

**DIRECT PROVIDER CERTIFICATION**  
**for Drug Medi-Cal for Fiscal Year 2012-13**  
**Year-End Claim for Reimbursement**

Name and Address of Direct Contract Provider: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DHCS Contract Number: \_\_\_\_\_

County Name: \_\_\_\_\_

I, HEREBY CERTIFY under penalty of perjury that I am the official person responsible for the administration of Drug Medi-Cal alcohol and drug program services in and for said program; that I have not violated any of the provisions of Section 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Division 10.5, Part 2, Chapter 4 and Chapter 13 of the California Health and Safety Code; and that to the best of my knowledge and belief this claim is in all aspects true, correct, and in accordance with the law.

SIGNATURE: \_\_\_\_\_  
 Contract Administrator

DATE: \_\_\_\_\_

EXECUTED AT \_\_\_\_\_, California

**FOR STATE USE ONLY**

Drug Medi-Cal Funds

- 1. Claim for Reimbursement \_\_\_\_\_
- 2. Advances Paid to Date <\_\_\_\_\_>
- 3. Less State Admin. <\_\_\_\_\_>
- 4. Less Share of Cost <\_\_\_\_\_>
- 5. Net Reimbursement \_\_\_\_\_

DHCS APPROVAL SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_