

\_\_\_\_\_ (County Name)

**COUNTY CERTIFICATION**  
 Prevention and Treatment Cost Report  
 Year-End Claim for Reimbursement  
 Fiscal Year 2012-13

***PART I: I HEREBY CERTIFY** under penalty of perjury that I am the official responsible for the administration of Department of Health Care Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1096 of the California 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 respects true, correct, and in accordance with law.*

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
 County Alcohol and Drug Program Administrator

EXECUTED AT \_\_\_\_\_, CALIFORNIA

***PART II: I CERTIFY** under penalty of perjury, that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts.*

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
 TITLE: \_\_\_\_\_  
 County Auditor-Controller, City Finance Officer, etc.

EXECUTED AT \_\_\_\_\_, CALIFORNIA

**FOR STATE USE ONLY**

	<b>CLAIM FOR REIMBURSEMENT</b>	<b>ADVANCES PAID TO DATE</b>	<b>ADJUSTMENTS</b>	<b>NET REIMBURSEMENT</b>
<b>Parolee Services</b>				
<b>Drug Medi-Cal (Federal)</b>				
<b>Block Grant – FFY 2012</b>				
<b>Block Grant – FFY 2013</b>				
<b>TOTAL FUNDING</b>				

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
 DEPARTMENT OF HEALTH CARE SERVICES