SECTION 7 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT

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General Information and Requirements for Children's Medical Services (CMS) Quarterly Administrative Expenditure Invoices

I. The quarterly administrative expenditure invoice forms contain the same five line items used in the budgets.

II. Counties/cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices. However, justification worksheets and/or documentation of how expenditure amounts were derived must be maintained at the county/city level for audit purposes.

III. Quarterly expenditure invoices for salaries and wages must be supported by time studies or attendance documentation maintained at the county/city level for audit purposes. Documentation for staff who qualify for enhanced federal funding and/or who work on more than one program must include quarterly time studies at a minimum, prepared for each budgeted position using the same representative month each quarter. (See Section 8, Federal Financial Participation).

IV. Tools for using time study information to allocate personnel services and benefits expenses are included in Section 8, FFP. These include time study policies, instructions for completion of the time study, time study function code definitions, and examples of activities for CMS programs.

V. Overhead costs submitted on the quarterly invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller (OASC) 10 federal guidelines. External overhead costs invoiced for reimbursement must be based on the plan approved by the State Controller's Office (A-87 approval letter). Documentation must be maintained by the county/city for audit purposes.

VI. Invoices must list **actual** expenditures made during the quarter for items approved in the budget justification worksheet, with the following exceptions:

   A. Indirect costs are approved estimates for invoicing purposes based on federal OASC-10 cost allocation methods.

   B. Staff benefits may be invoiced at an estimated rate for three quarters but must be adjusted to actual costs on the fourth quarter invoice.

   C. Counties may not invoice for goods (e.g., equipment, printing, videos, etc.) until after they have actually been received.

VII. For questions concerning the appropriate line item usage for an expense, refer to Section 6 for the definitions of the five line item categories listed on the quarterly invoice or contact the regional administrative consultant/analyst.

VIII. Round all figures to the nearest whole dollar; 50 cents or more is rounded up, and 49 cents and less is rounded down.

IX. **Quarterly invoices for expenditures authorized in CMS budgets shall be submitted no later than 60 days after the end of each quarter. All quarterly invoices are paid on a cash basis. Therefore, it is important to submit invoices timely.**

A. First quarter invoice (time period of July 1 through September 30) is due by November 30.

B. Second quarter invoice (time period of October 1 through December 31) is due by February 28.

C. Third quarter invoice (time period of January 1 through March 31) is due by May 31. Although the due date for the third quarter invoice is May 31, it is important to submit this invoice by the middle of May in order to allow sufficient time to process it out of the current year funds.

D. Fourth quarter invoice (time period of April 1 through June 30) is due by August 31.

E. Supplemental invoices for Child Health and Disability Prevention (CHDP) Administrative invoices; CHDP Foster Care invoices; Diagnostic, Treatment, and Therapy invoices; Healthy Families invoices; and CCS Administrative invoices will only be accepted up to six months after the close of the fiscal year for which they apply. **The fiscal year ends June 30, therefore, December 31 would be the last day to submit supplemental invoices for any given fiscal year. Please note supplemental invoices are paid on a cash basis and will be deducted from the current fiscal year allocation.**

X. Headings on invoices must contain the identification items identified below. Additional information as identified in the specific and separate California Children's Services (CCS) or CHDP instructions must also be provided:

A. Program name (i.e., CCS, CHDP)

B. Name of county or city

C. Fiscal year of invoicing period

D. Quarter ending date

Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

XI. **Signature/Certification blocks** must contain at a minimum the following, with additional information as identified in the specific and separate CCS or CHDP instructions:

A. Contact person name, e-mail address and telephone number with the area code.

B. Signatures of authorized officials certifying the accuracy of the expenditures reported. **Signatures must be original signatures, signature stamps are not acceptable.**

C. Date invoice signed.

NOTE: Invoices submitted without signatures will be returned for authorized signatures before being processed for payment. **Original signatures are required. Signature stamps are not acceptable.**

XII. Invoices that exceed budgeted funding sources, or do not compute, will be returned to the appropriate county for corrections.

XIII. Agencies are responsible for federal audit exceptions and must notify the State in the event any exceptions are found.

XIV. Numbered Letter 01-0106, California Children's Services (CCS) Expenditure Reporting to the California Department of Finance (DOF) for the purpose of Calculation of Realignment Caseload Growth, provided information on the development of the annual realignment caseload growth schedule by the California Department of Finance for programs covered by the State Local Program Realignment Initiative of 1993 which participates in caseload growth funding from the Caseload Sub-Account of the Sales Tax Growth Account of the Local Revenue Fund.

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Starting with the 2009 reporting cycle, for the purpose of reporting county CCS program expenditures to DOF for calculation of Realignment Caseload Growth, a cut-off date has been established for receipt of quarterly county CCS program diagnosis, treatment, and therapy expenditure reports that will be included in the calculation of CCS services costs included in the caseload growth expenditures that will be reported to DOF for the reporting period.

For fiscal year (FY) 2010-11 expenditures which will be reported to DOF for the FY 2011-12 Realignment Caseload Growth calculations, **the cut-off for receiving the diagnosis, treatment, and therapy expenditure reports will be December 31, 2011**. The FY 2010-11 county expenditures reported after that date will not be reported to DOF. CMS will continue to receive and reconcile CCS overdue expenditure reports for purposes of State/County share of cost determination after the cut-off, but this late data will not be reported to DOF and will not be included in DOF s caseload growth calculation for the reporting period.

XV. All invoices and supporting documentation should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

CHDP Quarterly Administrative Expenditure Initial Invoice Instructions (No County/City Match)

CHDP administrative expenditures are reimbursed according to the individual county/city percentages of the Medi-Cal and non-Medi-Cal portions of the approved program's budget. An exception to the application of the non-Medi-Cal percentage is for an expense qualifying as 100 percent Medi-Cal funded, i.e., costs of services exclusively for Medi-Cal eligibles. A county/city program having a category or line item that includes expenses designated as 100 percent Medi-Cal must asterisk (*) the category, footnote the specific amount and have supporting documentation on file. All other expenses must have the non-Medi-Cal percentage rate of the individual county/city approved budget applied to distribute the Medi-Cal and non-Medi-Cal share of the expenses.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Enter the total amount of personnel expenses for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

5) Enter the total of non-Medi-Cal personnel services claimed in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the percentage of the non-Medi-Cal share on the approved budget.

6) Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

7) Enter the total amount of Medi-Cal personnel services claimed for enhanced funds in Column 4 and the total amount claimed for non-enhanced funds in Column 5. These amounts are calculated using time study percentages and other applicable documentation.

Total Operating Expenses

8) Enter in Column 1 on this line, the total of all operating expenses.

9) Enter the non-Medi-Cal amount claimed of operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

10) Enter the Medi-Cal amount for operating expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for operating expenses.

11) Enter the total amount of enhanced operating expenses claimed in Column 4 and enter the non-enhanced operating expenses claimed in Column 5.

NOTE: Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 8).

Total Capital Expenses

12) Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found in Section 7, Page 114.

13) Enter in Column 2, the amount of non-Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

14) Enter the Medi-Cal amount for capital expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for Capital Expenses.

15) Enter the Capital Expenses amount from Column 3 into Column 5, non-enhanced.

Total Indirect Expenses

16) Enter in Column 1, the total of all Indirect Expenses.

17) Enter the amount of non-Medi-Cal indirect expenses in Column 2. This amount is derived by multiplying the total indirect expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

18) Enter the Medi-Cal amount for indirect expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for the indirect expenses.

19) Enter the indirect expenses amount from Column 3 in Column 5, non-enhanced.

Total Other Expenses

20) Enter the total of all other expenses on this line in Column 1.

21) Enter in Column 2, the non-Medi-Cal other expenses. This amount is derived by multiplying the total Other Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

22) Enter the Medi-Cal amount claimed for other expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount in Column 1 for Other Expenses.

23) Enter the amount claimed for Other Expenses from Column 3 into Column 5, non-enhanced.

Expenditure Grand Total

24) Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

Source of Funds

State Funds

25) Enter the amount for State in Column 2. This amount is the same as the Expenditure Grand Total amount for TOTAL CHDP Non-Medi-Cal.

Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal (25/75) and Column 5, Non-Enhanced State/Federal (50/50).

26) Enhanced State/Federal (25/75)

   a. Multiply the Expenditure Grand Total line of Column 4, Enhanced by 25 percent and enter this amount on the State Funds line in Column 4.

   b. Subtract the amount of State Funds for Column 4, Enhanced from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

27) Non-Enhanced State/Federal (50/50)

   a. Multiply the Expenditure Grand Total line of Column 5, Non-Enhanced by 50 percent and enter this amount on the State Funds line for Column 5.

   b. Subtract the amount of State Funds for Column 5, Non-Enhanced from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

28) Total Medi-Cal Funds

a. Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

b. Enter in Column 3 on the Federal Funds (Title XIX) line the total of Column 4 and Column 5, Federal Funds (Title XIX).

