



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

**AB 85/SB 98 FY 2014-15 Final Data Submission
County Certification Form**

I hereby certify, under penalty of perjury, that the amounts reported in the data submission form and supporting documentation on behalf of the County of _____, 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 95899-7436

Email: AB85@dhcs.ca.gov