3; : 4"E<"SHORT DOYLE/MEDI-CAL MONTHLY CLAIM FOR REIMBURSEMENT / QUALITY ASSURANCE1 UTILAZATION REVIEW (QA/UR) COSTS	*(See instruction on reverse side*	Fiscal Year Claim For (Month)
Date:	County Code	County

Name:	Position #:	
Classification:	Form #	
SPMP (Skilled Professional Medical Personnel)	A SPMP	B OTHER

		A SPMP	B OTHER
1	Salary		
2	Benefits		
3	Training		
4	Travel		
5	General Expense	■	
6	Communication	■	
7	Facility Operation	■	
8	TOTAL (1 thru 7)		
9	Percent of Time Spent on QA/UR		
10	Percent of Time Spent on QA/UR for Medi-Cal		
11	Claimable Amount (8) x (9) x (10)		
12	FFP – 75% Amount (11A) x (0.75)		■
13	FFP – 50% Amount (11B) x (0.50)	■	
14	County Match to FFP (11A minus 12A) and (11B minus 13B)		
15	TOTAL AMOUNT CLAIMABLE (12A + 13B)		

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 am authorized to sign this certification form on behalf of the County; that I have not violated any of the provisions of Section 1090 et. seq. 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; 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 further 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; and 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. Pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees to keep, for a minimum of three years after the final determination of costs is made through the DMH 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 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 Care Services (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 further certifies under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

Date: ______________________ Signature: ______________________

Local Mental Health Director

Executed at______________________ , California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official, as delegated by the Board of Supervisors, 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. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify that the claim is based on actual, total-funds expenditures necessary for claiming Federal Financial Participation (FFP) pursuant to all applicable requirements of state and federal law including, but not limited, to Sections 430.30 and 433.51 of Title 42, Code of Federal Regulations (CFR). I understand that DHCS may deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds included in this claim are subject to review and audit by DHCS and/or the federal government and that, pursuant to Section 433.32, Title 42, CFR all records of funds must be kept for a minimum of three years after the final determination of costs is made through the DHCS reconciled Cost Report settlement process and retained beyond the three year period if audit findings have not been resolved.

Date: ______________________ Signature: ______________________

Title: ______________________ Executed at ______________________, California

County Auditor-Controller, City Finance Officer, or Local Mental Health Accounting Officer

FOR STATE DEPARTMENT OF HEALTH CARE SERVICES USE ONLY

County Claim for Reimbursement $ ______________________

Signature: ______________________ Date: ______________________

Accounting Officer

Schedule Number: ______________________

INSTRUCTIONS FOR COMPLETING THE MH 1982 C QUALITY ASSURANCE/UTILIZATION REVIEW (QA/UR)

Enter the name, claim month, and fiscal year. If you are using this form for individual staff documentation in lieu of SB 910 time study, complete the name, classification, form number, and position number boxes.

Lines 1-7, Columns A & B: Enter the amounts expended for skilled professional medical personnel and their direct support staff in Column A. Enter the amounts expended for non-medical professionals and non-enhanced clerical staff in Column B.

Line 8, Column A: Enter total expenditures to be reimbursed at the enhanced Federal Medical Assistance Percentage (FMAP) of 75 percent. The Federal Financial Participation (FFP) reimbursement will be paid at this rate.

Line 8, Column B: Enter total expenditures to be reimbursed at the non-enhanced FMAP of 50 percent. The FFP reimbursement will be paid at this rate.

Line 9: Enter the percentage of time staff spent on QA/UR activities.

Line 10: Enter the percentage of time spent on Medi-Cal QA/UR. If your county only provides QA/UR only for Medi-Cal patients, then enter 100 percent. If your county provides quality assurance activities for all patients, then the percentage of Medi-Cal patients will be used here.

Lines 11, 12, 13, 14 and 15: Complete the calculations as shown.

Send a .pdf of the completed MH 1982 C to:

1982CClaim@dhcs.ca.gov