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COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - SUMMARY INVOICE

Local Governmental Agency: County Program/Department: Program Department

Contract Number: Contract Number Claiming Unit: Claiming Unit

Period of Service: Period of Service Invoice Number: _____

COST CATEGORIES

Total Amount to be Reimbursed at 50%	#DIV/0!
Total Amount to be Reimbursed at 75%	#DIV/0!
Total amount of Fed. Govt. Reimbursement	\$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.

Name _____ Printed Name of Signer _____ Signature _____

Title _____ Title _____ Date _____ 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 (SCHIP) 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 SCHIP 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.

Signature Date SSM I Title Analyst Initials

COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Quarterly Summary of Time Survey Results

A	B	C	D	E	F	G	H	I	J	K	L	M	
1	Local Governmental Agency: <u>County</u>							Program/Department: <u>Program Department</u>					
2	Contract Number: <u>Contract Number</u>							Claiming Unit: <u>Claiming Unit</u>					
3	Period of Service: <u>Period of Service</u>							Invoice Number: <u>0</u>					
4													
5	Code	Description	SPMP Total Hours	SPMP Activity %	Non-SPMP Total Hours	Non-SPMP Activity %	Medi-Cal %	Method Used					
6	1	Other Programs/Activities		0.00%		0.00%							
7	2	Direct Patient Care		0.00%		0.00%							
8	3	Outreach to Non Medi-Cal Programs		0.00%		0.00%							
9	4	Medi-Cal Outreach		0.00%		0.00%	100.00%						
10	5	Referral, Coordination, and Monitoring of Non Medi-Cal Services		0.00%		0.00%							
11	6	Referral, Coordination, and Monitoring of Medi-Cal Services		0.00%		0.00%		ACC					
12	7	Facilitating Non Med-Cal Application		0.00%		0.00%							
13	8	Facilitating Med-Cal Application		0.00%		0.00%	100.00%						
14	9	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Non Medi-Cal Covered Service		0.00%		0.00%							
15	10	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Medi-Cal Covered		0.00%		0.00%		ACC					
16	11	Contract Administration for Non Medi-Cal Covered Services		0.00%		0.00%							
17	12	Contract Administration (A) for Medi-Cal Services specific for Medi-Cal populations		0.00%		0.00%	100.00%						
18	13	Contract Administration (B) for Medi-Cal Services specific for Medi-Cal and Non Medi-Cal		0.00%		0.00%		ACC					
19	14	Program Planning & Policy Development for Non Medi-Cal Services		0.00%		0.00%							
20	15	Program Planning & Policy Development (A) (Non-enhanced) for Medi-Cal Services for Medi-Cal		0.00%		0.00%	100.00%						
21	16	Program Planning & Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal Services for Medi-Cal clients		0.00%		0.00%	100.00%						
22	17	Program Planning & Policy Development (B) (Non-enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal clients		0.00%		0.00%		ACC					
23	18	Program Planning & Policy Development (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal clients		0.00%		0.00%		ACC					
24	19	MAA/TCM Coordination and Claims Administration		0.00%		0.00%	100.00%						
25	20	MAA/TCM Implementation Training		0.00%		0.00%	100.00%						
26	21	General Administration		0.00%		0.00%							
27	22	Paid Time Off (PTO)		0.00%		0.00%							
28	23	Non-Targeted Case Management (TCM)		0.00%		0.00%							
29	24	Providing TCM Service Components		0.00%		0.00%							
30	25	TCM Encounter - Related Activities		0.00%		0.00%							
31	26	Travel Related to Providing TCM		0.00%		0.00%							
32	27	Supervision of Case Managers		0.00%		0.00%							
33	28	Encounter Entry into TCM On-Line System		0.00%		0.00%							
34	29	TCM Data Systems and Claiming Coordination		0.00%		0.00%							
35	30	TCM Quality Assurance/Performance Monitoring		0.00%		0.00%							
36	31	TCM Subcontract Administration		0.00%		0.00%							
37	32	TCM Program Planning & Policy Development		0.00%		0.00%							
38	TOTALS			0.00	0.00%	0.00	0.00%						
39	Total Claimable Portion			0.00	0.00%	0.00	0.00%						
40	Total Non-Claimable Portion			0.00	0.00%	0.00	0.00%						

Time Survey Frequency Used to Determine the Activity Percentages: _____

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.

