUNT ALLOWED IF TRADED IN OR SOLD

<p><b>*DISPOSITION CODE</b></p> <p>1. TRADE-IN 2. SALE (INCLUDING JUNK SALE) 3. JUNK-VALUELESS 4. LOST** 5. STOLEN** 6. DESTROYED (AS BY FIRE, ETC.)** } DEPARTMENT OF GENERAL SERVICES REVIEW NOT REQUIRED 7. TO BE SALVAGED 8. PROPERTY REUTILIZATION—GENERAL SERVICES, SURPLUS PROPERTY</p> <p style="font-size: x-small;">**IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 9840 FOR INSTRUCTIONS</p>	<p>EXPLANATION—REASONS FOR PROPOSED DISPOSITION OF EACH ITEM</p>
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<p><b>APPROVED BY PROPERTY SURVEY BOARD</b></p> <p style="font-size: x-small;">(A minimum of two signatures is required)</p> <p>The above statements regarding state property are true and correct; culpable negligence (check appropriate box)</p> <p><input type="checkbox"/> was      <input type="checkbox"/> was not</p> <p>involved in loss, theft, or damage; the disposition proposed is best for the public interest.</p> <p>SIGNATURE      DATE SIGNED</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p><b>CERTIFICATION OF DISPOSITION</b></p> <p>The above described property was disposed of as follows: (specify if no consideration was received)</p> <p>MANNER OF DISPOSAL</p> <p>DISPOSAL DATE</p> <p>SIGNATURE (Officer Suspending Disposal of the Property)</p> <p>TITLE</p>	<p><b>REVIEWED BY DEPT. OF GENERAL SERVICES</b></p> <p>FOR DGS REVIEW, SEND TO: Department of General Services, State Agency for Surplus Property</p> <p>NORTH: 1700 National Drive, Sacramento, CA 95834      SOUTH: 701 Burning Tree Road, Fullerton, CA 92833</p> <p>FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO: Department of General Services, Office of Fleet Administration, 802 J Street, Sacramento, CA 95814</p> <p>SIGNATURE</p> <p>DATE SIGNED</p>
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**(DO NOT USE HALF SHEETS OR STAPLES)**

1228RT.PRP

## Equipment Identification Tag Transmittal Letter

Date

County/City Program

Address

City, State Zip Code

Dear \_\_\_\_\_:

### EQUIPMENT IDENTIFICATION TAG TRANSMITTAL

In accordance with State requirements for equipment management, this equipment identification tag transmittal is being issued in response to your request dated \_\_\_\_\_ and detailed on the "Contractor Equipment Purchased with DHS Funds" form (HAS 1203). The enclosed Department of Health Services Equipment identification tag(s) is/are to be affixed by County/City staff to the equipment as follows:

#### ITEM DESCRIPTION

#### STATE ID NUMBER

- 1.
- 2.
- 3.
- 4.

All tags must be placed on the front left-hand corner of the item. Manufacturer's marks must be left intact.

If you have any questions regarding the instructions in this letter or the appropriate procedures for affixing the enclosed tag(s), please contact me at (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_.

Sincerely,

(State CMS Branch Staff Name)

Administrative Consultant

Children's Medical Services Branch