Quality Assurance Fee – Monthly Day Treatment Costs Payment
Designated Intermediate Care Facility

Facility Information	Payment Information
Facility Name:	**Rate Year:**
Street Address:	**Full Year Reconciliation: Yes ☐ No ☐**
City:	**Month Reporting:**
State:	**Amount Due:**
Zip Code:	**Due Date:**
NPI:	
Vendor Number:	
Phone:	

Fiscal Year	Reporting Structure	Account	App Ref	Service Location
	4260KB0B	4129200	980	84005
Activity	**Program**	**Alt Account**	**Fund**	**Project**
	9990	4129200016	3213	

The Supplemental Services Summary Claim (Invoice) is provided by Department of Developmental Services. Delinquent QAF Day Treatment Costs will subject the facility to the same penalties authorized by Health and Safety Code, § 1324 – 1324.14.

Amount Due:
1. 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):
c. Month/Year:
2. Enter Amount from 1a. **This is your QAF Day Treatment Costs**:

Payment Instructions:

Please visit http://dhcs.ca.gov/epay and use invoice number **DAY12345678** to pay via EFT, the preferred method of payment. To pay by mail, please submit payment and form 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.

Submitter Information:	
Name:	**Email:**
Original Signature:	**Date:**
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*.	