45 Name Classification/Title Signature Date
 46 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.

49 Name Classification/Title Signature Date
 50 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.

54 Printed Name of DHCS Reviewer Classification/Title Signature Date

COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Funding/Revenue Sources Worksheet

APPENDIX M (2)c

	A	B	C	D	E	F	G	H	I	J
1	Local Governmental Agency: <u>County</u>						Program: <u>Program Department</u>			
2	Contract Number: <u>Contract Number</u>						Claiming Unit: <u>Claiming Unit</u>			
3	Period of Service: <u>Period of Service</u>						Invoice #: <u>0</u>			
4	SOURCE and DESCRIPTION		Non Offset Funds	CP#1 SPMP	CP#2 Non-SPMP	CP#3 (a & b) Non-Claimable	CP#4 Direct-Enhanced	CP#5 Direct-Non-Enhanced	CP#6 Allocated	TOTAL (CPs 1 - 6)
5	Medi-Cal Fees + Match									
6	Title XIX (% of Exp) MAA Revenue									\$0
7	Title XIX (% of Exp) TCM Revenue									\$0
8	Medi-Cal Reimbursement (% of Exp) Directly Observed Therapy									\$0
9	Total Medi-Cal Fees + Match		\$0			\$0	\$0	\$0	\$0	\$0
10	Federal Grants + Match									
11	Federal Aid (% of Exp) Immunization									\$0
12	FMAP Federal (% of Exp)									\$0
13	SOURCE and DESCRIPTION									\$0
14	SOURCE and DESCRIPTION									\$0
15	Total Federal Grants + Match		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
16	State General Fund									
17	State - Other (% of Exp) - Immunization									\$0
18	SOURCE and DESCRIPTION									\$0
19	SOURCE and DESCRIPTION									\$0
20	Total State General Fund		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
21	Medicare									
22	SOURCE and DESCRIPTION									\$0
23	SOURCE and DESCRIPTION									\$0
24	SOURCE and DESCRIPTION									\$0
25	Total Medicare		\$0			\$0	\$0	\$0	\$0	\$0
26	Insurance									
27	SOURCE and DESCRIPTION									\$0
28	SOURCE and DESCRIPTION									\$0
29	SOURCE and DESCRIPTION									\$0
30	Total Insurance		\$0			\$0	\$0	\$0	\$0	\$0
31	Fees									
32	Charges for Services (% of Exp)									\$0
33	SOURCE and DESCRIPTION									\$0
34	SOURCE and DESCRIPTION									\$0
35	Total Fees		\$0			\$0	\$0	\$0	\$0	\$0
36	Other Revenue									
37	State Sales Tax Realignment									\$0
38	State VLF Realignment (% of Expense)									\$0
39	Other Miscellaneous Revenue									\$0
40	Total Other Revenue		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
41	TOTALS:		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
42	I certify that the revenue sources identified above represent accurate identifiable costs for the program/claiming entity and that the revenue sources 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.									
43										
44										
45	Signature _____			Date _____			Printed Name of Signer _____			
46										

COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Cost Worksheet

APPENDIX M (2)d

	A	B	C	D	E	F	G	H
1	Local Governmental Agency: County					Program: Program Department		
2	Contract Number: Contract Number					Claiming Unit: Claiming Unit		
3	Period of Service: Period of Service					Invoice #: 1/0/1900		
4			Cost Pool #1	Cost Pool #2	Cost Pool #3a	Cost Pool #5	Cost Pool #6	
5	SELECTED ITEMS OF COST		SPMP Costs	Non-SPMP Costs	Non-Claimable Costs	Non-SPMP Dir. Charge Other Costs	Allocated/Support Costs	
6								
7	SALARY COSTS							TOTALS
8	Wages/Salary:							\$0
9	Benefits:							\$0
10	Personal Services Contracts:							\$0
11	TOTAL Compensation for Personal Services:	\$0	\$0	\$0			\$0	\$0
12	NON-SALARY COSTS							TOTALS
13	Advertising and public relations costs							\$0
14	Audit costs and related services							\$0
15	Communication costs							\$0
16	Depreciation and use allowances							\$0
17	Employee morale, health, and welfare costs							\$0
18	Equipment and other capital expenditures							\$0
19	Insurance and indemnification							\$0
20	Maintenance, operations, and repairs							\$0
21	Materials and supplies costs							\$0
22	Meetings and conferences							\$0
23	Memberships, subscriptions, and professional activity costs							\$0
24	Plant and homeland security costs							\$0
25	Professional service costs							\$0
26	Proposal costs							\$0
27	Publication and printing costs							\$0
28	Rental costs of building and equipment							\$0
29	Taxes							\$0
30	Training costs							\$0
31	Travel Costs							\$0
32	Direct Charge Other Cost:							
33	Direct Charge Other Cost:							
34	Direct Charge Other Cost:							
35	Direct Charge Other Cost:							
36	Direct Charge Other Cost:							
37	Indirect Costs							\$0
38	TOTAL Non-Salary Costs:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
39	I certify that the costs identified above represent accurate identifiable costs for the program/claiming entity and that the costs 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.							
40								
41	Signature			Date		Type or Print Name of Signer		
42	Rev.12/8/14 DHCS/SNFD							

Enter item description that is eligible for Direct Charge.
 (LGA's must provide supporting documentation to substantiate any non-salary and/or overhead direct charges.)

COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Direct Charge Costs Worksheet

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
1	Local Governmental Agency: County							Program: Program Department								
2	Contract Number: Contract Number							Claiming Unit: Claiming Unit								
3	Period of Service: Period of Service							Invoice #: 0								
4																
5	Staff Member	Classification	Code	Description	Medi-Cal %	Activity % Results	Salary Costs	MAA Claimable Portion	Non Claimable Portion	Benefits Costs	MAA Claimable Portion	Non Claimable Portion	Non-Salary Costs	MAA Claimable Portion		
6	Ms. Nurse			#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
7	Mr. Doctor			#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
8				#N/A	#N/A		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
9				#N/A	#N/A		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
10				#N/A	#N/A		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
11	TOTALS							\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12																
13	Staff Member	Classification	Code	Description	Medi-Cal %	Activity % Results	Salary Costs	MAA Claimable Portion	Non Claimable Portion	Benefits Costs	MAA Claimable Portion	Non Claimable Portion	Non-Salary Costs	MAA Claimable Portion		
14	Ms. A			#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
15	Mr. D			#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
16				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
17				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
18				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
19				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
20				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
21				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
22				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
23				#N/A	#N/A			\$0	\$0		\$0	\$0	\$0	\$0	\$0	
24	TOTALS							\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
25	NON-ENHANCED MAA PERSONAL SERVICES CBO/CONTRACTOR COSTS															
26	CBO/Contractor	Expense Detail	Code	Description	Medi-Cal %		Pers. Svcs. Contract Costs	MAA Claimable Portion	Non Claimable Portion							
27				#N/A	#N/A			\$0	\$0							
28				#N/A	#N/A			\$0	\$0							
29				#N/A	#N/A			\$0	\$0							
30				#N/A	#N/A			\$0	\$0							
31				#N/A	#N/A			\$0	\$0							
32	TOTALS							\$0	\$0	\$0						
33	NON-ENHANCED MAA TRANSPORTATION COSTS															
34	Contractor	Expense Detail	Code	Description	Medi-Cal %		MAA Transportation Costs	Claimable Portion	Claimable Portion							
35				#N/A	#N/A			\$0	\$0							
36				#N/A	#N/A			\$0	\$0							
37				#N/A	#N/A			\$0	\$0							
38	TOTALS							\$0	\$0	\$0						
39	NON-ENHANCED MAA DIRECT CHARGE OTHER COSTS															
40				Description	Medi-Cal %		MAA Other Costs	MAA Claimable Portion								
41				Cost Pool#5 Direct Charge Other Costs Total	100%		\$0	\$0								
42	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.															
43																
44	Signature _____							Date _____				Name of Signer _____				
45												Type or Print Name of Signer _____				
46																

