

Attachment D
COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - BACKCASTING INVOICE
ANNUAL Summary of Time Survey Results

Local Governmental Agency: LGA
 Contract Number: Contract #
 Period of Service: Period of Service

Program/Department: Program/Department
 Claiming Unit: Claiming Unit
 Invoice Number: Invoice #

Code	Description	Medi-Cal %	Method Used	SPMP Total Hours	SPMP Activity %	Reallocated SPMP %	SPMP Medi-Cal %	Non-SPMP Total Hours	Non-SPMP Activity %	Reallocated Non-SPMP %	Non-SPMP Medi-Cal %
1	Other Programs/Activities			0.00	0.00%			0.00	0.00%		
2	Direct Patient Care			0.00	0.00%			0.00	0.00%		
3	Outreach to Non Medi-Cal Programs			0.00	0.00%			0.00	0.00%		
4	Medi-Cal Outreach	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
5	Referral, Coordination, and Monitoring of Non Medi-Cal Services			0.00	0.00%			0.00	0.00%		
6	Referral, Coordination, and Monitoring of Medi-Cal Services	0.00%	ACC	0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
7	Facilitating Non Med-Cal Application			0.00	0.00%			0.00	0.00%		
8	Facilitating Med-Cal Application	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
9	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Non Medi-Cal Covered Service			0.00	0.00%			0.00	0.00%		
10	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Medi-Cal Covered Service	0.00%	ACC	0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
11	Contract Administration for Non Medi-Cal Covered Services			0.00	0.00%			0.00	0.00%		
12	Contract Administration (A) for Medi-Cal Services specific for Medi-Cal populations	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
13	Contract Administration (B) for Medi-Cal Services specific for Medi-Cal and Non Medi-Cal populations	0.00%	ACC	0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
14	Program Planning & Policy Development for Non Medi-Cal Services			0.00	0.00%			0.00	0.00%		
15	Program Planning & Policy Development (A) (Non-enhanced) for Medi-Cal Services for Medi-Cal clients	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
16	Program Planning & Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal Services for Medi-Cal clients	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%		
17	Program Planning & Policy Development (B) (Non-enhanced) for Medi-Cal Services for Medi-Cal clients	0.00%	ACC	0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
18	Program Planning & Policy Development (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal clients	0.00%	ACC	0.00	0.00%	0.00%	0.00%	0.00	0.00%		
19	MAA/TCM Coordination and Claims Administration	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
20	MAA/TCM Implementation Training	100.00%		0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
21	General Administration			0.00	0.00%			0.00	0.00%		
22	Paid Time Off (PTO)			0.00	0.00%			0.00	0.00%		
23	Non-Targeted Case Management (TCM)			0.00	0.00%			0.00	0.00%		
24	Providing TCM Service Components			0.00	0.00%			0.00	0.00%		
25	TCM Encounter - Related Activities			0.00	0.00%			0.00	0.00%		
26	Travel Related to Providing TCM			0.00	0.00%			0.00	0.00%		
27	Supervision of Case Managers			0.00	0.00%			0.00	0.00%		
28	Encounter Entry into TCM On-Line System			0.00	0.00%			0.00	0.00%		
29	TCM Data Systems and Claiming Coordination			0.00	0.00%			0.00	0.00%		
30	TCM Quality Assurance/Performance Monitoring			0.00	0.00%			0.00	0.00%		
31	TCM Subcontract Administration			0.00	0.00%			0.00	0.00%		
32	TCM Program Planning & Policy Development			0.00	0.00%			0.00	0.00%		
TOTALS				0.00	0.00%			0.00	0.00%		
SPMP 50% Portion							0.00%				
SPMP 75% Portion							0.00%				
Total Claimable Portion				0.00	0.00%	0.00%	0.00%	0.00	0.00%	0.00%	0.00%
Total Non-Claimable Portion				0.00	0.00%	0.00%	100.00%	0.00	0.00%	0.00%	100.00%
Total Reallocated Portion				0.00	0.00%			0.00	0.00%		
TOTALS				0.00	0.00%	0.00%	100.00%	0.00	0.00%	0.00%	100.00%

Time Survey Frequency Used to Determine the Activity Percentages: Perpetual

Claiming unit certification:

I certify under penalty of perjury that the time survey participants within this claiming unit are not instructed to perform any additional MAA related activities (other than those related to the actual recording of time on the time survey form) during the time survey period and that the time recorded by the participants reflects only those activities that would be performed during the normal course of an average work day. Based on my knowledge of the activities normally performed by the time survey participants within this claiming unit, I believe that the summary time survey results are a reasonable proxy, or in the case of the perpetual time survey – actual results, of the time spent during the entire period of service and result in allowable costs consistent with the requirements of OMB Circular A-87.

