

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE (7/2013)

I. ACTIVITIES AND MEDI-CAL PERCENTAGES WORKSHEET

INVOICE INFORMATION	
1	Claiming Unit Name
	CDS Code
2	DHCS Contractor (Region)
3	Contract #
4	Prepared by
5	Title
6	Phone #
7	Date
8	Contract year/quarter
9	Period of Service

A	B	C	D E F G H				
Type of Activity	Code	Medi-Cal Discount %	MAA TIME SURVEY STAFF				
			Survey Results Percentages (a)	Quarter Average Percentages	Total Weighted-Average Survey Results	Allocate Gen. Admin./Paid Time Off (Code 16)	Apply Medi-Cal Discount % (Col. C X Col. G)
Non-Discounted:				-			
10 Initial Medi-Cal Outreach	4	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
11 Facilitating Medi-Cal Application	6	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
12 Medi-Cal Claims Administration, Coordination & Training	15	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
Discounted:							
13 Ongoing Referral, Coordination, and Monitoring of Medi-Cal Services	8	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
14 Arranging Transportation in Support of Medi-Cal Services	10	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
15 Translation Related to Medi-Cal Services	12	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
16 Program Planning, Policy Development & Interagency Coord. Related to Medi-Cal Services	14	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
Non-claimable:							
17 School-Related, Education, and Other Activities	1				#DIV/0!	#DIV/0!	
18 Direct Medical Services	2				#DIV/0!	#DIV/0!	
19 Non-Medi-Cal Outreach	3				#DIV/0!	#DIV/0!	
20 Facilitating Application for Non-Medi-Cal Programs	5				#DIV/0!	#DIV/0!	
21 Ongoing Referral, Coordination, and Monitoring of Non-Medi-Cal Services	7				#DIV/0!	#DIV/0!	
22 Transportation for Non-Medi-Cal Programs	9				#DIV/0!	#DIV/0!	
23 Non-Medi-Cal Translation	11				#DIV/0!	#DIV/0!	
24 Prog. Planning, Policy Dev., & Interagency Coord. Related to Non-Medi-Cal Services	13				#DIV/0!	#DIV/0!	
Allocated:							
25 General Administration/Completing the MAA Time Survey Form/Paid Time Off	16				#DIV/0!	Allocated	
26 TOTAL TIME			100.00%	100.00%	#DIV/0!	#DIV/0!	#DIV/0!
27 Number of Claiming Unit Staff Included in Each Survey							
28 State Approved Indirect Cost Rate for the Current Billing Period							

(a) A summary report supporting amounts entered in these columns are required to be submitted with the invoice. Invoices will not be processed or paid by DHCS without this supporting documentation.

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE

(7/2013)

II. DIRECT CHARGES WORKSHEET

Claiming Unit Name _____
 DHCS Contractor (Region) _____
 Contract # _____

Date _____
 Contract Year/Qtr. _____
 Period of Service _____

A	B	C SALARIES (Object 1000-2999)					D BENEFITS (Object 3000-3999)					E PERSONAL SERVICE CONTRACTS (Object 5800)				F OTHER COSTS (Object 4000-5999)			
		GROSS STAFF SALARIES	Medi-Cal Certified Time Factor (b)	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	GROSS STAFF BENEFITS	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Contract Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Total Other Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE
29	Initial Medi-Cal Outreach	4																	
a		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
b		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
c		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
d		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
	TOTAL	0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
30	Facilitating Medi-Cal Application	6																	
a		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
b		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
c		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
d		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
	TOTAL	0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
31	Medi-Cal Claims Admin., Coord. & Training	15																	
a		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
b		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
c		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
d		0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
	TOTAL	0	0.00%		0	0	0	0.00%		0	0	0	0	0	0	0	0	0	0
	NON-DISCOUNTED SUB-TOTAL	0			0	0	-			-	-	0	0	0	0	0	0	0	0
32	Ongoing Referral, Coord. and Monitoring of Medi-Cal Svcs	8																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
33	Arranging Transportation in Support of Medi-Cal Services	10																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
34	Translation Related to Medi-Cal Svcs	12																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
35	Program Planning, Policy Dev. & Intergency Coord Related to M/C Svcs	14																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	DISCOUNTED SUB-TOTAL	0			0	0	0			0	0	0		0	0	0	0	0	0
	TOTAL SALARY COSTS	0			0	0	-			-	-	0	0	0	0	0	0	0	0

(b) Signed calendars/documentation that support the Medi-Cal certified time factor, which must also include the certified time calculations.

