



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 on behalf of the County of \_\_\_\_\_, for the period of \_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_ are, to

the best of my knowledge, true and accurate. To the extent that the cost and revenue data and documentation include estimates, the estimates are based on the best available data determined based on the County's good faith interpretation of applicable rules, and are subject to any disclosures made by the County at the time of original submission of such data to the State.

To the extent that the amounts rely on estimates which are based on data from the Department of Health Care Services (DHCS), I understand those estimates are based on DHCS' best available information at the time provided.

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](mailto:AB85@dhcs.ca.gov)