Name _____ Classification/Title _____
 Printed Name of Claiming Unit Reviewer _____ Classification/Title _____ Signature _____ Date _____

LGA certification:

I hereby certify to the best of my knowledge and belief that the information contained herein accurately describes the MAA activities performed during the time survey period and the time survey results are reflective of MAA activities performed during the entire period of service. I concur with the claiming unit's assessment that the summary time survey results are a reasonable proxy, or in the case of the perpetual time survey – actual results, of the claiming unit's activities for the entire period of service and result in allowable costs consistent with the requirements of OMB Circular A-87.

Name _____ Classification/Title _____
 Printed Name of LGA Reviewer _____ Classification/Title _____ Signature _____ Date _____

DHCS certification:

I hereby certify to the best of my knowledge and belief that the information contained herein accurately describes the MAA activities performed by the time survey participants of the named claiming unit. I concur with the claiming unit's assessment that the summary time survey results are a reasonable proxy, or in the case of the perpetual time survey – actual results, of the claiming unit's activities for the entire period of service and result in allowable costs consistent with the requirements of OMB Circular A-87. I have evaluated the actual activities performed, the positions of the staff performing the activities, and the amount of time spent in the performance of the activities and believe they are necessary for the proper and efficient administration of the Medi-Cal Program.

Name _____ Classification/Title _____
 Printed Name of DHCS Reviewer _____ Classification/Title _____ Signature _____ Date _____

LGA LETTER HEAD (delete)

MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) - BACKCASTING INVOICE

Local Governmental Agency: LGA Program/Department: Program/Department
 Contract Number: Contract # Claiming Unit: Claiming Unit
 Period of Service: Period of Service Invoice Number: Invoice #

COST CATEGORIES

Line 1 Total Amount to be Reimbursed at 50% (Detail invoice-line CG)
 Line 2 Total Amount to be Reimbursed at 75% (Detail invoice-line CH)
 Line 3 TOTAL to be Reimbursed by Federal Government (Detail invoice-line CI)

Interim Claim Amounts Paid	Backcasting Claim Amount Owed/Due
\$0	\$0
\$0	\$0
No	No
\$0	\$0

CPE Restricted:

NO PAYMENT ADJUSTMENT OWED OR DUE: \$0

I HEREBY CERTIFY under penalty of perjury that:

- 1) I am the official responsible for the administration, examination, and settlement of accounts concerning Medicaid Administrative Activities for the above-named agency and am authorized to make this certification on behalf of the agency.
- 2) To the best of my knowledge and belief each expenditure is in all respects true, correct, and in accordance with state and federal law, and regulation, including Section 1903(a) of the Social Security Act and 42 C.F.R. Section 433.51.
- 3) The expenditures certified are based on actual, total expenditures of public funds that have been made to eligible Medicaid beneficiaries pursuant to all applicable requirements of federal law and regulation.
- 4) The expenditures certified are allowable Medicaid costs in accordance with all applicable requirements of federal law and regulation.
- 5) The expenditures certified have not previously been, nor will they be, certified at any other time to receive federal financial participation under Medicaid or any other program (unless being resubmitted under correction or revision).
- 6) The costs certified in this invoice have not been paid in an all-inclusive or capitation rate.

I understand that the State of California must deny payment of any invoice submitted if it determines the certification is not adequately supported for purposes of claiming federal financial participation. I have notice that this information is to be used for filing of a claim with the federal government for federal financial participation and that a knowing misrepresentation constitutes a violation of the federal and state False Claims Acts.

Typed Name of Signer

Signature

Title

Date

For DHCS Program use only

I hereby certify to the best of my knowledge and belief that the claims submitted and attached herein, are claims for the Medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the State Children's Health Insurance Program (CHIP) under Title XXI of the Act, and are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan (including any approved waivers of the state plan) approved by the Secretary and in effect at the corresponding time commensurate with the claims aforementioned and furthermore, I certify that federal matching funds are not being claimed for any expenditure under any Medicaid and/or CHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the applicable quarter associated with the claims aforementioned. Further, I direct the Accounting section to process the attached claims for payment certifying to the best of my knowledge and belief that the payee has met the contractual conditions for such payment(s) and the following Accounting codes are appropriate for such payment(s). This invoice has been checked against our records and found to be the original one presented for payment and has not previously been paid. We have recorded this payment so as to prevent a later duplicate payment.

