



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

**AB 85/SB 98 FY 2015-16 Interim Data Submission
County Certification Form**

_____ County chooses the option selected below to
County Name

determine interim payments to the Family Support Subaccount for fiscal year 2015-16:

- Historical Realignment Percentage** – The County’s historical realignment percentage will be applied to the projected realignment available provided by the Department of Finance.
- County Savings Determination Process** - The formula pursuant to Welfare and Institutions (W&I) Code, Section 17613.1 using projected data.

I hereby certify, that the option selected above is the option that said county will pursue in determining the county’s interim redirection amount. If said county selected the County Savings Determination Process, said county certifies, under penalty of perjury, that the amounts and projected amounts reported in the data submission form and supporting documentation in said county for said period are, to the best of my knowledge, true and accurate based on county data at the time of submission.

County Official: _____ Date: _____
Signature

County Official Title: _____

County Name: _____

Primary Contact: _____ Alternate: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Submit completed form to:
DEPARTMENT OF HEALTH CARE SERVICES
REALIGNMENT UNIT
P.O. BOX 997436, MS 4519
SACRAMENTO, CA 95899-7436
EMAIL: AB85@dhcs.ca.gov