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE

(7/2013)

III. PAYROLL DATA COLLECTION WORKSHEET

Claiming Unit Name	0	Date	
DHCS Contractor (Region)	0	Contract year/qtr	0
Contract #	0	Period of Service	

A		B		
SALARIES (Objects 1000-2999):	Functions 1000-9999, excluding 2700 & 7000-7199	BENEFITS (Objects 3000-3999):	Functions 1000-9999, excluding 2700 & 7000-7199	Total Claiming Unit Salaries & Benefits
36 Total Non-Federally Funded Claiming Unit Salaries (c)		Total Non-Federally Funded Claiming Unit Benefits (c)	-	-
37 Less: Time Survey Participant (Employee) Salary Costs		Less: Time Survey Participant (Employee) Benefit Costs	-	
38 Less: Direct Charge Salary Costs		Less: Direct Charge Benefit Costs	-	
39 TO NON-MAA COST POOL (P.4, Line 44, Col. G)	-	TO NON-MAA COST POOL (P. 4, Line 45, Col. G)	-	
School Administration and General Administration	Functions 2700 & 7000-7199	School Administration and General Administration	Functions 2700 & 7000-7199	
40 Total Non-Federally Funded Claiming Unit Salaries (c)		Total Non-Federally Funded Claiming Unit Benefits (c)		-
41 Less: Time Survey Participant (Employee) Salary Costs		Less: Time Survey Participant (Employee) Benefit Costs		
42 Less: Direct Charge Salary Costs		Less: Direct Charge Benefit Costs		
43 TO ALLOCATED COST POOL (P. 4, Line 44, Col. H)	-	TO ALLOCATED COST POOL (P. 4, Line 45, Col. H)	-	-

(c) A summary general ledger report supporting amounts entered in these cells (Row 36, Column A & B and Row 40, Column A & B) are required to be submitted with the invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE

(7/2013)

IV. COSTS AND REVENUES WORKSHEET

Claiming Unit Name: _____
 DHCS Contractor (Region) _____
 Contract #: _____

Date _____
 Contract year/quarter _____
 Period of Service _____

CATEGORY (OBJECTS)	TIME SURVEY				DIRECT CHARGE		NON-MAA	ALLOCATED	CONTROL TOTAL
	Participant	MAA Time Survey Percentage	Equals MAA Funded Costs (A X B)	Non-Claimable Time Survey Costs (A - C)	Claimable	NON-CLAIMABLE	NON CLAIMABLE (Funct. 1000-9999 excluding 2700 and 7000-7199)	GENERAL & ADMIN. (Funct. 2700 & 7000-7199)	
PERSONNEL COSTS									
	\$	\$	\$	\$	\$	\$	\$	\$	\$
44 Salaries (1000-2999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
45 Benefits (3000-3999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
46 SUBTOTAL PERSONNEL	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
REVENUE OFFSETS									
Non-Offset									
47 Federal Revenues (8100-8299)					0	0			-
48 State Revenue Limit Sources (8010-8099)									-
49 Other State Revenues (8300-8599)					0	0			-
50 Other Local Revenues (8600-8799)									-
51 Other Financing Sources (8910-8979)								0	0
52 Contributions to Restricted Programs (8980-8999)								0	0
53 Total Revenues					0	0		0	0
54 Personnel Costs less Revenue Offsets			#DIV/0!	#DIV/0!	0	0	0		
55 Allocation Percentages			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
OTHER COSTS AND ALLOCATIONS									
									Enter Amount of Other Costs from Columns C thru F included in Column J
56 Personal Service Contracts		#DIV/0!	#DIV/0!	#DIV/0!	-	0			0
57 Direct Charge Other Costs					-	-			0
58 ALLOCATION OF OTHER COSTS:			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		-
59 ALLOCATION OF GENERAL & ADMIN.			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		-
60 Subtotal Costs			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
61 Indirect Rate Applied			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
62 TOTAL COSTS			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
FFP CALCULATIONS									
63 MAA CLAIMABLE COSTS			#DIV/0!						#DIV/0!
64 Apply FFP Percentage (50%)			#DIV/0!						#DIV/0!
65 TOTAL FEDERAL SHARE			#DIV/0!						#DIV/0!