29) Total Funds

a. Enter in Column 1, Total Funds for the State Funds (non-Medi-Cal) line, the same amount as entered in Column 2, Total CHDP Funds.

b. Add Columns 4 and 5 together for the State Funds line under Medi-Cal Funds and enter the total in Column 3, total Medi-Cal and Column 1, Total Funds.

c. Add Columns 4 and 5 together for the Federal Funds (Title XIX) line and enter the total in Column 3, Total Medi-Cal Funds, and Column 1, Total Funds.

NOTE: The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the "Expenditure Grand Total" line.

Certification

30) Provide the contact name, e-mail address and telephone number, with the area code, of the county/city staff person who is responsible for processing the invoice form.

31) The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

32) Print or type the name and title of the official who signed the invoice.

Submission

33) Submit all invoices with original signatures. **Signature stamps are not acceptable.** Additional copies are not necessary.

34) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. Supplemental invoices for FY 2011-2012 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE
(No County / City Match)
FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non Medi-Cal	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	1 = 2 + 3	2	3 = 4 + 5	4	5
I. TOTAL PERSONNEL EXPENSES	0		0		
II. TOTAL OPERATING EXPENSES	0		0		
III. TOTAL CAPITAL EXPENSES	0		0		
IV. TOTAL INDIRECT EXPENSES	0		0		
V. TOTAL OTHER EXPENSES	0		0		
EXPENDITURES GRAND TOTAL	0	0	0	0	0

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	0
FEDERAL FUNDS (TITLE XIX)	0		0	0	0
EXPENDITURES GRAND TOTAL	0	0	0	0	0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-mail Address | Date | Area Code / Telephone No.

CHDP Director/Deputy Director (Signature) | Date | Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure Initial Invoice (County / City Match)

The county/city match invoice for expanded services for Medi-Cal recipients is 100 percent county/city funds with federal fund match. **No State funds are included on this invoice.**

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Enter the total amount of personnel expenses for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

5) Enter the total amount of personnel expenses invoiced in Column 2 for enhanced funding and the total amount invoiced in Column 3 for non-enhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

Total Operating Expenses

6) Enter in Column 1, the total of all operating expenses.

7) Enter the total amount of enhanced operating expenses claimed in Column 2 and enter the non-enhanced operating expenses claimed in Column 3.

NOTE: Only travel and training expenses may qualify as operating expenses for enhanced funding, and only when claimed by an SPMP following specific FFP guidelines (see Section 8).

Total Capital Expenses

8) Enter the total Capital Expenses on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found in Section 7, Page 114.

Total Indirect Expenses

9) Enter the total Indirect Expenses on this line in Column 1 and Column 3.

Total Other Expenses

10) Enter the total other expenses on this line in Column 1 and Column 3.

Expenditure Grand Total

11) Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

Source of Funds

County/City Funds

12) County/city expenditures must meet the federal fund (Title XIX) match requirements to obtain this reimbursement but county/city matching funds are not reimbursed. Therefore, a county/city fund line is not completed on the invoice form.

Federal Funds (Title XIX)

13) Enhanced Funds

- Multiply the Enhanced "Expenditure Grand Total" amount (Column 2) by 75 percent. Enter the amount on the "Federal Funds (Title XIX)" line, Enhanced, in the "Source of Funds" section.

14) Non-Enhanced Funds

- Multiply the non-enhanced "Expenditure Grand Total" amount (Column 3) by 50 percent. Enter this amount on the "Federal Funds (Title XIX)" line, non-enhanced, in "Source of Funds" section.

15) Total Funds

- Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

Certification

16) Provide the contact name, e-mail address and telephone number, with the area code, of the county/city staff person who is responsible for processing the invoice form.

17) The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

18) Print or type the name and title of the official who signed the invoice.

Submission

19) Submit all invoices with original signatures. **Signature stamps are not acceptable.** Additional copies are not necessary.

20) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. Supplemental Invoices for FY 2011-2012 are due no later than December 31, 2012.

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE

(County / City Match)

FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	*1 = 2 + 3*	*2*	*3*
I. TOTAL PERSONNEL EXPENSES	0		
II. TOTAL OPERATING EXPENSES	0		
III. TOTAL CAPITAL EXPENSES	0		
IV. TOTAL INDIRECT EXPENSES	0		
V. TOTAL OTHER EXPENSES	0		
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL (25/75)	NON-ENHANCED COUNTY/FEDERAL (50/50)
COLUMN	*1 = 2 + 3*	*2*	*3*
COUNTY/CITY MATCH	0	0	0
FEDERAL FUNDS (TITLE XIX)	0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By E-mail Address Date Area Code / Telephone No.

CHDP Director/Deputy Director (Signature) Date Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure Supplemental Invoice Parts A and B Instructions

No County/City Match

A supplemental invoice identifies the differences between the expenditures and funding amounts previously submitted on the Initial Invoice and the expenditures and funding amounts that are currently true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices for the Child Health and Disability Prevention (CHDP) administrative expenditures are prepared on an as needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- **Supplemental Invoice – Part A, Approved Invoice Plus Changes** – represents the Initial Invoice that has been approved by Children's Medical Services (CMS) and any changes that update the information previously reported on the Initial Invoice.

  Example: The Initial Invoice showed an expenditure of $1,500 for Total Operating Expense in Quarter One. Several months after the Initial Invoice was approved by CMS for reimbursement, the county found a supply order for $500 that was paid in Quarter One.

  In order to be reimbursed for the $500 supply order, the county shall submit a Supplemental Invoice – Part A for Quarter One that shows $2,000 ($1,500 + $500) for Total Operating Expense.

- **Supplemental Invoice – Part B, Amounts of Changes** – represents the differences between the Initial Invoice and the Supplemental Invoice – Part A.

  Example: After the Supplemental Invoice – Part A has been completed the county shall then complete Supplemental Invoice – Part B for Quarter One. To do this, the county shall subtract the $1,500 Total Operating Expense which was reported on the Initial Invoice from the Total Operating Expense costs of $2,000 that was reported on the Supplemental Invoice – Part A. The difference of $500 shall be reported for Total Operating Expenses on the Supplemental Invoice – Part B.

In summary, the Supplemental Invoice – Part A represents the desired total expenditures. The Supplemental Invoice – Part B represents the dollar amount of change (increase or decrease) to the approved total expenditures.

Separate instructions are prepared for the Supplemental Invoice – Part A, Approved Invoice Plus Changes and Supplemental Invoice – Part B, Amounts of Changes.

CHDP Quarterly Administrative Expenditure – Supplemental (Part A)

(No County/City Match)

Approved Invoice Plus Changes

Instructions for Completion

The following are instructions for the completion of the Supplemental Invoice – Part A, Approved Invoice Plus Changes for the Child Health and Disability Prevention (CHDP) Quarterly Administrative Expenditure Invoice.

Please use whole numbers when preparing the supplemental invoices.

County/City

1) Enter the name of the county or city for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Column B – Total Expenditures

5) Enter the amounts of Total Expenditures that were previously approved on the Initial Invoice for each category/line item listed in Column A and any changes that update these amounts.

6) Enter the Grand Total by adding all entries in Column B.

For each category/line item, the amounts entered in Column B must equal the sum of respective amounts in Columns C and D.

Column C – Total CHDP Non-Medi-Cal

7) Enter the amount of Total CHDP Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column A.

   The amount of Total CHDP Non-Medi-Cal expenditures is derived by multiplying the Total Expenditures identified in Column B by the percentage of the non-Medi-Cal share from the approved CHDP No County/City Administrative Budget.

8) Enter the Grand Total by adding all entries in Column C.

Column D – Total Medi-Cal

9) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column A.

   The amount of Total Medi-Cal expenditures is derived by subtracting the amount of Total CHDP Non-Medi-Cal expenditures in Column C from the amount of Total Expenditures in Column B for each category/line item.

10) Enter the Grand Total by adding all entries in Column D.

    For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

    Also, the Grand Total in Column D must equal the difference after subtracting the Grand Total in Column C from the Grand Total in Column B.

Column E – Enhanced State/Federal (25/75)

11) Enter the amount of Enhanced Medi-Cal funding charged during the quarter to Total Personnel Expenses.

    The amount of Enhanced Medi-Cal funding for Total Personnel Expenses is calculated using time study percentages and other applicable documents that are based on program activities eligible for enhanced Medi-Cal funding.

12) Enter the amount of Enhanced Medi-Cal funding charged during the quarter to Total Operating Expenses.

    NOTE: Only travel and training expenses may qualify as Operating Expenses in the enhanced funding category and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines.

    The amount of Enhanced Medi-Cal funding for Total Operating Expenses may only be claimed in accordance with the travel and training costs that were approved in the CHDP No County/City Administrative Budget.

13) Enter the Grand Total by adding all entries in Column E.

Column F – Non-Enhanced State/Federal (50/50)

14) Enter the amounts of Non-Enhanced Medi-Cal funding charged during the quarter to Total Personnel Expenses and Total Operating Expenses.

