**TEMPLATE**

# **DMC-ODS COUNTY CERTIFICATION**

**I hereby certify that I am the Plan’s Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has been delegated authority by the Plan’s CEO or CFO in [INSERT COUNTY NAME HERE] County to certify that the following are true and correct:**

The following data, information, and documentation has been certified, compiled, and submitted in full compliance with Title 42, Code of Federal Regulations Parts 438.604 and 438.606. The requirements outlined here do not supersede existing requirements related to certification of Certified Public Expenditures and/or Short-Doyle/ Medi-Cal claims and annual cost reports.

I attest that the data, information, and documentation submitted is accurate, complete, and truthful to the best of my information, knowledge, and belief.

The certified data submitted for the [INSERT SPECIFIED MONTH AND YEAR] includes: [PROVIDE THE TYPE OF SUBMISSION AS DESCRIBED BELOW]

* Enrollee encounter data;
* Documentation to demonstrate compliance with DHCS’ requirements for availability and accessibility of services, including the adequacy of the provider network;
* Information on ownership and control;
* Quarterly data submitted to DHCS on beneficiary grievance and appeals;
* Monthly American Society of Addiction Medicine Level of Care data;
* Annual report of overpayment recoveries; or,
* Other data, information, or documentation related to the performance of the county’s obligations as required by DHCS or the Secretary of Health and Human Services, and in the intergovernmental agreement.

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**