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: _____