The amount of Non-Enhanced Medi-Cal funding is derived by subtracting the amount of Enhanced Medi-Cal funding in Column E from the amount of Total Medi-Cal expenditures in Column D for Total Personnel Expenses and Total Operating Expenses, respectively.

15) Enter the amounts of Non-Enhanced Medi-Cal funding charged during the quarter to Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses from Column D.

16) Enter the Grand Total by adding all entries in Column F.

The Grand Total in Column F must equal the difference after subtracting the Grand Total in Column E from the Grand Total in Column D.

Source of Funds

Column H – Total Funds

17) Enter the Grand Total amount from Column I – Total CHDP Non-Medi-Cal for State General Funds.

18) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: State Funds.

19) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

20) Enter the Grand Total by adding all entries in Column H.

The entry for the Grand Total must equal the Grand Total amount in Column B – Total Expenditures in Category/Line Item.

Column I – Total CHDP Non-Medi-Cal

21) Enter the Grand Total amount from Column C –Total CHDP Non-Medi-Cal in Category/Line Item for State General Funds.

22) Enter the Grand Total by adding all entries in Column I.

The entry for the Grand Total must equal the Grand Total amount in Column C – Total CHDP Non-Medi-Cal in Category/Line Item.

Column J – Total Medi-Cal

23) Enter the amount for Total Medi-Cal for Medi-Cal Funds: State Funds.

The amount for Total Medi-Cal for Medi-Cal Funds: State Funds is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

24) Enter the amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

The amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX) is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

25) Enter the Grand Total by adding all entries in Column J.

For each source of funds, the amounts entered in Column J must equal the sum of respective amounts in Columns K and L.

Also, the Grand Total in Column J must equal the difference after subtracting the Grant Total in Column I from the Grand Total in Column H.

Additionally, the entry for the Grand Total in Column J must equal the Grand Total amount in Column D – Total Medi-Cal in Category/Line Item.

Column K – Enhanced State/Federal (25/75)

26) Enter the amount for Medi-Cal Funds: State Funds by multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 25 percent.

27) Enter the amount for Medi-Cal Funds: Federal Funds (Title XIX) by multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 75 percent.

28) Enter the Grand Total by adding all entries in Column K.

The entry for the Grand Total must equal the Grand Total amount in Column E – Enhanced State/Federal (25/75) in Category/Line Item.

Column L – Non-Enhanced State/Federal (50/50)

29) Enter the amount for Medi-Cal Funds: State Funds by multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

30) Enter the amount for Medi-Cal Funds: Federal Funds (Title XIX) by multiplying the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) by 50 percent.

31) Enter the Grand Total by adding all entries in Column L.

The entry for the Grand Total must equal the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) in Category/Line Item.

Certification

32) Type or print the name of the person who prepared the supplemental invoices.

All questions concerning the supplemental invoices will be addressed to the name of the person identified here.

33) Enter the e-mail address of the person preparing the invoices.

34) Enter the date the supplemental invoices were prepared.

35) Enter the telephone number, including the area code, for the person preparing the invoices.

36) Affix the signature of the CHDP Director, CHDP Deputy Director, or an official who is authorized to sign the CHDP Quarterly Administrative Expenditure Invoices and Supplemental Invoices –Parts A and B.

Original signatures are required. **Signature stamps are not acceptable.**

37) Enter the date that the signature was affixed.

38) Type or print the name of the authorized official.

Submission

39) Submit the Supplemental Invoice (Part A) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section –Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental Invoice (Parts A) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices (Part A) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health & Human Services Agency | Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)

FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART A

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non-MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	0
FEDERAL FUNDS (TITLE XIX)	0		0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By/Contact Person | E-mail Address | Date | Area Code/ Telephone Number

CHDP Director/Deputy Director (Signature) | Date | Type or Print Name of Signer

Revised June 2011

CHDP Quarterly Administrative Expenditure – Supplemental (Part B)

(No County / City Match)

Amounts of Changes

Instructions for Completion

The following are instructions for the completion of the Supplemental Invoice – Part B, Amounts of Changes for the Child Health and Disability Prevention (CHDP) Quarterly Administrative Expenditure Invoice.

Please use whole numbers when preparing the supplemental invoices.

County/City

1) Enter the name of the county or city for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Column B – Total Expenditures

5) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total Expenditures amount that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total Expenditures amount reported on the Supplemental Invoice – Part A.

6) Enter the Grand Total by adding all entries in Column B.

For each category/line item, the amounts entered in Column B must equal the sum of respective amounts in Columns C and D.

Column C – Total CHDP Non-Medi-Cal

7) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total CHDP Non-Medi-Cal expenditure that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total CHDP Non-Medi-Cal expenditure amount reported on the Supplemental Invoice – Part A.

8) Enter the Grand Total by adding all entries in Column C.

Column D – Total Medi-Cal

9) Enter the amount of change for each category/line item listed in Column A.

The amount of change is calculated by subtracting the Total Medi-Cal expenditure that was previously reported on the Initial Invoice for each category/line item listed in Column A from the corresponding Total Medi-Cal expenditure amount reported on the Supplemental Invoice – Part A.

10) Enter the Grand Total by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Also, the Grand Total in Column D must equal the difference after subtracting the Grand Total in Column C from the Grand Total in Column B.

Column E – Enhanced State/Federal (25/75)

11) Enter the amount of change for Total Personnel Expenses.

The amount of change is calculated by subtracting the Total Personnel Expenses amount that was previously reported on the Initial Invoice from the corresponding Total Personnel Expenses amount reported on the Supplemental Invoice – Part A.

12) Enter the amount of change for Total Operating Expenses.

The amount of change is calculated by subtracting the Total Operating Expenses amount that was previously reported on the Initial Invoice from the corresponding Total Operating Expenses amount reported on the Supplemental Invoice – Part A.

NOTE: Only travel and training expenses may qualify as Operating Expenses in the enhanced funding category and only when claimed for Skilled

Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines.

The amount of Enhanced Medi-Cal funding for Total Operating Expenses may only be claimed in accordance with the travel and training costs that were approved in the CHDP No County/City Administrative Budget.

13) Enter the Grand Total by adding all entries in Column E.

Column F – Non-Enhanced State/Federal (50/50)

14) Enter the amounts of change for each category/line item listed in Column A.

The amounts of change are calculated by subtracting the category/line item amounts that were previously reported on the Initial Invoice from the corresponding category/line item amounts reported on the Supplemental Invoice – Part A.

15) Enter the amounts of change for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

The amounts of change are calculated by subtracting the Total Capital, Indirect, and Other Expenses amounts that were previously reported on the Initial Invoice from the corresponding Total Capital, Indirect, and Other Expenses amounts reported on the Supplemental Invoice – Part A.

16) Enter the Grand Total by adding all entries in Column F.

The Grand Total in Column F must equal the difference after subtracting the Grand Total in Column E from the Grand Total in Column D.

Source of Funds

Column H – Total Funds

17) Enter the Grand Total amount from Column I – Total CHDP Non-Medi-Cal for State General Funds.

18) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: State Funds.

19) Enter the amount from Column J – Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

20) Enter the Grand Total by adding all entries in Column H.

The entry for the Grand Total must equal the Grand Total amount in Column B – Total Expenditures in Category/Line Item.

Column I – Total CHDP Non-Medi-Cal

21) Enter the Grand Total amount from Column C – Total CHDP Non-Medi-Cal in Category/Line Item for State General Funds.

22) Enter the Grand Total by adding all entries in Column I.

The entry for the Grand Total must equal the Grand Total amount in Column C – Total CHDP Non-Medi-Cal in Category/Line Item.

Column J – Total Medi-Cal

23) Enter the amount for Total Medi-Cal for Medi-Cal Funds: State Funds.

The amount for Total Medi-Cal for Medi-Cal Funds: State Funds is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (25/75) by 25 percent.

24) Enter the amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX).

The amount for Total Medi-Cal for Medi-Cal Funds: Federal Funds (Title XIX) is calculated by adding the amounts in Column K – Enhanced State/Federal (25/75) and Column L – Non-Enhanced State/Federal (50/50).

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E – Enhanced State/Federal (50/50) by 50 percent.

25) Enter the Grand Total by adding all entries in Column J.

For each source of funds, the amounts entered in Column J must equal the sum of respective amounts in Columns K and L.

Also, the Grand Total in Column J must equal the difference after subtracting the Grand Total in Column I from the Grand Total in Column H.

Additionally, the entry for the Grand Total in Column J must equal the Grand Total amount in Column D – Total Medi-Cal in Category/Line Item.

Column K –Enhanced State/Federal (25/75)

26) Enter the amount of change for Medi-Cal Funds: State Funds.

The amount of change is calculated by subtracting the Medi-Cal Funds: State Funds amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: State Funs amount reported on the Supplemental Invoice –Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E –Enhanced State/Federal (25/75) by 25 percent.

27) Enter the amount of change for Medi-Cal Funds: Federal Funds (Title XIX).

The amount of change is calculated by subtracting the Medi-Cal Funds: Federal Funds (Title XIX) amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: Federal Funds (Title XIX) amount reported on the Supplemental Invoice –Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column E –Enhanced State/Federal (25/75) by 75 percent.

