



TOBY DOUGLAS
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

**AB 85 (as amended by SB 98) FY 2015-16 Projected Data Submission
County Certification Form**

_____ County chooses the option selected below
County Name

to determine interim payments to the Family Support Subaccount for the period of
FY 2015-16 _____ :

County Savings Determination Process - The formula pursuant to
Welfare and Institutions (W&I) Code, Section 17612.5 using projected
data as certified below.

I hereby certify, under penalty of perjury, that the projected amounts for FY 2015-16
reported by Los Angeles County 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 997413
EMAIL: AB85@dhcs.ca.gov