Signed: _____ Date: _____ Title: SSMI Analyst Initials _____

CALSTARS CODE 0__-95918-9912-702-42-60 LGA

**MEDI-CAL ADMINISTRATIVE ACTIVITIES - BACKCASTING INVOICE
DIRECT CHARGE WORKSHEET**

Local Governmental Agency: LGA
 Contract Number: Contract #
 Period of Service: Period of Service

Program: Program/Department
 Claiming Unit: Claiming Unit
 Invoice #: Invoice #

SECTION 1

ENHANCED - COST POOL #4

Description (from claiming plan)

PPPD ENHANCED - COST POOL #4

(Formula)

(Formula)

(All other costs are entered as non-enhanced)

(Formula)

(Formula)

	Medi-Cal Factor	Staff Salaries	Apply MC %	Staff Benefits	Apply MC %	Personal Services Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Claimable Costs	S & B net of MC %
From P P P D (B) Wksheet	100.00%	\$0	\$0	\$0	\$0							\$0	\$0
TOTAL COST POOL #4		\$0	\$0	\$0	\$0							\$0	\$0

SECTION 2

NON- ENHANCED - COST POOL #5

Description (from claiming plan)

PPPD NON - ENHANCED - COST POOL #5

(Formula)

(Formula)

(Formula)

(Formula)

	Medi-Cal Factor	Staff Salaries	Apply MC %	Staff Benefits	Apply MC %	Personal Services Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Claimable Costs	S & B net of MC %
From P P P D (B) Wksheet - non-SPMPs	100.00%	\$0	\$0	\$0	\$0					\$0	\$0	\$0	\$0
From P P P D(B) Wksheet - SPMPs	100.00%	\$0	\$0	\$0	\$0					\$0	\$0	\$0	\$0
SUBTOTAL COST POOL #5		\$0	\$0	\$0	\$0					\$0	\$0	\$0	\$0

SECTION 3

NON- ENHANCED - COST POOL #5

Description (from claiming plan)

NON - ENHANCED - COST POOL #5

(Enter)

(Enter)

(Formula)

(Enter)

(Formula)

(Enter)

(Formula)

(Enter)

(Formula)

(Enter)

(Formula)

(Formula)

(Formula)

(Formula)

	Medi-Cal/Certified Time Factor %	Gross Staff Salaries	Apply MC %	Gross Staff Benefits	Apply MC %	Pers. Serv. Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Total Costs	Net of MC %	Balance Remaining to CP#3b
Paul Jones (Outreach)	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
People, Inc. (Outreach)	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MTA (Tokens)	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
SUBTOTAL Section 3		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
SUBTOTAL Section 2		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL COST POOL #5		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

SECTION 4

TOTAL TO COST POOL # 3B

Staff Salaries	Staff Benefits	Pers. Serv. Contracts	MAA Transportation	Other Costs	Remaining to CP#3b
\$0	\$0	\$0	\$0	\$0	\$0

I certify that the direct charges identified above represent accurate identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief, and that I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

 Signature

 Type or Print Name of Signer

 Date

Local Governmental Agency: LGA
 Contract Number: Contract #
 Period of Service: Period of Service

Program: Program/Department
 Claiming Unit: Claiming Unit
 Invoice #: Invoice #

**MEDI-CAL ADMINISTRATIVE ACTIVITIES - BACKCASTING INVOICE
 PROGRAM PLANNING AND POLICY DEVELOPMENT (B) WORKSHEET**

SPMP

(Enter) (Formula)

DA Salaries	\$0	0.00%
DB Benefits	\$0	0.00%
DC Total Salaries and Benefits	\$0	0.00%
DD Other Costs	\$0	
DE TOTAL COST	\$0	

NON-SPMP

(Enter) (Formula)

EA Salaries	\$0	0.00%
EB Benefits	\$0	0.00%
EC Total Salaries and Benefits	\$0	0.00%
ED Other Costs	\$0	
EE TOTAL COST	\$0	

