

Quality Assurance Fee (QAF) - Annual Report Designated Intermediate Care Facility (DICF)

Fiscal Year 14/15

Name
Address

National Provider Identifier:

Due Date: **9/30/2015**

Completion and submission of this form is mandatory.

Please complete this form and return by the due date to:

Department of Health Care Services
QAF Overpayments Section, Mail Stop 4720
1500 Capitol Avenue, Suite 72.320
P.O. Box 997425
Sacramento, CA 95899-7421

Gross receipts do not include:

- a. Return of overpayments
- b. Uncollected debts
- c. Vendor rebates received by the DICF
- d. Charitable contributions, grants, and any other contributions to the DICF that are not fees for services provided to a Medi-Cal beneficiary

1. Gross receipts for the year 2013-2014

- a. Medi-Cal fee-for-service (including share of costs) \$ _____
- b. Medi-Cal Managed Care health plans
 (e.g., Cal-Optima, Partnership Health plan, etc.) \$ _____
- c. Other non-Medi-Cal (e.g., private pay) \$ _____
- d. QAF Day Treatment Costs
 (including non-Medical Transportation) \$ _____

2. Total of gross receipts for the year (sum of lines a, b, c and d) \$ _____

The Department of Health Care Services may request documentation to verify the amounts stated on this form.

I am an administrator, officer, or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, correct, and complete.

Print name and title of person signing declaration

Phone

Original signature

Date

E-mail

The information requested on this form is required by the Department of Health Care Services, Third Party Liability and Recovery Division, and will be used for the sole purpose of reconciling QAF payments.