CLAIMING UNIT FUNCTIONS GRID

Name of LGA _____ Submittal Date _____

Name of Claiming Unit _____ Number of Staff _____

Address _____

Contact Person _____ Phone Number _____

Description of Claiming Unit Functions

STAFF JOB CLASSIFICATIONS	NUMBER OF STAFF			MEDI-CAL ADMINISTRATIVE ACTIVITY CODE (ENTER NUMBER OF STAFF UNDER EACH ACTIVITY)											
	SPMP	NON-SPMP	DIRECT CHARGE	4	6	8	10	12	13	15	16	17	18	19	20

CODE 4 =	Medi-Cal Outreach
CODE 6 =	Referral, Coordination, and Monitoring of Medi-Cal Services
CODE 8 =	Facilitating Medi-Cal Application
CODE 10 =	Arranging and/or providing Non-Emergency, Non-Medical Transportation to a Medi-Cal covered service
CODE 12 =	Contract Administration (A) for Medi-Cal services specific for Medi-Cal populations
CODE 13 =	Contract Administration (B) for Medi-Cal services specific for Medi-Cal and Non Medi-Cal populations
CODE 15 =	Program Planning and Policy Development (A) (Non-Enhanced) for Medi-Cal services for Medi-Cal clients
CODE 16 =	Program Planning and Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal services for Medi-Cal clients
CODE 17 =	Program Planning and Policy Development (B) (Non-Enhanced) for Medi-Cal services for Medi-Cal and Non Medi-Cal clients
CODE 18 =	Program Planning and Policy Development Skilled Professional Medical Personnel (SPMP) (B) (Enhanced) for Medi-Cal services for Medi-Cal and Non Medi-Cal clients
CODE 19 =	MAA/TCM Coordination and Claims Administration
CODE 20 =	MAA/TCM Implementation Training

In signing this certification, I certify the information provided herein is true and correct and accurately reflects the performance of the Medi-Cal Administrative Activities (MAA) described in this Claiming Unit Functions Grid (CUFG) and on the Comprehensive Claiming Unit Grid (CCUG). I also certify that invoices submitted to the state Department of Health Care Services for reimbursement shall be based on the information included in the CUFG and the CCUG. I confirm that all necessary and appropriate documentation to support the CUFG for all of the staff job classifications included herein is accurate and maintained on file. I understand the claiming unit documents shall be subject to the review and approval of the state Department of Health Care Services and the Centers for Medicare & Medicaid Services. Any knowing misrepresentation of the activities described herein may constitute violation of the Federal False Claims Act.

Signature (MAA Coordinator) _____ Date _____

Approval Signature (CMAA Analyst) _____ Date _____