28) Enter the Grand Total by adding all entries in Column K.

The entry for the Grand Total must equal the Grand Total amount in Column E – Enhanced State/Federal (25/75) in Category/Line Item.

Column L –Non-Enhanced State/Federal (50/50)

29) Enter the amount of change for Medi-Cal Funds: State Funds.

The amount of change is calculated by subtracting the Medi-Cal Funds: State Funds amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: State Funds amount reported on the Supplemental Invoice –Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column F –Non-Enhanced State/Federal (50/50) by 50 percent.

30) Enter the amount of change for Medi-Cal Funds: Federal Funds (Title XIX)

The amount of change is calculated by subtracting the Medi-Cal Funds: Federal Funds (Title XIX) amount that was previously reported on the Initial Invoice from the corresponding Medi-Cal Funds: Federal Funds (Title XIX) amount reported on the Supplemental Invoice –Part A.

Also, the amount of change must equal the result from multiplying the Grand Total amount in Column F –Non-Enhanced State/Federal (50/50) by 50 percent.

31) Enter the Grand Total by adding all entries in Column L.

The entry for the Grand Total must equal the Grand Total amount in Column F – Non-Enhanced State/Federal (50/50) in Category/Line Item.

Also, the entry for Grand Total must equal the difference from subtracting the Grand Total amount in Column K from the Grand Total amount in Column J.

Certification

32) Type or print the name of the person who prepared the supplemental invoices.

All questions concerning the supplemental invoices will be addressed to the name of the person identified here.

33) Enter the e-mail address of the person preparing the invoices.

34) Enter the date the supplemental invoices were prepared.

35) Enter the telephone number, including the area code, for the person preparing the invoices or contact person.

36) Affix the signature of the CHDP Director, CHDP Deputy Director, or an official who is authorized to sign the CHDP Quarterly Administrative Expenditure Invoices and Supplemental Invoices – Parts A and B.

Original signatures are required. **Signature stamps are not accepted**.

37) Enter the date that the signature was affixed.

38) Type or print the name of the authorized official.

Submission

39) Submit the Supplemental Invoice (Part B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental Invoice (Part B) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices (Parts A and B) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health & Human Services Agency | Department of Health Care Services - Children's Medical Services

COUNTY/CITY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART B

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON ENHANCED STATE/FEDERAL (50/50)
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	0

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON ENHANCED STATE/FEDERAL (50/50)
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE FUNDS	0		0	0	0
FEDERAL FUNDS (TITLE XIX)	0		0	0	0
EXPENDITURES GRAND TOTAL	**0**	**0**	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By/Contact Person | E-mail Address | Date | Area Code/ Telephone Number

CHDP Director/Deputy Director (Signature) | Date | Type or Print Name of Signer

RevisedJune 2011

HCPCFC Quarterly Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Health Care Program for Children in Foster Care (HCPCFC) expenditures, the Quarterly HCPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HCPCFC Quarterly Administrative Expenditure invoice form is found in Section 7, page 33.

The HCPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the invoice form. Local county and city Child Health and Disability Prevention (CHDP) programs administering the HCPCFC are reimbursed for the actual administrative costs according to the amount of State general funds and federal funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is in Section 7, page 2.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Column 1 is the total expenditures for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

5) Enter the total amount of State and federal funds at the enhanced percentage in Column 2.

6) Enter the total amount of State and federal funds at the non-enhanced percentage in Column 3.

   The amount of enhanced and non-enhanced percentages are calculated using completed time study documents and other applicable documentation.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

Total Operating Expenses

7) The total amount of state and federal funds for the quarter are in Column 1.

8) Enter the total amount of enhanced travel and training expenses in Column 2.

9) Enter the non-enhanced travel and training expenses in Column 3.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

NOTE: Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 8).

Total Capital Expenses

- Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

Total Indirect Expenses

Indirect expenses are non-enhanced; they may not be claimed at the enhanced rate.

10) Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

11) The Total Invoiced amount in Column 1 should be the same as the amount in Column 3.

Total Other Expenses

- Total Other Expenses are not allowed on the HCPCFC Administrative Budget.

Expenditure Grand Total

12) Expenditure Grand Total is the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the invoice form.

Source of Funds

State Funds

13) The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

Federal Funds (Title XIX)

14) The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

Enhanced State/Federal (25/75)

15) Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

16) Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

Non-Enhanced State/Federal (50/50)

17) Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

18) Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

Expenditure Grand Total

19) Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

20) Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

NOTE: The totals of funding amount entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

Certification

21) Enter the name, e-mail address, and telephone number with the area code of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure invoice form.

22) Type or print the name of the authorized official.

23) Enter the date that the signature was affixed.

24) Type or print the name of the CHDP Director or Deputy Director that has signed the expenditure invoice.

Submission

25) Submit the invoice with original signature. **Signature stamps are not acceptable.** No additional copies are required.

26) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section –Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter. The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

All invoices shall be submitted no later than September 30th after the end of the fiscal year.

Example: FY 2011-2012 ends June 30, 2012. All invoices for FY 2011-2012 are due no later than September 30, 2012.

State of California – Health and Human Services Agency | Department of Health Care Services – Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

HCPCFC Quarterly Administrative Expenditure Invoice
Fiscal Year _____

Category/Line Item	Total Invoiced	Enhanced State/Federal (25/75)	Non-Enhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
I. Total Personnel Expenses	0		
II. Total Operating Expenses	0		
III. Total Capital Expenses			
IV. Total Indirect Expenses	0		
V. Total Other Expenses			
Expenditures Grand Total	0	0	0

Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Non-Enhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
State Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
Expenditures Grand Total	0	0	0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date / Area Code /Telephone No.

CHDP Director or Deputy Director (Signature) | Date | Print or Type Name of Signer

Revised June 2011

CHDP Foster Care Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Child Health and Disability Prevent (CHDP) Foster Care expenditures, the quarterly foster care administrative expenditure invoice must be prepared in accordance with the following instructions. The Foster Care Quarterly Administrative Expenditure invoice form is in Section 7, page 38.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Submission sections of the invoice form. Local county and city CHDP administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is in Section 7, page 2.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund public health nurse (PHN) and supervising public health nurse (SPHN) staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with federal funds (Title XIX) for this budget. No State General Funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure invoice form.

County/City

1) Enter the name of the county or city for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the fiscal year (FY) for which this invoice applies.

Category / Line Item

Total Personnel Expenses

4) Column 1 is the amount of total personnel expenses for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

5) Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

6) Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other application documentation.

Total Operating Expenses

7) Column 1 is the total amount of operating expenses for the quarter.

8) Enter the total amount of enhanced operating expenses in Column 2.

9) Enter the non-enhanced operating expenses in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by a Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 8).

Total Capital Expenses

- Total Capital Expenses are not allowed on this budget.

Total Indirect Expenses

- External Indirect Expenses are not allowed on this budget.

10) Enter the total amount of indirect expenses for the quarter on this line in Column 3.

Total Other Expenses

- Total Other Expenses are not allowed on this budget.

Expenditures Grand Total

11) Column 1 Expenditures Grand Total is the sum total of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses.

Source of Funds

County/City Funds

County/city expenditures must meet the federal funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

Federal Funds (Title XIX)

12) Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the Federal Funds (Title XIX) line, Enhanced, in the Source of Funds section.

13) Non-Enhanced Funds

Multiply the non-enhanced Expenditure Grand Total amount (Column 3) by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, non-enhanced in Source of Funds section.

14) Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

Certification

15) Type or print the name of the staff person responsible for preparing the Foster Care Administrative Expenditure invoice form.

16) Enter the e-mail address of the person preparing the invoice form.

17) Enter the date the invoice was prepared.

18) Enter the telephone number including the area code of the person preparing the invoice.

19) The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

20) Type or print the name and title of the CHDP Director or Deputy Director that is signing the invoice.

Submission

21) **Submit all invoices with original signatures. Signature stamps are not acceptable.** Additional copies are not necessary.

22) All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California – Health and Human Services Agency | Department of Health Care Services – Children's Medical Services

COUNTY/CITY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CHDP Foster Care Quarterly Administrative Expenditure Invoice
Fiscal Year _____

Category/Line Item	Total Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
I. Total Personnel Expenses	0		
II. Total Operating Expenses	0		
III. Total Capital Expenses			
IV. Total Indirect Expenses	0		
V. Total Other Expenses			
Expenditures Grand Total	0	0	0

Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Column	*1 = 2 + 3*	*2*	*3*
County-City Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
Expenditures Grand Total	0	0	0

Source County-City Funds:

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date / Area Code /Telephone Number

CHDP Director or Deputy Director (Signature) | Date | Print or Type Name of Signer

Revised June 2011

CCS Quarterly Administrative Expenditure Invoice Instructions

Initial Invoice Instructions

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual**.