**SPMP
FORMULAS**

PROGRAM TYPE	(Enter) Medi-Cal %	(Enter) Time Units*	Time %	Salary & Benefit Cost	Other Cost	Reallocate PTO %	Distribute PTO \$ - S & B	Distribute PTO \$-other	Distribute Admin. %	Admin. to S & B \$	Admin. to Other \$	Total Program Cost S & B	Total Program Cost Other	Cost Pool #5 Apply Medi-Cal % to Admin	Cost Pool #5 Apply Medi-Cal % to Other	Cost Pool #4 Apply Medi-Cal % to Program	Cost Pool #3b S & B	Cost Pool #3b Other	TOTAL
DF Medi-Cal Services for Medi-Cal Clients Only	100.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DG Medi-Cal Services (general population) CWA	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DH Non Medi-Cal Program	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DI Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DJ Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DK Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DL Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DM Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DN Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DO Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DP General Administration		0.00	0.00%	\$0	\$0	0.00%	\$0	\$0											
DQ Paid Time Off		0.00	0.00%	\$0	\$0														
DR SPMP Total		0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DS SPMP Salaries														\$0			\$0	\$0	
DT SPMP Benefits														\$0			\$0	\$0	

DA% x DR
DB% x DR

**PROGRAM TYPE
NON-SPMP**

**NON-SPMP
FORMULAS**

PROGRAM TYPE	(Enter) Medi-Cal %	(Enter) Time Units*	Time %	100% Cost	Other Cost	Reallocate PTO %	Distribute PTO \$ - S & B	Distribute PTO \$-other	Distribute Admin. %	Admin. to S & B \$	Admin. to Other \$	Total Program Cost S & B	Total Program Cost Other	Cost Pool #5 Apply Medi-Cal % to Program	Cost Pool #5 Apply Medi-Cal % to Other	Cost Pool #4 Apply Medi-Cal % to Program	Cost Pool #3b S & B	Cost Pool #3b Other	TOTAL
EF Medi-Cal Services for Medi-Cal Clients Only	100.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EG Medi-Cal Services (general population) CWA	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EH Non Medi-Cal Program	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EI Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EJ Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EK Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EL Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EM Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EN Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EO Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
EP General Administration		0.00	0.00%	\$0	\$0	0.00%	\$0	\$0											
EQ Paid Time Off		0.00	0.00%	\$0	\$0														
ER NON-SPMP Total		0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	\$0
ES TOTAL (SPMP+nonSPMP)		0.00	0.00%	\$0	\$0	0.00%	\$0	\$0	0.00%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ET Non-SPMP Salaries														\$0			\$0	\$0	
EU Non-SPMP Benefits														\$0			\$0	\$0	

DR+ER

EA% x EP
EB% x EP

*Unit of time used:

Local Governmental Agency: LGA
 Contract Number: Contract #
 Period of Service: Period of Service

**MEDI-CAL ADMINISTRATIVE ACTIVITIES
 BACKCASTING INVOICE**

Program: Program/Department
 Claiming Unit: Claiming Unit
 Invoice #: Invoice #

COST CATEGORIES:	FORMULA	CP#1	CP#2	CP#3a	CP#3b (Formulas)	CP#4 (Formulas)	CP#5 (Formulas)	CP #6 (Enter)
	alpha = line numeric = cost pool	SPMP (Enter)	Non-SPMP (Enter)	Non-Claim. (Enter)	Non-Claim. Bal. from Dir. Chg.	DIRECT CHARGES ENHANCED	DIRECT CHARGES NON-ENHANCED	Allocated Cost & Revenue
A Salary	(Enter)				\$0	\$0	\$0	
B Benefits	(Enter)				\$0	\$0	\$0	
C SUBTOTAL	A+B	\$0	\$0	\$0	\$0	\$0	\$0	\$0
D Personal Service Contracts	(Enter)				\$0	\$0	\$0	
E SUBTOTAL PERSONNEL	C+D	\$0	\$0	\$0	\$0	\$0	\$0	\$0
F Distribution %	E/(CP1...CP5)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
G MAA Transportation	(From Direct Charges.)				\$0	\$0	\$0	
H Other Costs	(Enter)				\$0	\$0	\$0	
I Costs to be Distributed	E6+H6							\$0
J Distribution of Costs	I6 x F	\$0	\$0	\$0	\$0	\$0	\$0	
K SUBTOTAL OTHER COSTS	G+H+J	\$0	\$0	\$0	\$0	\$0	\$0	
L Collapse CP#3b	E3b+K3b							
M TOTAL COSTS	E+K+L	\$0	\$0	\$0		\$0	\$0	\$0
N % OF TOTAL COST	M/(CP1-CP5)	0.00%	0.00%	0.00%		0.00%	0.00%	
FUNDING SOURCE ADJUSTMENT:								
O Funding Sources	From Funding Sources				\$0	\$0	\$0	\$0
P Reallocated CP#6 Funding Sources	O6 X N	\$0	\$0	\$0		\$0	\$0	\$0
Q TOTAL FUNDING SOURCES	O + P	\$0	\$0	\$0		\$0	\$0	
R Non-Claimable Services Cost: CP#3	M3				\$0			
S Non-Claimable Service Cost: CPs #1 & 2	M x (AL+AM+AN)/(AQ-AO-AP)	\$0	\$0					
T Remaining Funding Sources CP#3	(Q-R)>\$0				\$0			
U Distribution %	S1/(S1+S2);S2/(S1+S2)	0.00%	0.00%					
V Reallocated CP#3 Funding Sources	T3 x U	\$0	\$0					
W Remaining Revenue	If M=\$0 or V<S,Q;else,V+Q-S	\$0	\$0					
X Revenue to Personnel Services	If E=0,0; else W * E/M	\$0	\$0					
XX Revenue to Other Costs	If K=0,0; else W * K/M	\$0	\$0					
Y Adjusted Personnel Services Cost	If (E-X)=0,0; else E-X	\$0	\$0					
YY Adjusted Other Cost	If (K-XX)=0,0; else K-XX	\$0	\$0					
Z TOTAL ADJUSTED COST	Y+YY	\$0	\$0			\$0	\$0	

