



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 Projected 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