Caseload in FY 2011-12 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS) Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate "eligible months" for caseload. There is one report in CMS Net Legacy titled "Monthly Caseload Count Report" (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled "Healthy Families Caseload Count Report". In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report "Monthly Caseload Count Report" (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the BO report "Healthy Families Caseload County" only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months

TOTAL **465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

The Initial Invoice is the first invoice prepared for a quarter that is submitted to Children's Medical Services (CMS) for reimbursement. This means that no other invoice had been previously submitted to CMS for this particular quarter.

The following are instructions for the completion of the CCS Program Administrative Expenditure Invoice – Initial, which are prepared on a quarterly basis.

County

1) Enter the name of the county for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

3) Enter the state fiscal year (FY) for which this invoice applies.

CCS Caseload

Column B – Actual Caseload

Medi-Cal Cases

4) Enter the Average Total Cases of Open (Active) Medi-Cal Children.

Calculate the average total cases by adding the total cases of open (active) Medi-Cal Children for each month in the quarter and dividing by 3.

5) Enter Total Medi-Cal Cases.

Non-Medi-Cal Cases: Healthy Families

6) Enter the Average Total Cases of Open (Active) Healthy Families (HF) Children.

   Calculate the average total cases by adding the total cases of open (active) HF Children for each month in the quarter and dividing by 3.

7) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

8) Enter the Average Total Cases of Open (Active) Straight CCS Children.

   Calculate the average total cases by adding the total cases of open (active) Straight CCS Children for each month in the quarter and dividing by 3.

9) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

10) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

11) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

12) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

13) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

14) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

15) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

16) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

17) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

18) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

19) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

Administrative Expenditures

County

20) Enter the name of the county for which this invoice applies.

Quarter Ending

21) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

22) Enter the state fiscal year (FY) for which this invoice applies.

Column C –Total Expenditures

23) Enter the total of all expenditures charged during the quarter to each category/line item listed in Column B.

24) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the total of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

25) Enter the amount of Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column B in Columns E and F.

The amount of Total Non-Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Non-Medi-Cal Cases as calculated in step 24 for CCS Caseload.

The percentage for Total Non-Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Non-Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to non-Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

+	Total Other Expenses
-	All M&T Expenditures
=	Remaining Balance
x	Total Non-Medi-Cal Cases Percent
=	Share of Total Other Expenses for Total Non-Medi-Cal Cases
+	M&T Expenditures for Non-Medi-Cal Clients
=	Amount of Total Other Expenses for Total Non-Medi-Cal Cases

26) Enter the Total Expenditures for Total Non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the total of respective amounts in Columns E and F.

Column E – Straight CCS

27) Enter the amount of Straight CCS expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Straight CCS expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total Straight CCS Cases as calculated in step 23 for CCS Caseload.

28) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

29) Enter the amount of HF expenditures charged during the quarter to each category/line item listed in Column B.

The amount of HF expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total HF Cases as calculated in step 20 for CCS Caseload.

30) Enter the Total Expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

31) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column G.

The amount of Total Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Medi-Cal Cases as calculated in step17 for CCS Caseload.

The percentage for Total Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

+	Total Other Expenses
-	All M&T Expenditures
=	Remaining Balance
x	Total Medi-Cal Cases Percent
=	Share of Total Other Expenses for Total Medi-Cal Cases
+	M&T Expenditures for Medi-Cal Clients
=	Amount of Total Other Expenses for Total Medi-Cal Cases

32) Enter the Total Expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the total of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced State/Federal (25/75)

33) Enter the amount of Medi-Cal Enhanced expenditures charged during the quarter to Total Personnel Expenses and Total Operating Expenses listed in Column B.

The amount of expenditures charged to Personnel Expenses is based on time studies for:

a. Skilled Professional Medical Personnel (SPMP) who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and

b. Clerical staff who directly support and are supervised by the SPMP.

Only training and travel costs for SPMP are allowed as expenditures for Operating Expenses.

Medi-Cal Enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I – Medi-Cal Non-Enhanced State/Federal (50/50)

34) Enter the amount of Medi-Cal non-enhanced expenditures charged during the quarter to each category/line item listed in Column B.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; ancillary staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

The amount of Medi-Cal non-enhanced expenditures for each category/line item listed in Column B is determined by subtracting the entries in Column H from the corresponding entries in Column G.

Maintenance and Transportation (M&T)

35) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, Straight CCS, HF, and Total Medi-Cal for M&T.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

Source of Funds

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

36) Enter the amount of State and County funds that were used to pay straight CCS expenditures.

The funding distribution for straight CCS expenditures is 50 percent State funds and 50 percent County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

37) Enter Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families

38) Enter the amount of federal, State, and County funds that were used to pay HF expenditures.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent State funds, and 17.5 percent County funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of State funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of County funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

39) Enter Total Source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

40) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

41) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the total of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

42) Enter the amount of State and federal funds that were used to pay Medi-Cal enhanced expenditures.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent State funds and 75 percent federal funds (Title XIX).

The amount of State funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

43) Enter Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

44) Enter the amount of State and federal funds that were used to pay Medi-Cal non-enhanced expenditures.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent State funds and 50 percent federal funds (Title XIX).

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

45) Enter Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

46) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

47) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the total of respective amounts in Columns P and Q.

Column K – Total Expenditures

48) Enter the amounts for Medi-Cal State and federal funds (Title XIX) from Column O to Column K.

49) Enter the amounts for HF State, County, and federal funds (Title XXI) from Column N to Column K.

50) Enter the amounts for straight CCS State and County funds from Column M to Column K.

Total Source of Funds

51) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

Certification

52) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices. **Original signature is required. Signature stamps are not acceptable.**

53) Type or print the name of the authorized official.

54) Enter the date that the signature was affixed.

55) Type or print the name of the contact person for the expenditure invoice.

56) Enter the e-mail address and telephone number with the area code for the contact person.

Submission

57) Submit the invoice with original signature. **Signature stamps are not acceptable.** No additional copies are required.

58) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section –Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY:

QUARTER ENDING:

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

FISCAL YEAR _____

CCS CASELOAD	ACTUAL CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL
FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	0	0	**0**	**0**	**0**
	Maintenance & Transportation	$ -	$ -	$ -	$ -	$ -		

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		0	0	0	0	0	0	0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-mail Address | Date | Area Code / Telephone Number

Signature of Authorized Official | Date | Print or Type Name of Signer | Title

Revised June 2011

CCS Quarterly Administrative Expenditure Invoice Instructions –Supplemental (Part A)

Instructions for Completion

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) –represents the Initial Invoice that has been approved by Children's Medical Services (CMS), and any changes that update the information previously reported on the Initial Invoice.

  Example: The Initial Invoice showed an expenditure total of $500 for General Expenses in the first quarter. Several months after the Initial Invoice was submitted to CMS for reimbursement, the county found a supply order for $1,000 that was paid in the first quarter.

  In order to be reimbursed for the $1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the first quarter that shows an expenditure total of $1,500 ($500 + $1,000) for General Expenses.

- Supplemental (Part B) –represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

  Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the first quarter. To do this, the county must subtract the $500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of $1,500 that was reported on the Supplemental (Part A) Invoice. The difference of $1,000 ($1,500 - $500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part A) Invoice for the CCS Program Administrative Expenditure Invoice.

County

1) Enter the name of the county for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter Ending

3) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

CCS Caseload

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual**.

Caseload in FY 2011-12 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS) Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate "eligible months" for caseload. There is one report in CMS Net Legacy titled "Monthly Caseload Count Report" (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled "Healthy Families Caseload Count Report". In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report "Monthly Caseload Count Report" (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the BO report "Healthy Families Caseload County" only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months

TOTAL **465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

Column B – Correct Caseload

Medi-Cal Cases

5) Enter the Average Total Cases of Open (Active) Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.

6) Enter Total Medi-Cal Cases.

Non-Medi-Cal Cases: Healthy Families (HF)

7) Enter the Average Total Cases of Open (Active) HF Children that was previously reported on the Initial Invoice and any changes to this figure.

8) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

9) Enter the Average Total Cases of Open (Active) Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.

10) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

11) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

12) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

13) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

14) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

15) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

16) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

17) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.

18) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

19) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

20) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

Administrative Expenditures

The entries for County, Supplemental No., Quarter Ending, and Fiscal Year must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

County

21) Enter the name of the county for which this invoice applies.

Supplemental No.

22) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter Ending

23) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

24) Enter the state fiscal year (FY) for which this invoice applies.