\$0

ACTIVITIES	(Enter)	(Enter)	(Enter)	INDICATE METHODOLOGY USED TO DETERMINE MEDI-CAL %
	MEDI-CAL %	ACTIVITY RESULTS PERCENTAGES SPMP	NON-SPMP	
AA Medi-Cal Outreach (A)	100.00%	0.00%	0.00%	
AB Medi-Cal Outreach (B1)		0.00%	0.00%	CWA ___ AC ___ Other ___
AC Medi-Cal Outreach (B2)		0.00%	0.00%	CWA ___ AC ___ Other ___
AD Facilitating Medi-Cal Application	100.00%	0.00%	0.00%	
AE Arranging for Transportation		0.00%	0.00%	CWA ___ AC ___ Other ___
AF Contract Administration A	100.00%	0.00%	0.00%	
AG Contract Administration B		0.00%	0.00%	CWA ___ AC ___ Other ___
AH Program Planning & Policy Develop. (A) (non-enhanced)	100.00%	0.00%	0.00%	
AI Program Planning & Policy Develop. (B) (non-enhanced)		0.00%	0.00%	CWA ___ AC ___ Other ___
Program Planning & Policy Develop. (A) (enhanced)	100.00%	0.00%		
Program Planning & Policy Develop. (B) (enhanced)		0.00%		CWA ___ AC ___ Other ___
AJ MAA/TCM Coord./Claims Admin.	100.00%	0.00%	0.00%	
AL Other Programs/Activities		0.00%	0.00%	CWA = County-wide Average AC = Actual Count
AM Direct Patient Care		0.00%	0.00%	
AN Targeted Case Management		0.00%	0.00%	
AO General Admin. Time		0.00%	0.00%	
AP Paid Time Off		0.00%	0.00%	
AQ TOTAL TIME		0.00%	0.00%	

Local Governmental Agency: LGA
 Contract Number: Contract #
 Period of Service: Period of Service

