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

Fiscal Year and Quarter _____– _____

National Provider Identifier:

Due Date:

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
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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.