



TOBY DOUGLAS
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

**AB 85 Data Submission
County Certification Form**

I hereby certify, under penalty of perjury, that the amounts reported in the data submission form and supporting documentation in said county for the period of _____ / _____ through _____ / _____ are, to the best of my knowledge, true and accurate.

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 997413
EMAIL: AB85@dhcs.ca.gov