

State of California—Health and Human Services Agency



Department of Health Care Services



JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

NPI:

August 21, 2015

INTERMEDIATE CARE FACILITY/DEVELOPMENTALLY DISABLED QUALITY ASSURANCE FEE PROGRAM

The California *Health and Safety Code*, Sections 1324 – 1324.14 and California Code of Regulations, Title 22, Sections 52100 – 52104 require the California Department of Health Care Services (DHCS) to implement a Medi-Cal Quality Assurance Fee (QAF) Program for all Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative and ICF/DD-Nursing facilities (including those ICF/DD facilities participating in the continuous Nursing Waiver). The QAF Program, which became effective on July 1, 2003, imposes a fee of six percent on a facility's gross receipts during each calendar quarter.

Enclosed are the four (4) QAF quarterly payment invoices and the Annual Report for the 15/16 Fiscal Year to be completed by the ICF/DD facility.

ICF/DD Quality Assurance Fee Quarterly Payment Invoices are used to calculate the quality assurance fee for the following periods:

- 1st Quarter – July 1, 2015 through September 30, 2015
- 2nd Quarter - October 1, 2015 through December 31, 2015
- 3rd Quarter – January 1, 2016 through March 31, 2016
- 4th Quarter – April 1, 2016 through June 30, 2016
- Annual Report

If you need additional forms please go to

<http://www.dhcs.ca.gov/provgovpart/Pages/DesignatedIntermediateCareFacility.aspx>

For purposes of this program, the term “gross receipts” is defined as compensation for services provided to all residents in the facility. In accordance with federal rules, “gross receipts” does not include any amounts the facility may receive as a result of the following:

- Return of overpayments;
- Write-off of bad debts;
- Vendor rebates; or
- Charitable contributions

As a condition for facilities to participate in the Medi-Cal program, the QAF must be paid to DHCS on or before the due date printed on each quarterly form.

Please submit the quarterly payment form with your payment, and the QAF Annual Report to the following address by the due date indicated on the forms. Write your provider number on the front of your check or money order to ensure the payment is properly credited to the correct facility and to help expedite the payment process.

Department of Health Care Services
Accounting Section/Cashiers Unit
MS 1101
P.O. Box 997415
Sacramento, CA 95899-7415

If you have questions regarding the QAF Program and/or the completion of the enclosed forms, please contact the ICF/DD QAF Program Coordinator at (916) 650-0583.

Sincerely,

John Beshara

John Beshara, Chief
Quality Assurance Fee Unit

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>Please complete this form and return with payment by due date to:</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;">Gross receipts do not include:</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. This is your QAF. \$ _____</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	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 processing QAF payments.

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

Fiscal Year and Quarter 2015-16 – 3rd QTR (JAN - MAR)

National Provider Identifier:

Due Date: June 30, 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.

Please complete this form and return with payment by due date to:

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

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 this quarter
- a. Medi-Cal fee-for-service (including share of costs)
\$ _____
 - b. Medi-Cal Managed Care health plans (e.g., Cal-Optima, Molina, etc.)
\$ _____
 - c. Other non-Medi-Cal (e.g., private pay)
\$ _____
2. Total of gross receipts for this quarter (sum of lines a, b, and c) \$ _____

3. Multiply line 2 by 6.0% [.06]. \$ _____
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.
\$ _____
5. Subtract line 4 from line 3 and write it here. If line 4 is blank, enter total from line 3.
This is your QAF. \$ _____

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 processing QAF payments.

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

Fiscal Year and Quarter 2015-16 – 4th QTR (APR - JUNE)

National Provider Identifier:

Due Date: September 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>Please complete this form and return with payment by due date to:</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>Gross receipts do not include:</p> <ul style="list-style-type: none"> 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
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<p>1. Gross receipts for this quarter</p> <ul style="list-style-type: none"> a. Medi-Cal fee-for-service (including share of costs) \$ _____ b. Medi-Cal Managed Care health plans (e.g., Cal-Optima, Molina, etc.) \$ _____ c. Other non-Medi-Cal (e.g., private pay) \$ _____ <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. This is your QAF. \$ _____</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

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 processing QAF payments.

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

Fiscal Year 15/16

National Provider Identifier:

Due Date: **9/30/2016**

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 General Collection 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.

Quality Assurance Fee (QAF) - Monthly Day Treatment Costs Payment Designated Intermediate Care Facility (DICF)

Month & Year: _____

Facility Name:
Address:

National Provider Identifier:

Due Date:

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.

Please complete this form and return with payment by due date to:

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

Supplemental Services Summary Claim (Invoice):

- a. Provided by Department of Developmental Services
- b. Delinquent QAF Day Treatment Costs will subject the facility to the same penalties authorized by Health and Safety Code, § 1324 – 1324.14

1. Enter your Vendor number, located at the top of the **ICF Supplemental Services Remittance Advice**.
(Example: 000ICF0199-09)

2. QAF Day Treatment Costs (including non-Medical Transportation). **Please enter information from the ICF Supplemental Services Summary Claim (Invoice).**

a. Line 7 - Summary Claim (Invoice) \$ _____

b. Total Claims (Revenue) \$ _____ Qtr/Yr _____

3. Enter Amount from 2a. **This is your QAF Day Treatment Costs.**

\$ _____

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 processing QAF payments.