Column C –Total Expenditures

25) Enter the amounts of Total Expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

26) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

27) Enter the amounts of total non-Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how maintenance and transportation (M&T) costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

a. Subtract all M&T expenditures (which were previously reported on the Initial Invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).

b. Multiply the remaining balance by the percentage for Total Non-Medi-Cal from the Supplemental (Part) Invoice.

c. To this end result, add the correct M&T expenditures directly related to non-Medi-Cal clients.

d. The subsequent total is the correct amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

+	Total Other Expenses (amounts previously reported and any changes)
-	All M&T Expenditures (amounts previously reported and any changes)
=	Remaining Balance (amounts previously reported and any changes)
x	Total Non-Medi-Cal Cases Percent (from Supplemental (Part A) Invoice)
=	Correct Share of Total Other Expenses for Total Non-Medi-Cal Cases
+	Correct M&T Expenditures for Non-Medi-Cal Clients
=	Correct Amount of Total Other Expenses for Total Non-Medi-Cal Cases

28) Enter the total expenditures for total non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E – Straight CCS

29) Enter the amounts of straight CCS expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

30) Enter the total expenditures for straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

31) Enter the amounts of HF expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

32) Enter the total expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

33) Enter the amounts of total Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how M&T costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total Medi-Cal expenditures for Total Other Expenses, use the following formula.

a. Subtract all M&T expenditures (which were previously reported on the initial invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).

b. Multiply the remaining balance by the percentage for Total Medi-Cal from the Supplemental (Correct) Invoice.

c. To this end result, add the correct M&T expenditures directly related to Medi-Cal clients.

d. The subsequent total is the correct amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

+	Total Other Expenses (amounts previously reported and any changes)
-	All M&T Expenditures (amounts previously reported and any changes)
=	Remaining Balance (amounts previously reported and any changes)
x	Total Medi-Cal Cases Percent (from Supplemental (Part A) Invoice)
=	Correct Share of Total Other Expenses for Total Medi-Cal Cases
+	Correct M&T Expenditures for Medi-Cal Clients
=	Correct Amount of Total Other Expenses for Total Medi-Cal Cases

34) Enter the total expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced

35) Enter the amounts of Medi-Cal enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

Only personnel expenses and operating expenses (i.e., training and travel costs) for SPMP are allowed as expenditures for Medi-Cal Enhanced.

Medi-Cal enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I – Medi-Cal Non-Enhanced

36) Enter the amounts of Medi-Cal non-enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; associate staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

Maintenance and Transportation (M&T)

37) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal for M&T that were previously reported on the Initial Invoice and any changes to these amounts.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

Source of Funds

Complete the non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

38) Enter the amounts of State and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for straight CCS expenditures is 50 percent State funds and 50 percent county funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

Column N – Healthy Families

39) Enter the amounts of federal, State, and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent State funds, and 17.5 percent county funds.

The amount of federal funds is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

Column L – Total Non-Medi-Cal

40) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

41) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

42) Enter the amounts of State and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal Enhanced expenditures is 25 percent State funds and 75 percent federal funds (Title XIX).

The amount of State funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column H by 75 percent.

Column Q – Medi-Cal Non-Enhanced

43) Enter the amounts of State and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent State funds and 50 percent federal funds (Title XIX).

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

Column O – Total Medi-Cal

44) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

45) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K – Total Expenditures

46) Enter the amounts for Medi-Cal State and federal funds (Title XIX) from Column O to Column K.

47) Enter the amounts for HF State, county, and federal funds (Title XXI) from Column N to Column K.

48) Enter the amounts for straight CCS State and county funds from Column M to Column K.

Total Source of Funds

49) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

Certification

50) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). An original signature is required. **Signature stamps are not acceptable**.

51) Type or print the name of the authorized official.

52) Enter the date that the signature was affixed.

53) Type or print the name of the contact person for the expenditure invoice.

54) Enter the e-mail address and telephone number with the area code for the contact person.

Submission

55) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature. **Signature stamps are not acceptable**. No additional copies are required.

56) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR _____

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Revised June 2011

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:** MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Maintenance & Transportation	$ -	$ -	$ -	$ -	$ -		-

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		**0**	**0**	**0**	**0**	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-mail Address | Date | Area Code / Telephone Number

Signature of Authorized Official | Date | Print or Type Name of Signer | Title

Revised June 2011

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**
MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR 2011 / 2012

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	2,133	58.94%
TOTAL MEDI-CAL CASES	2,133	58.94%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	323	8.93%
TOTAL HEALTHY FAMILIES CASES	323	8.94%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	1,163	32.14%
TOTAL STRAIGHT CCS CASES	1,163	32.14%
TOTAL NON-MEDI-CAL CASES	1,486	41.06%
TOTAL CASELOAD	3,619	100.00%

Revised June 2011

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**
MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

FISCAL YEAR 2011/2012

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	200,958	82,594	64,628	17,966	118,364	98,436	19,928
II.	Total Operating Expenses	63,752	26,202	20,503	5,699	37,550	26,507	11,043
III.	Total Capital Expenses	-	-	-	-	-		-
IV.	Total Indirect Expenses	32,611	13,403	10,488	2,915	19,208		19,208
V.	Total Other Expenses	9,053	2,574	1,823	751	6,479		6,479
	TOTAL EXPENDITURES	306,374	124,773	97,442	27,331	181,601	124,943	56,658
	Maintenance & Transportation	$ 5,731	$ 1,209	$ 755	$ 454	$ 4,522		4,522

	SOURCE OF FUNDS							
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	59,565				59,565	31,236	28,329
	Federal Funds (Title XIX)	122,036				122,036	93,707	28,329
HEALTHY FAMILIES								
	State Funds	4,783	4,783		4,783			
	County Funds	4,783	4,783		4,783			
	Federal Funds (Title XXI)	17,765	17,765		17,765			
STRAIGHT CCS								
	State Funds	48,721	48,721	48,721				
	County Funds	48,721	48,721	48,721				
TOTAL SOURCE OF FUNDS		**306,374**	**124,773**	**97,442**	**27,331**	**181,601**	**124,943**	**56,658**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

JANE DOE	Jane.Doe@anycounty.california.com	11/30/2011	(000) 123-45678
Prepared By	E-mail Address	Date	Area Code / Telephone Number

John Smith

11/30/2011	JOHN SMITH	CCS ADMINISTRATOR
Signature of Authorized Official	Date	Print or Type Name of Signer	Title

Revised June 2011

CCS Quarterly Administrative Expenditure Invoice Instructions – Supplemental (Part B)

Instructions for Completion

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual**.

Caseload in FY 2011-12 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate "eligible months" for caseload. There is one report in CMS Net Legacy titled 'Monthly Caseload Count Report" (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled 'Healthy Families Caseload Count Report". In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report 'Monthly Caseload Count Report" (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the BO report 'Healthy Families Caseload County" only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months

TOTAL **465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) –represents the Initial Invoice that has been approved by CMS, and any changes that update the information previously reported on the Initial Invoice.

  Example: The Initial Invoice showed an expenditure total of $500 for General Expenses in the first quarter. Several months after the Initial Invoice was submitted to CMS for reimbursement, the county found a supply order for $1,000 that was paid in the first quarter.

  In order to be reimbursed for the $1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the first quarter that shows an expenditure total of $1,500 ($500 + $1,000) for General Expenses.

- Supplemental (Part B) –represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

  Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the first quarter. To do this, the county must subtract the $500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of $1,500 that was reported on the Supplemental (Part A) Invoice. The difference of $1,000 ($1,500 - $500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part B) Invoice for the CCS Program Administrative Expenditure Invoice.

County

1) Enter the name of the county for which this invoice applies.

Supplemental No.

2) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

CCS Caseload

Column B –Difference in Caseload

Medi-Cal Cases

5) Enter the difference for Average Total Cases of Open (Active) Medi-Cal Children by subtracting the Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.

6) Enter Total Medi-Cal Cases.

Non-Medi-Cal Cases: HF

7) Enter the difference for Average Total Cases of Open (Active) Healthy Families (HF) Children by subtracting the Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) HF Children on the Supplemental (Part A) Invoice.

8) Enter Total Healthy Families Cases.

Non-Medi-Cal Cases: Straight CCS

9) Enter the difference by subtracting the Average Total Cases of Open (Active) Straight CCS Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Straight CCS Children on the Supplemental (Part A) Invoice.

10) Enter Total Straight CCS Cases.

Total Non-Medi-Cal Cases

11) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

12) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column E – Percent of Grant Total

Medi-Cal Cases Percentages

13) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.

14) Enter the percentage for Total Medi-Cal Cases.

Non-Medi-Cal Percentages: HF

15) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.

16) Enter the percentage for Total HF Cases.

Non-Medi-Cal Percentages: Straight CCS

17) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.

18) Enter the percentage for Total Straight CCS Cases.

Total Non-Medi-Cal Cases Percentage

19) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

20) Enter the percentage for Total Caseload by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

The Total Caseload Percentage must equal zero percent (0%).

Administrative Expenditures

County

21) Enter the name of the county for which this invoice applies.

Supplemental No.

22) Enter the number in the sequence of supplemental invoices submitted to CMS. Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter Ending

23) Enter the date for which the quarter ends, using the chart below:

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

24) Enter the state fiscal year (FY) for which this invoice applies.

Column C –Total Expenditures

25) Enter the difference for each category/line item listed in Column B by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.

26) Enter the difference for Total Expenditures by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

27) Enter the difference for each category/line item listed in Column B by subtracting the Total Non-Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

28) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Non-Medi-Cal that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column D. For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E – Straight CCS

29) Enter the difference for each category/line item listed in Column B by subtracting the Straight CCS expenditures that were previously reported on the Initial Invoice from the correct Straight CCS expenditures reported on the Supplemental (Part A) Invoice.

30) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Straight CCS that were previously reported on the Initial Invoice from the correct Total Expenditures for Straight CCS reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column E.

Column F – Healthy Families (HF)

31) Enter the difference for each category/line item listed in Column B by subtracting the HF expenditures that were previously reported on the Initial Invoice from the correct HF expenditures reported on the Supplemental (Part A) Invoice.

32) Enter the difference for Total Expenditures by subtracting the Total Expenditures for HF that were previously reported on the Initial Invoice from the correct Total Expenditures for HF reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column F.

Column G – Total Medi-Cal

33) Enter the difference for each category/line item listed in Column B by subtracting between the Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

34) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced

35) Enter the difference for Total Personnel Expenses and Total Operating Expenses listed in Column B by subtracting the Medi-Cal Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Enhanced expenditures reported on the Supplemental (Part A) Invoice.

36) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column H.

Column I – Medi-Cal Non-Enhanced

37) Enter the difference for each category/line item listed in Column B by subtracting the Medi-Cal Non-Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Non-Enhanced expenditures reported on the Supplemental (Part A) Invoice.

38) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Non-Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Non-Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column I.

Maintenance & Transportation (M&T)

39) Enter the differences for Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal by subtracting the Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts that were previously reported on the Initial Invoice from the correct Total Expenditures,

Total Non-Medi-Cal, and Total Medi-Cal amounts reported on the Supplemental (Part A) Invoice.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

Source of Funds

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

40) Enter the difference for each source of funds listed in Column J by subtracting the state and county funds that were previously reported on the Initial Invoice from the correct state and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for straight CCS expenditures is 50 percent state funds and 50 percent county funds.

The amount of state funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

41) Enter the Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families (HF)

42) Enter the difference for each source of funds listed in Column J by subtracting the federal, State, and county funds that were previously reported on the Initial Invoice from the correct federal, State, and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent State funds, and 17.5 percent county funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of State funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

43) Enter the Total Source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

44) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

45) Enter Total Source of Fund by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

46) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct state and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent state funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

47) Enter the Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

48) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct State and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

49) Enter the Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

50) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

51) Enter Total Source of Fund by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K – Total Expenditures

52) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

53) Enter the amounts for HF State, county, and federal funds (Title XXI) from Column N to Column K.

54) Enter the amounts for straight CCS state and county funds from Column M to Column K.

Total Source of Funds

55) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the sum of Columns M and N.

The entry in Column O must equal the sum of Columns P and Q.

The entry in Column K must equal the sum of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

Certification

56) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). Original signatures are required. **Signature stamps are not allowed**.

57) Type or print the name of the authorized official.

58) Enter the date that the signature was affixed.

59) Type or print the name of the contact person for the expenditure invoice.

60) Enter the e-mail address and telephone number, with the area code, for the contact person.

Submission

61) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature. **Signature stamps are not acceptable.** No additional copies are required.

62) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of each fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices (Parts A and B) for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR _____

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: **SUPPLEMENTAL NO.:** **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR _____

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0			0		
II.	Total Operating Expenses	0	0			0		
III.	Total Capital Expenses	0	0			0		
IV.	Total Indirect Expenses	0	0			0		
V.	Total Other Expenses	0	0			0		
	TOTAL EXPENDITURES	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Maintenance & Transportation	0	0	0	0	0		0

SOURCE OF FUNDS								
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
STRAIGHT CCS								
	State Funds	0	0	0				
	County Funds	0	0	0				
TOTAL SOURCE OF FUNDS		**0**	**0**	**0**	**0**	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By E-mail Address Date Area Code / Telephone Number

Signature of Authorized Official Date Print or Type Name of Signer Title

Revised June 2011

Page 2 of 2

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**

MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR 2011/2012

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	*B*	*C*
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	1,163	24.75%
TOTAL HEALTHY FAMILIES CASES	1,163	32.19%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	-1,163	-24.75%
TOTAL STRAIGHT CCS CASES	-1,163	-32.16%
TOTAL NON-MEDI-CAL CASES	0	0.00%
TOTAL CASELOAD		

Revised June 2011

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: ANY COUNTY, CALIFORNIA **SUPPLEMENTAL NO.: 01** **QUARTER ENDING: SEPTEMBER 30, 2011**
MONTH/DAY/YEAR

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

FISCAL YEAR 2011 / 2012

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS State/County (50/50)	HEALTHY FAMILIES Fed/State/Co (65/17.5/17.5)	TOTAL MEDI-CAL	ENHANCED State/Federal (25/75)	NON-ENHANCED State/Federal (50/50)
A	*B*	*C=D+G*	*D=E+F*	*E*	*F*	*G=H+I*	*H*	*I*
I.	Total Personnel Expenses	0	0	-64,628	64,628	0		
II.	Total Operating Expenses	0	0	-20,503	20,503	0		
III.	Total Capital Expenses	0	0	0	0	0		
IV.	Total Indirect Expenses	0	0	-10,488	10,488	0		
V.	Total Other Expenses	0	0	-1,823	1,823	0		
	TOTAL EXPENDITURES	**0**	**0**	**-97,442**	**97,442**	**0**	**0**	**0**
	Maintenance & Transportation	0	0	-755	755	0		0

SOURCE OF FUNDS								
	J	*K=L+O*	*L*	*M*	*N*	*O=P+Q*	*P*	*Q*
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	17,052	17,052		17,052			
	County Funds	17,052	17,052		17,052			
	Federal Funds (Title XXI)	63,337	63,337		63,337			
STRAIGHT CCS								
	State Funds	-48,721	-48,721	-48,721				
	County Funds	-48,721	-48,721	-48,721				
TOTAL SOURCE OF FUNDS		**0**	**0**	**-97,442**	**97,442**	**0**	**0**	**0**

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

JANE DOE	JANE.DOE@ANYCOUNTY.CALIFORNIA.COM	11/30/2011	(000) 123-4567
Prepared By	E-mail Address	Date	Area Code / Telephone Number
John Smith	11/30/2011 JOHN SMITH	CCS ADMINISTRATOR	
Signature of Authorized Official	Date Print or Type Name of Signer	Title	

Revised June 2011

CCS Diagnostic, Treatment, and Therapy Quarterly Expenditure Reporting

Part I. Summary Report of Diagnostic and Treatment Expenditures

Instructions

1) Open the Excel file and go to the worksheet tab labeled "Part I Dx Trtmnt" (yellow tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Diagnostic Expenditures

5) Enter on line **1.a** the total amount of Diagnostic expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports**. **(If the amount is negative, enter as a negative.)**

6) Enter on line **1.b** the total of **County paid diagnostic** expenditures for the quarter. *(Please note, an entry on this line should only be made if the county has prior approval* from Children's Medical Services (CMS) or the transition to the fiscal intermediary (FI) *provider payment processing occurred within the last 18 months of the quarter being claimed.)*

7) Enter on line **1.c** the total amount of approved diagnostic expenditure **Adjustments** *(the approved adjustment documentation must be attached).* The amount entered must be entered as **a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.

8) Enter on line **1.d** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes deposits made within the county for returned warrants and provider refunds, enter amount as a positive.)

9) Lines **1.e** and **1. f** are formula driven and will calculate based on the data entered in the lines a, b, c, and d.

10) Enter on line **1.g** the amount of **Emergency Relief Funding (100% State).** Per H&SC Section 123945, a board of supervisors signed request is required and must be on file with CMS. The amount entered must be entered as **a positive.** ***(Please note: an entry on this line should only be made provided the county has prior approval and has coordinated with state personnel the correct amount.)***

Treatment Expenditures

11) Enter on line **2.a** the total amount of treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports** that are applicable. **(If the amount is negative, enter as a negative.)**

12) Enter on line **2.b** the sum of the three **MR-O-163(M) Monthly CCS Financial Reports,** CCS Funded totals, (**Aid Code 9K**), Net Paid Amount. **(If the amount is negative, enter as a negative.** (See CCS HF Expenditures Form for aid codes 9K/OC, 9K/9H, 9U/OC, 9U/9H in Section 7, Page 107.)

13) Enter on line **2.c** the total of **County Paid Treatment** expenditures for the quarter (this includes county paid dental). *(Please note; an entry on this line should only be made if the county has prior approval or the transition to FI provider payment processing occurred within the last 18 months of the quarter being claimed.)*

14) Enter on line **2.d** the total amount of approved treatment expenditure **Adjustments,** this amount also includes Delta Dental *(the approved adjustment documentation must be attached)*. The amount entered must be entered as **a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.

15) Enter on line **2.e** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes returned warrants and provider refunds, enter amount as a positive.)

16) Lines **2.f** and **2.g** are formula driven and will calculate based on the data entered in the lines a, b, c, d, and e.

