

MAA CLAIMING PLAN AMENDMENT CHECKLIST

LGA:	Fiscal Year:	Quarter:
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Claiming Unit Name:	Date:
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This Checklist must accompany the MAA Claiming Plan amendment package/e-mail.

DO NOT resubmit the entire MAA Claiming Plan – please submit **ONLY** the pages that are changing. Mail the claiming plan amendment package to:

Department of Health Care Services
 Safety Net Financing Division
 Administrative Claiming, Local & Schools Services Branch
 Attn: (program analyst name)
 1501 Capitol Avenue, Suite 71.2101
 P.O. Box 997436, **MS 4603**
 Sacramento, CA 95899-7436

NOTE: Federally Qualified Health Centers (FQHC) **CANNOT** participate in the MAA program.

Place an (X) before the item(s)	MAA Claiming Plan Amendment:	Required Documents:
<input type="checkbox"/>	<p>1. Addition of new CLAIMING UNIT: _____ <div style="text-align: center;">Name</div> <p>a. Is the Claiming Unit a Community Based Organization (CBO)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b. Is the Claiming Unit a Federally Qualified Health Center (FQHC)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, do not proceed. This Claiming Unit cannot participate in the MAA program.</p> <p>c. Is the Claiming Unit associated with an FQHC? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please attach a detailed explanation to this checklist.</p> <p>d. Is the Claiming Unit an entity that is paid a capitated or all-inclusive rate? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>e. What is the funding source(s) for this claiming unit (please list out the funding source(s) below)?:</p> </p>	Submit new amendment package including a Certification Statement .
<input type="checkbox"/>	<p>2. Addition of new MAA Category to an existing Claiming Unit; e.g., adding PP&PD</p> <p>Adding Activity: _____</p>	Submit new amendment package including a Certification Statement.
<input type="checkbox"/>	<p>3. Addition of a new Subcontractor to an existing Claiming Unit performing MAA.</p> <p>Name of new Subcontractor: _____</p>	Submit new amendment package including a Certification Statement.
<input type="checkbox"/>	<p>4. Change in Types of activities and/or services in the contract for which Medi-Cal services or MAA activities are performed.</p> <p>Describe changes _____</p> <p>_____</p>	Submit new amendment package including a Certification Statement.

For the following, send an e-mail to your program analyst along with any necessary documents for each requirement. This **Checklist** must accompany the MAA Claiming Plan e-mail:

LGA:		Fiscal Year:	Quarter:
Claiming Unit Name:		Date:	
Place an (X) before the item(s)	DELETE:	Required Documents:	
<input type="checkbox"/>	1. Previously approved Subcontractor from an existing Claiming Unit. Name of Subcontractor: _____	None.	
<input type="checkbox"/>	2. Previously approved Claiming Unit . Claiming Unit Name: _____	None.	
<input type="checkbox"/>	3. Previously approved Activity from an existing classification. Deleted Activity : _____	Revised Claiming Unit Functions Grid and Duty Statements, as applicable.	
<input type="checkbox"/>	4. Previously approved Classification . Deleted Classification: _____	Revised Claiming Unit Functions Grid.	
Place an (X) before the item(s)	CHANGE:	Required Documents:	
<input type="checkbox"/>	5. A Classification from the STAFF JOB CLASSIFICATION GRID, as described in box #9, on the Claiming Unit Functions Grid. Classification change: _____	Revised Claiming Unit Functions Grid and Duty Statement.	
<input type="checkbox"/>	6. In the Methodology used in calculating the Medi-Cal discount percentage for MAA.	Revised Activity Sheet(s) and Claiming Unit Functions Grid.	
<input type="checkbox"/>	7. In the Methodology used for determining how the time and costs for MAA will be developed and documented.	Revised Activity Sheet(s)	
<input type="checkbox"/>	8. In how (methodology/basis) the rate is calculated for Transportation costs.	Revised Activity Sheet(s)	
<input type="checkbox"/>	9. The Address, Phone Number or Contact Person for the Claiming Unit.	Revised pages where this information appears.	
<input type="checkbox"/>	10. The Name of the Claiming Unit . Name Changed to: _____	Revised pages where the Claiming Unit name appears.	
<input type="checkbox"/>	11. In the total Number of Staff for which MAA will be claimed -- increase or decrease of 25% or more than the number in the approved Claiming Plan.	Revised Claiming Unit Functions Grid.	
<input type="checkbox"/>	12. In the number of staff who are SPMP or Non-SPMP , as described in box #10, on the Claiming Unit Functions Grid.	Revised Claiming Unit Functions Grid.	
<input type="checkbox"/>	13. In the Targeted Population , e.g., addition of pregnant women who need treatment.	Revised Activity Sheet.	
<input type="checkbox"/>	14. Within the "Medi-Cal Covered Health Services" for which PP&PD is performed.	Revised PP&PD Activity Sheet.	
<input type="checkbox"/>	15. In the Description of the specific Claiming Unit Functions performed by the Claiming Unit, as described in box #8, on the Claiming Unit Functions Grid.	Revised Claiming Unit Functions Grid.	

Place an (X) before the item(s)	ADD:	Required Documents:
<input type="checkbox"/>	16. New Campaign, Program or Activity that is different from those already approved.	Revised Activity Sheet(s).
<input type="checkbox"/>	17. New Position Classifications performing MAA New position classification: _____	Revised Claiming Unit Functions Grid and Duty Statements.
<input type="checkbox"/>	18. Approved MAA Activity to an existing position classification performing MAA as described in boxes #9 and #11 on the Claiming Unit Functions Grid. Position and new activity: _____	Revised Claiming Unit Functions Grid and Duty Statement.
<input type="checkbox"/>	19. Other (please describe) _____ _____	Request assistance from DHCS regarding required documentation.