SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)

REASONABLENESS TEST CRITERIA (RTC) Certification

Claiming Unit Name:		**Today's Date:**	
DHCS Contractor:		**Contract Year/Quarter:**	
Contract #:		**Period of Service:**	

1. Provide a detailed description of all activities performed for billable codes that exceed the established benchmark percentages listed in the RTC. List the specific code and the reasons for the excess time being claimed. (Use additional sheets as necessary and attach a copy of the overall Time Survey results.)

2. For each job classification requested that is not on the Time Survey Participant Universe Authorized Positions list, please provide a detailed description of the activities to be performed for each billable SMAA activity code.

Claiming Unit Certification

I certify under penalty of perjury that the time survey participants within this claiming unit are not instructed to perform any additional SMAA related activities *(other than those related to the actual recording of time on the time survey form)* during the time survey week and that the activities recorded by the participants accurately represent 100% of time and effort for the specified time frame and reflect only those activities that would be performed during the normal course of an average work day. Based on my knowledge of the activities normally performed by the time survey participants within this claiming unit, I believe that the summary time survey results are a reasonable proxy of the time spent during the entire period of service and will result in allowable costs consistent with the requirements of OMB Circular A-87.

Name	Signature
Title	Date

LEC/LGA Certification

I hereby certify to the best of my knowledge and belief that the information contained herein accurately describes the SMAA activities performed during the time survey period and the time survey results capture 100% of the activities performed in the specified timeframe (whether Medicaid allocable or not) and are reflective of SMAA activities performed during the entire period of service. I concur with the claiming unit's assessment that the summary time survey results are a reasonable proxy of the claiming unit's activities for the entire period of service and result in allowable costs consistent with the requirements of OMB Circular A-87.

Name	Signature
Title	Date

For DHCS Program Use

I hereby certify to the best of my knowledge and belief that the information contained herein captures 100% of the activities performed in the specified timeframe (whether Medicaid allocable or not) and accurately describes the SMAA activities performed by the time survey participants of the named claiming unit. I concur with the claiming unit's assessment that the summary time survey results are a reasonable proxy of the claiming unit's activities for the entire period of service and result in allowable costs consistent with the requirements of OMB Circular A-87. I have evaluated the actual activities performed, the positions of the staff performing the activities, and the amount of time spent in the performance of the activities and believe they are necessary for the proper and efficient administration of the Medi-Cal Program.

Name	Signature
Title	Date