Quality Assurance Fee (QAF) - Monthly Day Treatment Costs Payment Designated Intermediate Care Facility (DICF)

Month & Year: _____

Facility Name:
Address:

National Provider Identifier:

Due Date:

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1780	000	00	H	125600	59	84005	A15	3213

Completion and submission of this form is mandatory.

Please complete this form and return with payment by due date to:

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Supplemental Services Summary Claim (Invoice):

a. Provided by Department of Developmental Services
b. Delinquent QAF Day Treatment Costs will subject the facility to the same penalties authorized by Health and Safety Code, § 1324 – 1324.14

1. Enter your Vendor number, located at the top of the **ICF Supplemental Services Remittance Advice**. (Example: 000ICF0199-09)

   _____

2. QAF Day Treatment Costs (including non-Medical Transportation). **Please enter information from the ICF Supplemental Services Summary Claim (Invoice).**

   a. Line 7 - Summary Claim (Invoice) $_____

   b. Total Claims (Revenue) $_____ Qtr/Yr _____

3. Enter Amount from 2a. **This is your QAF Day Treatment Costs**.

   $_____

I am an administrator, officer, or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, correct, and complete**.**

_____ _____
Print name and title of person signing declaration Phone

_____ _____
Original signature Date E-mail

The information requested on this form is required by the Department of Health Care Services, Third Party Liability and Recovery Division, and will be used for the sole purpose of processing QAF payments.