J
CLAIMING UNIT OTHER COSTS - NET OF FEDERALLY FUNDED EXPENDITURES (d)
 (Objects 4000-5999, Functions 2700 & 7000-7199, and excluding Resources 3000-5639 and 5650-5999)
 Enter Amount of Other Costs from Columns C thru F included in Column J
 Less Other Unallowable Costs
K
 (d) A summary general ledger report supporting amounts entered in this cell (Row 56, Column J) are required to be submitted with the invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

Prior Year Corresponding Quarter Variance Check		Prior Quarter Variance Check	
Enter PY Same Quarter's Reimbursement =>		Enter Prior Quarter's Reimbursement =>	-
Displayed is Percent Change from PY Same Quarter =>	0.00%	Displayed is Percent Change from Prior Quarter =>	0.00%
	#DIV/0!		#DIV/0!

0

 Typed Name of Preparer

0

 Title

0

 Telephone #

Typed Name of Authorized LEA Business Official

Title

Signature of Authorized LEA Business Official (Blue Ink Only)

Date

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit for the period claimed, that the funds/contributions have been expended as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51 for allowable activities and that these claimed expenditures have not previously been, nor will subsequently be, used for the federal match for this or any other program. Furthermore, I certify that the revenue sources identified in this invoice represent accurate and identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. 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 a violation of the Federal False Claims Act.

**LEC SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)
SUMMARY INVOICE**

(7/2013)

Claiming Unit Name: 0
 DHCS Contractor (Region) 0
 Contract # 0

Date _____
 Contract year/quarter

0

 Period of Service _____

Type of Invoice (check one):

Original Invoice
Revised Invoice
Corrected Invoice

Enter the Total Amount Previously Reimbursed for the Period of Service \$ _____
 Amount Previously Over or Under Reimbursed for the Period of Service \$

0

 TOTAL to be Reimbursed by Federal Government Representing 50% Share \$ #DIV/0!

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall 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 Claims Act.

 Typed Name of Signer

 LEC Coordinator Signature

 Title

 Date

<p>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 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.</p>		
_____ Signed	_____ SSMI Title	_____ Date

 Analyst Initials
CALSTARS Code 1__-95929-9912-702-42-60 LEC

**Department of Health Care Services
 Safety Net Financing Division
 School Medi-Cal Administrative Activities
 1501 Capitol Ave., MS 4603
 PO Box 997413
 Sacramento, CA 95899-7413**

**LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)
SUMMARY INVOICE**

(7/2013)

Claiming Unit Name	0	Date	<input type="text"/>
DHCS Contractor	0	Contract year/quarter	0
Contract #	0	Period of Service	<input type="text"/>

Type of Invoice (check one):

Original Invoice

Revised Invoice

Corrected Invoice

Enter the Total Amount Previously Reimbursed for the Period of Service \$ _____

Amount Previously Over or Under Reimbursed for the Period of Service \$ _____ 0

TOTAL to be Reimbursed by Federal Government Representing 50% Share \$ #DIV/0!

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall 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 Claims Act.

_____	_____
Typed Name of Signer	LGA Coordinator 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 (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 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.

_____	_____	_____
Signed	SSMI Title	Date
_____	<p>Department of Health Care Services Safety Net Financing Division School Medi-Cal Administrative Activities 1501 Capitol Ave., MS 4603 PO Box 997413 Sacramento, CA 95899-7413</p>	

CALSTARS Code 1__-95910-9912-702-42-60 LGA