COUNTY BASED MEDICAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Claim Calculation Worksheet (page 2)

A	B	C	D	E	F	G	H		
1	Local Governmental Agency: <u>County</u>			Program: <u>Program Department</u>					
2	Contract Number: <u>Contract Number</u>			Claiming Unit: <u>Claiming Unit</u>					
3	Period of Service: <u>Period of Service</u>			Invoice #: <u>0</u>					
4									
5	COSTS:	Cost Pool #1	Cost Pool #2	Cost Pool #3a	Cost Pool #3b	Cost Pool #4	Cost Pool #5	Cost Pool #6	
6		SPMP	Non-SPMP	Non-Claimable	Non-Claimable	SPMP	Non-SPMP	Allocated/Support	
7		Costs	Costs	Costs	Dir. Charge Costs	Dir. Charge Costs	Dir. Charge Costs	Costs	
8		Salary:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
9		Benefits:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
10		Salary + Benefits SUBTOTAL:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11		Personal Service Contracts	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12		All Personnel Costs SUBTOTAL:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
13		Personnel Costs Distribution Percentage:	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
14		MAA Transportation Costs:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
15		Non-Salary Costs:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
16		Other Costs:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
17		CP #6 Allocated/Support Costs to be Distributed TOTAL:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
18		Distribution of CP #6 Allocated/Support Costs:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
19		Non-Salary Costs SUBTOTAL:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
20		CP #3b All Personnel + Non-Salary Costs TOTAL:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
21		TOTAL COST:	\$0	\$0	\$0	\$0	\$0	\$0	\$0
22		PERCENTAGE OF TOTAL COST:	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
23									
24		FUNDING/REVENUE:	Cost Pool #1	Cost Pool #2	Cost Pool #3	Cost Pool #4	Cost Pool #5	Cost Pool #6	
25			SPMP	Non-SPMP	Non-Claimable	SPMP Dir. Chg.	Non-SPMP Dir. Chg.	Allocated/Support	
26			Funding/Revenue	Funding/Revenue	Funding/Revenue	Funding/Revenue	Funding/Revenue	Funding/Revenue	
27	Funding/Revenue:		\$0	\$0	\$0	\$0	\$0	\$0	
28	Distribution of CP #6 Funding/Revenue:		\$0	\$0	\$0	\$0	\$0	\$0	
29	Funding/Revenue TOTAL:		\$0	\$0	\$0	\$0	\$0	\$0	
30	Non-Claimable Activity Percentage:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
31	Non-Claimable Activity Cost:		\$0	\$0	\$0	\$0	\$0	\$0	
32	CP #3 Remaining Non-Claimable Funding/Revenue:		\$0	\$0	\$0	\$0	\$0	\$0	
33	Non-Claimable Activity Distribution Percentage:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
34	Distribution of CP #3 Reman. Non-Claim. Funding/Revenue:		\$0	\$0	\$0	\$0	\$0	\$0	
35	Adjusted Remaining Funding/Revenue:		\$0	\$0	\$0	\$0	\$0	\$0	
36	Remaining Funding/Revenue Distributed to Personnel Svcs:		\$0	\$0	\$0	\$0	\$0	\$0	
37	Remaining Fund/Rev Distributed to Non-Salary Costs:		\$0	\$0	\$0	\$0	\$0	\$0	
38	Adjusted Remaining Personnel Services Costs	\$0	\$0	\$0	\$0	\$0	\$0		
39	Adjusted Remaining Non-Salary Costs	\$0	\$0	\$0	\$0	\$0	\$0		
40	TOTAL ADJUSTED COST	\$0	\$0	\$0	\$0	\$0	\$0		
41									
42	I certify that the information above represents accurate and identifiable data for the program/claiming entity. 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.								
43									
44	Signature	Date		Type or Print Name of Signer					
45									

COUNTY BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (CMAA) - INVOICE DETAIL
Claim Calculation Worksheet (page 2)

	A	B	C	D	E	F	G	H
46	Local Governmental Agency: <u>County</u>				Program: <u>Program Department</u>			
47	Contract Number: <u>Contract Number</u>				Claiming Unit: <u>Claiming Unit</u>			
48	Period of Service: <u>Period of Service</u>				Invoice #: <u>0</u>			
49								

