State of California – Health and Human Services Agency Department of Health Care Services

# CARE Act Quarterly Administrative Cost Reimbursement Claim

Date: _____ Fiscal Year: _____ County: _____ County Code: ____

Quarter: _____ Number of CARE Act Participants: _____

| Activity | Total Hours | Activity Rate | Total Claim Amount |
|---|---|---|---|
| Court Report Activity | | | |
| Court Hearing Time Activity | | | |
| Notice Activity | | | |
| Outreach and Engagement Activity | | | |
| Data Reporting | | | |
| Total Claim: | | | |

**Certification**

Executed at: _____

Name: _____ Title: _____

I certify that the staff hours spent on CARE Act activities are accurate and verifiable.

Signature: _____ Date: _____