

**SHORT-DOYLE/MEDI-CAL CERTIFICATION AND CLAIM FOR
REIMBURSEMENT-TREATMENT COST**
MH1982 A (Rev. 3/08)

Date (m/d/yy)	County Code	County
Fiscal Year (yy/yy)	Claim Service Period (mm/yyyy)	
Total Actual Expenditures:		\$ TOTAL

CERTIFICATION FOR SERVICES RENDERED:

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; that this claim is based on actual, total expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. The County certifies under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the County. The services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan. The County certifies that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. The County agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives. Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19th) birthday who were assessed or treated for a serious emotional disturbance (SED). The County also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I FURTHER CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract with the California Department of Mental Health (DMH). The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary. The services included in the claim were actually provided to the beneficiary. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the DMH. For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the DMH.

Date: _____ Signature: _____
Local Mental Health Director

Executed at: _____, California

CERTIFICATION OF TOTAL FUNDS EXPENDITURES:

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts and that the information is to be used for filing a claim with the federal government for federal funds and, I understand that misrepresentation of any information provided herein constitutes violation of federal and state law. I further CERTIFY that this claim is based on actual, total expenditures of public funds as necessary for claiming federal financial participation pursuant to all applicable requirements of federal law, including Section 1903(a) of the Social Security Act and 42 C.F.R. 433.51 and that the expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive federal participation funds under Medicaid or any other program. I understand that the Department must deny payment of any claim submitted if it determines that the certification is not adequately supported for purposes of claiming federal financial participation. I acknowledge that all records of funds expended are subject to review and audit by the Department of Mental Health, the Department of Health Care Services, and/or the Federal Government, and that all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum period of three years from the date of service.

Date: _____ Signature: _____

Title: _____ Executed at: _____, California
(County Auditor-Controller, City Finance Officer, or Local
Mental Health Accounting Officer or other authorized official)

Please fax the completed form to the Department of Mental Health (DMH), Information Technology (IT) Operations Support at (916) 654-3007. Keep a copy of the form for your files and send the original form to DMH. If you have any questions, please call DMH Information Technology helpdesk at (916) 654-3117.

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