**MEDI-CAL ADMINISTRATIVE ACTIVITIES
 BACKCASTING INVOICE**

Page 2

Program: Program/Department
 Claiming Unit: Claiming Unit
 Invoice #: Invoice #

		ALL FORMULAS					
				1	11	111	
		Medi-Cal %	SPMP	Apply MC% SPMP (50%)	SPMP (75%)	Non-SPMP	Apply MC% Non-SPMP
(Formula - Disc Column)							
BA	Medi-Cal Outreach (A)	{AA/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%		0.00%
BB	Medi-Cal Outreach (B1)	{AB/SUM(AA..AN)}xMC%	0.00%	0.00%		0.00%	0.00%
BC	Medi-Cal Outreach (B2)	{AC/SUM(AA..AN)}xMC%	0.00%	0.00%		0.00%	0.00%
BD	Facilitating Medi-Cal Application	{AD/SUM(AA..AN)}xMC%	100.00%	0.00%		0.00%	0.00%
BE	Arranging for Transportation	{AE/SUM(AA..AN)}xMC%	0.00%	0.00%		0.00%	0.00%
BF	Contract Administration A	{AF/SUM(AA..AN)}xMC%	100.00%	0.00%		0.00%	0.00%
BG	Contract Administration B	{AG/SUM(AA..AN)}xMC%	0.00%	0.00%		0.00%	0.00%
BH	Program Planning & Policy Development(A)(enhanced)	{AH/SUM(AA..AO)}xMC%	100.00%	0.00%	0.00%		0.00%
	Program Planning & Policy Development(A)(non-enhanced)	{AH/SUM(AA..AN)}xMC% (less enh)	100.00%	0.00%		0.00%	0.00%
BI	Program Planning & Policy Development(B)(enhanced)	{AI/SUM(AA..AO)}xMC%	0.00%	0.00%	0.00%		0.00%
	Program Planning & Policy Development(B)(non-enhanced)	{AI/SUM(AA..AN)}xMC% (less enh)	0.00%	0.00%		0.00%	0.00%
BJ	MAA/TCM Coord./Claims Admin.	{AJ/SUM(AA..AN)}xMC%	100.00%	0.00%		0.00%	0.00%
BL	Other Programs/Activities	AL/SUM(AA..AN)		0.00%		0.00%	
BM	Direct Patient Care	AM/SUM(AA..AN)		0.00%		0.00%	0.00%
BN	Targeted Case Management	AN/SUM(AA..AN)		0.00%		0.00%	0.00%
BO	TOTAL			0.00%	0.00%	0.00%	0.00%
				0.00%	0.00%		0.00%

		ALL FORMULAS		BACKCASTING FORMULA		
		SPMP	Non-SPMP	SPMP	Non-SPMP	
CA	Federal Non-Enhanced Basis Cost Pool #1	Z x (BO1)+ YY x (BO11)	\$0		Federal Non-Enhanced Basis CP1	\$0
	Federal Non-Enhanced Basis Cost Pool #2	Z x (BO11)		\$0	Federal Non-Enhanced Basis CP2	\$0
CB	Federal Non-Enhanced Share	(CA1 or CA2) x 50%	\$0	\$0	Federal Enhanced Share	\$0
CC	Federal Enhanced Basis	Y1 x (BO11)	\$0		Federal Enhanced Basis	\$0
CD	Federal Enhanced Share	CC1 x 75%	\$0		Federal Enhanced Share	\$0
CE	Direct Charge: Enhanced Federal Share	Z4 x 75%	\$0		Dir Chg: Enhanced Fed Share	\$0
CF	Direct Charge:Non-Enhanced Federal Share	Z5 x 50%		\$0	Dir Chg:Non-Enhanced Fed Share	\$0
CG	FFP @ 50%	CB1+CB2+CF2		FFP @ 50%		\$0 FFP @ 50%
CH	FFP @ 75%	CD1 + CE1		FFP @ 75%		\$0 FFP @ 75%
CI	TOTAL FEDERAL SHARE	CG + CH		\$0		\$0 Total Federal Share
				CPE Compliant		CPE Compliant
				Yes		Yes
Activity Percentages Determined by One Month Time Study Completed in: _____ (month/year).				TOTAL Federal Share (CPE Compliant)		\$0 TOTAL Fed Share (CPE Compliant)
				TOTAL FFP @ 50% (CPE Compliant)		\$0 TOTAL FFP @ 50% (CPE Compliant)
				TOTAL FFP @ 75% (CPE Compliant)		\$0 TOTAL FFP @ 75% (CPE Compliant)

I certify under penalty of perjury that the information provided on the invoice is true and correct, based on actual expenditures for the period claimed, and that the funds/contributions have been expended, as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these claimed expenditures have not previously been nor will not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claim Act.

(Correspondence Mail)
 Department of Health Care Services
 Administrative Claiming, Local and Schools Services Branch
 County-Based Medi-Cal Administrative Activities Unit
 Attn: (Program Analyst)
 P.O. Box 997436, MS 4603
 Sacramento, CA 95899-7436

 Typed name of signer

 Signature

 Date

 Title

(Overnight Mail)
 Department of Health Care Services
 Administrative Claiming, Local and Schools Services Branch
 County-Based Medi-Cal Administrative Activities Unit
 Attn: (Program Analyst)
 1501 Capitol Avenue, Suite 71.2101 MS 4603
 Sacramento, CA 95814

INVOICE PREPARATION INFORMATION

 Typed name of preparer

 Classification

 Telephone #