DRUG MEDI-CAL CERTIFICATION FOR FEDERAL REIMBURSEMENT

Date (mm/dd/yyyy)	County Code	County
	Claim EDI Filename	

	TOTAL
Total Actual Expenditures	**$**

CERTIFICATION FOR SERVICES RENDERED:

I HEREBY CERTIFY under penalty 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 violated 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 and regulations, including Section 1903(a) of the Social Security Act and 42 C.F.R. Section 433.51, and any falsification or concealment of a 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 (FFP) pursuant to all applicable requirements of federal law, including 42 C.F.R. Section 433.51 and that the expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program (except those claims, if any, that are being submitted as Void and/or Replacement claims). I also understand that misrepresentation of any 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 are made through the California Department of Health Care Services (DHCS) reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County also agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the Department of Health Care Services Medi-Cal Fraud Unit; 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.**

I understand that the State of California must deny payment of any claim file submitted if it determines the certification is not adequately supported for purposes of claiming federal financial participation.

Date:_____ Signature:_____
County Representative

Executed at:_____ **,** California

I HEREBY CERTIFY under penalty of perjury that—

1. **I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts, and that I 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 federal 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 et. 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 applicable requirements of federal law, including 42 C.F.R. Section 433.51 and that the expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program (except those claims, if any, that are 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 that 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 a minimum of three years after the final determination of costs are made through the DHCS reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved.**

I understand that the State of California must deny payment of any claim file submitted if it determines the certification is not adequately supported for purposes of claiming federal financial participation.

Date:_____ Signature: _____

Title: _____ Executed at: _____ **,** California
(County Auditor-Controller, City Finance Officer, or County Accounting Officer)

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.