DHCS 5312 Claim Form Attestation: Drug Medi-Cal (DMC) Services Claim for Reimbursement of County Administrative Expenses

Date:		County Code:		County Name:	
Fiscal Year:		Quarter/Total FY:		ODS Waiver Services:	

MCHIP		Drug Medi-Cal Administrative Expenses	
FFP Contingency Management Amount Calculated:		FFP Contingency Management Amount Calculated:	
Total FFP Amount Calculated:		Total FFP Amount Calculated:	
Total SGF Amount Calculated:		Total SGF Amount Calculated:	

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Medi-Cal services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Sections 1090-1099 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Welfare and Institutions Code Section 14124.24; that the claim is based on actual, total-fund 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 the law. The County further certifies under penalty of perjury that: all claims for services provided to county clients have been provided to the clients by the County or County-contracted provider; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete. The County understands that payment of these claims from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. For Non-ODS Waiver counties, pursuant to the Code of the Federal Regulations (CFR) Title 42, Section 433.32, the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS 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. Pursuant to the Code of Federal Regulations (CFR) Title 42, Section 438.3 (u), ODS Waiver participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for a period of ten years from the date of service for all claims for reimbursement. of California to DHCS, the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, gender, or physical or mental disability.

Signature: _____

County Alcohol and Other Drug Programs Administrator

Date: _____

I CERTIFY under penalty of perjury that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement ofaccounts; 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 CFR Title 42, Section 430.30. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law, including, but not limited to CFR Title 42, Section 430.30 and 433.51, and the Federal Office of Management and Budget Circular A-87, 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. I understand that DHCS must deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all the records of funds expended are subject to review and audit by DHCS and/or the federal government and that, pursuant to CFR Title 42, 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 is made through the DHCS cost report settlement process and retained beyond the three year period if audit findings have not been resolved. I understand that ODS Waiver records must be maintained for a period of ten years after the date of service for all claims for reimbursement, pursuant to the code of Federal Regulations (CFR) Title 42, Section 438.3 (u).

Signature: _____ Date: _____

Title: _____

County Auditor-Controller, Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer

Instructions

Heading Instructions:

County: From Dropdown Selection, select the County Name
County Code: From dropdown selection, select the County Code
Date: Enter the date the claim form is submitted
Fiscal Year: From dropdown selection, select Fiscal Year in which costs were incurred
ODS Waiver Services: Mark "X" if county is a DMC-ODS county
The MCHIP and DMC Administrative Expenses table should be transferred directly from the table at the bottom of the claiming workbook.

Certifications:

Each claim form must include the signed certification of the County Alcohol and Other Drug Programs Administrator and either County Auditor-Controller, Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer.

Completed form is due within 60 calendar days following the end of the service quarter. After completing and signing the claim form attestation, combine with the the completed MC 5312 Claim Workbook as a PDF attachment to SUDFMAB@dhcs.ca.gov.