

# Quality Assurance Fee (QAF) - Quarterly Payment Designated Intermediate Care Facility (DICF)

**Fiscal Year and Quarter 2015-16 – 2nd QTR (OCT - DEC)**

National Provider Identifier:

**Due Date: March 31, 2016**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1780	000	00	H	125600	59	84005	A15	3213

**Completion and submission of this form is mandatory.**

<p><b>Please complete this form and return with payment by due date to:</b></p> <p>Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415</p>	<p style="text-align: center;"><b>Gross receipts do not include:</b></p> <p>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</p>
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<p>1. Gross receipts for this quarter</p> <p style="margin-left: 20px;">a. Medi-Cal fee-for-service (including share of costs) \$ _____</p> <p style="margin-left: 20px;">b. Medi-Cal Managed Care health plans (e.g., Cal-Optima, Molina, etc.) \$ _____</p> <p style="margin-left: 20px;">c. Other non-Medi-Cal (e.g., private pay) \$ _____</p> <p>2. Total of gross receipts for this quarter (sum of lines a, b, and c)     \$ _____</p>	<p>3. Multiply line 2 by 6.0% [.06]. \$ _____</p> <p>4. Enter license fee (or credit of license fee from previous quarter). If you have already deducted the entire license fee this fiscal year, leave this line blank. \$ _____</p> <p>5. Subtract line 4 from line 3 and write it here. If line 4 is blank, enter total from line 3. <b>This is your QAF.</b> \$ _____</p>
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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	E-mail
Date	

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 processing QAF payments.