STA	ATE OF CALIFORNIA – Health	and Human Services Agency		Department of Health Care Servi	
	DRUG I	MEDI-CAL CERTIFICATION FO	R FEDERAL REIMBURSE	MENT	
Date (mm/dd/yyyy)		County Code	County	County	
		Claim EDI Filename			
		Total Actual Expen	ditures	TOTAL \$	
CE	RTIFICATION FOR SERVICES	RENDERED:			
ΙH	EREBY CERTIFY under penal	ty of perjury that—			
1.	I am the official responsible for the administration of the Drug Medi-Cal services for the above-named agency, and that I have not violation any of the provisions of Section 1090 et. seq. of the Government Code.				
2.	To the best of my knowledge and belief, each claim file is in all respects true, correct, and in accordance with state and federal law a regulations, including Section 1903(a) of the Social Security Act and 42 C.F.R. Section 433.51, and any falsification or concealment o material fact may be prosecuted under federal and/or state laws.				
3.	This certification is based on actual, total-fund expenditures of public funds necessary for claiming Federal Financial Participation (FF pursuant to all applicable requirements of federal law, including 42 C.F.R. Section 433.51 and that the expenditures claimed have no previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program (excest those claims, if any, that are being submitted as Void and/or Replacement claims). I also understand that misrepresentation of an information constitutes a violation of federal and state law.				
4.	Pursuant to 42 C.F.R. Section 433.32, the County agrees to keep for a minimum of three years after the final determination of costs a made through the California Department of Health Care Services (DHCS) reconciled Cost Report settlement process and retained beyo the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose furthe extent of services furnished to the client. The County also agrees to furnish these records and any information regarding paymer claimed for providing the services, on request, within the State of California, to the Department of Health Care Services Medi-Cal Fra Unit; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Ri Medical Insurance Board or their duly authorized representatives.				
sup	oported for purposes of claim	California must deny payment o ing federal financial participatio	on.	if it determines the certification is not adequat	
Da	i.e		Signature	County Representative	
Fx	ecuted at:		California		
	EREBY CERTIFY under penal				
	1. I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts, and that am authorized to sign this certification on behalf of the County, and that the information is to be used for filing a claim with the feder government for federal funds pursuant to 42 C.F.R. Section 430.30, and that I have not violated any of the provisions of Section 1090 e seq. of the Government Code.				
2.	This certification is based on actual, total-funds expenditures of public funds necessary for claiming FFP pursuant to all applicab requirements of federal law, including 42 C.F.R. Section 433.51 and that the expenditures claimed have not previously been, nor will the be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program (except those claims, if any, that a being submitted as Void and/or Replacement claims). I also understand that misrepresentation of any information constitutes a violation of federal and state law.				
3.	I acknowledge that all records of funds expended are subject to review and audit by DHCS and/or the federal government and the pursuant to 42 C.F.R. Section 433.32, all records necessary to fully disclose the extent of services furnished to clients must be kept for minimum of three years after the final determination of costs are made through the DHCS reconciled Cost Report settlement process are retained beyond the three-year period if audit findings have not been resolved.				
		California must deny payment o ing federal financial participatio		if it determines the certification is not adequat	
Da	te:		Signature:		
Titl	le:		Executed at:	, California	

Please fax the completed form to DHCS, Fiscal Management and Accountability Branch, at (916) 322-1176. The original form is for your files. If you have any questions, please call your assigned county analyst of the Fiscal Management and Accountability Branch.

DHCS 100224A (Revised 7/2014)

(County Auditor-Controller, City Finance Officer, or County Accounting Officer)