MEDI-CAL QUARTERLY CLAIM FOR REIMBURSEMENT -
MENTAL HEALTH MEDI-CAL ADMINISTRATIVE ACTIVITIES (MH MAA)
MC 1982 D (Revised 7/12)

Date:	County Code:	County:	Legal Entity #:
Claiming Unit:			Provider #:
Fiscal Year:	Claim for Quarter of: **xx/xx/xx - xx/xx/xx/**		

			Column A	Column B	Column C	Column D	Column E
	Enter Service Function Codes in Columns A, B and D:				Col. A + B		Col. C + D
			Non-Enhanced	Non-Enhanced	Non-Enhanced	Enhanced SPMP	Claim
			No Medi-Cal disc.	Apply Medi-Cal %	Sub-Total	Apply Medi-Cal %	Totals
1	Number of MAA Units		-	-	-	-	-
2	MAA Salaries and Benefits		$ -	$ -		$ -	
3	Direct Claim Amount **(Attach supporting documentation)**		$ -	$ -		$ -	
4	Total Salaries and Benefits	(1 x 2 + 3)	$ -	$ -		$ -	
5	Operating Expenses-Enter %	0.00%	$ -	$ -	$ -	$ -	$ -
6	Total MAA Expenditures	(4 + 5)	$ -	$ -	$ -	$ -	$ -
7	Medi-Cal Eligibility Factor		N/A	0.00%		0.00%	
8	Total Eligible MAA Expenditures	(6 x 7)	$ -	$ -	$ -	$ -	$ -
9	Offsetting Revenues **(If any)-Not Claimable Under Medi-Cal**		$ -	$ -	$ -	$ -	$ -
10	**Total Allowable Expenditures**	(8 - 9)	$ -	$ -	$ -	$ -	**$ -**
11	**FFP* @ 50%**	(10A x 0.5, 10B x 0.5)	**$ -**	**$ -**	**$ -**		**$ -**
12	**FFP @ 75%**	(10D x .75)				**$ -**	**$ -**
13	**Local Match to FFP**	(10Ax0.5, 10Bx0.5, 10Dx0.25)	**$ -**	**$ -**	**$ -**	**$ -**	$ -
14	**TOTAL FFP CLAIMABLE**	(11E + 12E)					**$ -**

***Federal Financial Participation**

NOTE: With the exception of lines 1 and 2, all cells are formatted to calculate to two decimal places.

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for administration of Mental Health Medi-Cal Administrative Activities (MAA) and that I have not violated any of the provisions of Section 1090 et. seq. of the Government Code; that I am authorized to sign this certification on behalf of the county; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete and to the best of my knowledge this claim is in all respects true, correct and in accordance with law. The county understands that any payment to the county resulting from this invoice will be paid with federal funds and that any falsification or concealment of material fact may be prosecuted under federal and/or state laws. The County agrees to furnish any information regarding payments claimed for MAA, on request, to the California Department of Health Care Services (DHCS) and/or the Centers for Medicare and Medicaid Services. I further certify that this invoice is based upon actual, total funds expenditures of public funds for the period claimed.

Signature: _____ Date: _____

Print Name: _____ Title: _____

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts and am authorized to sign this certification on behalf of the County. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total funds expenditures necessary for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law including but not limited to Sections 430.30 and 433.51 of Title 42, Code of Federal Regulations (CFR). I understand that DHCS may deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds included in this claim are subject to review and audit by DHCS and/or the federal government and must be kept, pursuant to Section 433.32 of Title 42, CFR, for a minimum of three years after the final determination of costs is made through the DHCS reconciled Cost Report settlement process and retained beyond the 3-year period if audit findings have not been resolved.

Date: _____ Signature: _____

Title: _____
County Auditor Controller or City Financial Officer