50	51	ACTIVITIES:	MEDI-CAL %	ACTIVITY RESULTS PERCENTAGES		REALLOCATED SPMP %	SPMP Medi-Cal %	REALLOCATED Non-SPMP %	Non-SPMP Medi-Cal %
				SPMP	NON-SPMP				
52		CODE 4: Medi-Cal Outreach	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
53		CODE 6: Referral, Coordination, and Monitoring of Medi-Cal Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
54		CODE 8: Facilitating Med-Cal Application	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
55		CODE 10: Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Medi-Cal Covered Service	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
56		CODE 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%
57		CODE 13: Contract Administration (B) for Medi-Cal Services specific for Medi-Cal and Non Medi-Cal populations	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
58		CODE 15: PP & PD (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%
59		CODE 16: PP & PD (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%
60		CODE 17: PP & PD (B) (Non-enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal clients	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
61		CODE 18: PP & PD (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal clients	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
62		CODE 19: MAA/TCM Coordination and Claims Administration	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
63		CODE 20: MAA/TCM Implementation Training	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
64		CODES 1, 2, 3, 5, 7, 9, 11, 14, 23-32: All NON-CLAIMABLE Activities		0.00%	0.00%	0.00%		0.00%	
65		CODE 21: General Administration		0.00%	0.00%				
66		CODE 22: Paid Time Off (PTO)		0.00%	0.00%				
67		TOTAL		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

68							
69	CLAIM CALCULATION:	CP1	CP2	CP4	CP5	FFP @ 50%	FFP @ 75%
70	Non-Enhanced Federal Share	\$0	\$0		\$0	\$0	
71	Enhanced Federal Share	\$0		\$0			\$0

72						
73	TOTAL FEDERAL SHARE:	\$0			Total Inv. Amt.	\$0
74	CPE Eligibility:	COMPLIANT			50% Inv. Portion	#DIV/0!
75	CPE Compliant Federal Share:	\$0			75% Inv. Portion	#DIV/0!
76						

77 I certify that the information above represents accurate and identifiable data for the program/claiming entity. 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.

78 _____

79 Signature _____ Date _____ Type or Print Name of Signer _____

80

(delete this text) *PRINT ON LGA LETTER HEAD* (delete this text)

Date: Date

To: The Department of Health Care Services
County Based Medi-Cal Administrative Activities Unit

From: County
Claiming Unit

Subject: CMAA Program Invoice Percentage Variance Documentation for Period of Service

The following information represents the CMAA Program invoice variance data for the LGA/Claiming Unit and Period of Service notated above.

Prior Year Corresponding Quarter Variance Data	
PY Corresponding Quarter Invoice Amount:	
Current Quarter Invoice Amount:	\$0
Variance Percentage:	#DIV/0!
A variance percentage explanation is:	#DIV/0!

Prior Quarter Variance Data	
Prior Quarter Invoice Amount:	
Current Quarter Invoice Amount:	\$0
Variance Percentage:	#DIV/0!
A variance percentage explanation is:	#DIV/0!

*If an explanation of the variance percentage is "REQUIRED", please fill out the appropriate variance narrative information below

Prior Year Corresponding Quarter Variance Narrative (check all that apply):

- Change in the number of Time Survey Participants
- Time Survey results were materially different
- Increase/Decrease to other costs
- Change in Medi-Cal Percentage
- Difference in the number of Pay Periods
- Other: _____

Detailed Explanation:

Prior Quarter Variance Narrative (check all that apply):

- Change in the number of Time Survey Participants
- Time Survey results were materially different
- Increase/Decrease to other costs
- Change in Medi-Cal Percentage
- Difference in the number of Pay Periods
- Other: _____

Detailed Explanation:

If you have any questions or require further information, please feel free to contact me.

Signature
Printed Name
Classification/Title

Date
Date

Phone number
Phone number

LGA: County
Contract #: Contract Number
Period of Service: Period of Service

Program: Program Department
Claiming Unit: Claiming Unit
Invoice Number: 0.00