CERTIFICATION FOR SERVICES RENDERED:

I HEREBY CERTIFY under penalty of perjury that I am the 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 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: ___________________________

Local Mental Health Director

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

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.