17) Enter on line **2.h** the amount of **Emergency Relief Funding (100% State).** Per H&SC Section 123945, a board of supervisors signed request is required and must be on file with CMS. The amount entered must be entered as **a positive**. ***(Please note: an entry on this line should only be made if the county has prior approval and has coordinated with state personnel the correct amount.)***

Subtotals Diagnostic and Treatment Expenditures

18) Lines **3.a** and **3.b** are formula driven and will calculate from the data entered in the lines above. Line **3.a** represents the total reportable expenditures, and line **3.b** represents a gross total which is used in determining the amount of reimbursement due to the state or due to the county.

Total County Share 50 Percent Net Diagnostic & Treatment Expenditures

19) This line calculates the **total county share** of the CCS diagnostic and treatment expenditures for the quarter. *This amount is the total reportable county cost of the non-Medi-Cal and non-Healthy Families CCS diagnostic and treatment expenditures for the quarter. This amount does not necessarily equal the amount of the Claim for Reimbursement which is determined by a number of different variables.*

Assessment Fees

20) Enter in field **5.a** the amount of the year to date outstanding assessment fees and enter in field **5.b** the amount collected for the quarter.

Enrollment Fees

21) Enter in field **6.a** the amount of the year to date outstanding enrollment fees and enter in field **6.b** the amount collected for the quarter.

Total Fees Collected

- This line calculates from the entries in lines 5 and 6.

Gross Diagnostic and Treatment Expenditures, and Fees Collected

- This line will calculate from the data in the fields „3.b." and „7".

50 Percent of Gross Diagnostic and Treatment and Fees Collected

- This field will calculate from the field on line 8.

Amount Due State (Positive) or Due County (Negative)

- This field will pull the same amount as line 9, and is displayed only for summary purposes.

COUNTY: **QUARTER ENDING:**
MONTH/DAY/YEAR

CCS DIAGNOSTIC AND TREATMENT QUARTERLY EXPENDITURE REPORTING

FISCAL YEAR:_____

(Per H&S Code, Sections 123800-123995 and related legislation)

PART I SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

1. DIAGNOSTIC Expenditures

a. MR-0-940 $ _____

* b. County paid diagnostic (***requires approval***) _____

c. Adjustments (approval documentation must be attached) _____
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.

d. Misc. Revenue & Refunds _____

e. Net Diagnostic Expenditures = a + b + c - d **$0**
the 'Net' amount represents total reportable expenditures less revenues & refunds

f. Gross Diagnostic = a - b + c + d **$0**
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

g. Emergency Relief Funding (100% State) $ _____
H&SC Section 123945, Bd of Supvs signed request required & on file.

* transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.

2. TREATMENT Expenditures

a. MR-0-940 $ _____

b. MR-0-163 (M) Delta Dental ***(Aid Code 9K Only)*** _____

* c. County paid treatment (***requires approval***) _____

d. Adjustments (approval documentation must be attached) _____
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.

e. Misc. Revenue & Refunds $ _____

f. Net Treatment Expenditures = a + b + c + d - e **$0**
the 'Net' amount represents total reportable expenditures less revenues & refunds.

g. Gross Treatment = a + b - c + d + e **$0**
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

h. Emergency Relief Funding (100% State) $ _____
H&SC Section 123945, Bd of Supvs signed request required & on file.

* transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.

3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES

a. Net Diagnostic and Treatment (1.e. + 2.e.) **$0**

b. Gross Diagnostic and Treatment (1.f. + 2.f.) **$0**

4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures **$0**
(amount reportable as actual County share of expenditures)

5. ASSESSMENT FEES a. receivables _____ b.collected _____

6. ENROLLMENT FEES a. receivables _____ b.collected _____

7. TOTAL FEES COLLECTED **$0**

8. GROSS Diagnostic and Treatment Expenditures, and Fees collected **$0**
The gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

9. 50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED **$0**

10. AMOUNT DUE STATE (positive) or DUE COUNTY (-) **$0**

AMOUNT DUE may change if any State approved adjustments were entered by the State during processing.

CCS Diagnostic, Treatment, and Therapy Quarterly Expenditure Reporting

Part II. Summary Report of Therapy Expenditures

Information pertaining to the expenditures claimed for the Medical Therapy Program (MTP) can be found in Numbered Letters 33-1293 and 35-0994. Additionally, County programs can find specific detail on the types of supplies and equipment that may be purchased and claimed through their California Children's Services (CCS) MTP in CCS Information Notice No.: 07-01, Revised Interagency Agreement (IA) between California Department of Health Care Services, Children's Medical Services (CMS) and California Department of Education (CDE), Special Education Division.

Instructions

1) Open the Excel file and go to the worksheet tab labeled "Part II Therapy" (orange tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

MTP Caseload

Non-Medi-Cal

5) Enter the number of cases that qualify as non-Medi-Cal.

Medi-Cal

6) Enter the number of cases that qualify as Medi-Cal.

Total

7) Enter the total number of cases by adding the number of cases for non-Medi-Cal and Medi-Cal.

Section I. County Employed Medical Therapy Unit (MTU) Staff (Excluding Staff Designated as MTP Liaison and for Individualized Education Program (IEP) Attendance)

Name

8) Enter the name of each county employed therapist and supporting staff (therapy aides, therapy assistants, etc.) allocated by the State who provided direct patient care in the MTU and/or directly supervised therapists during the reporting period.

Classification

9) Enter the appropriate civil service classification for each staff person.

Monthly Salary

10) Enter the monthly salary for each staff person listed.

Full Time Equivalent (FTE) Percent

11) Enter, in decimals, the percent of time that each staff person worked in the therapy program.

A staff person cannot claim time worked in both MTP and the administrative program. Also, a staff person's time cannot exceed 100 percent.

Expenditures Paid for Quarter

12) Enter the total expenditures paid for each staff person by:

a. Multiplying the appropriate Monthly Salary in Column 3 by 3 (for the three months in the quarter), and

b. Multiplying the result by the corresponding FTE percent in Column 4.

Total, Personal Services

13) Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

Staff Benefits

14) Enter the staff benefits percentage paid by the county for county employed therapy staff.

15) Enter the amount paid by the county for staff benefits by multiplying the amount in Line 6. Total, Personal Services by the staff benefits percentage.

Costs for staff benefits must be normal, reasonable, program related, and consistently applied to all employees, and must be in conformity with county policy for therapy positions.

Travel Costs

16) Enter the total amount of travel expenses incurred by therapy staff during the reporting quarter.

Allowable travel expenses are:

a. Mileage defined as travel within the county to perform job related duties, and

b. Expenses related to in-service training and State sponsored seminars. These expenses may include per diem, commercial auto rental, air travel, and private vehicle mileage costs.

All travel costs shall be supported by employee travel expense documents.

No travel outside the state of California shall be claimed without prior written State authorization.

Internal Indirect Costs

17) Enter the percentage paid by the county for internal indirect costs.

18) Enter the amount paid by the county for internal indirect costs by multiplying the total of the amounts in Line 6. Total, Personal Services and Line 7. Staff Benefits by the internal indirect costs percentage.

Total County Employed MTU Staff

19) Enter the total for county employed MTU staff by adding the amounts entered in Line 6. Total, Personal Services; Line 7. Staff Benefits; Line 8. Travel Costs; and Line 9. Internal Indirect Costs.

20) Enter the State share due county by multiplying the total from Line 10a by 50 percent.

Section II. Contract Therapists

Name

21) Enter the name of each therapist contracted by the county to provide direct patient care in the MTU during the reporting period.

Job Title

22) Enter the job title of each therapist contracted by the county for the reporting quarter.

Hourly Rate

23) Enter the hourly rate paid by the county for each contract therapist.

Number of Hours Worked

24) Enter the number of hours, or fractions thereof, that each contract therapist worked during the reporting quarter.

Expenditures Paid for Quarter

25) Enter the total expenditures paid for each contract therapist by multiplying the appropriate hourly rate in Column 3 by the corresponding number of hours worked in Column 4.

Total Contract Therapists

26) Enter the total for contract therapists by adding all entries in Column 5. Expenditures Paid for Quarter.

27) Enter the State share due county by multiplying the total from Line 6a by 50 percent.

Section III. MTP Coordination With Special Education Local Planning Area/Local Education Agency (SELPA/LEA) Liaison Activities and IEP Attendance by MTP Staff

This section is specific to the MTP requirements that are outlined in interagency regulations. The State allocates the staffing levels and reimburses the County for the expenditures incurred by these staff with 100 percent State funding.

Name

28) Enter the name of each county employed therapist allocated by the State who performs SELPA/LEA/IEP functions during the reporting period.

Classification

29) Enter the appropriate civil service classification for each staff person.

Monthly Salary

30) Enter the monthly salary for each staff person listed.

FTE Percent

31) Enter, in decimals, the percent of time that each staff person worked in the therapy program.

Expenditures Paid for Quarter

32) Enter the total expenditures paid for each staff person by:

a. Multiplying the appropriate Monthly Salary in Column 3 by 3 (for the three months in the quarter), and

b. Multiplying the result by the corresponding FTE Percent in Column 4.

Total, Personal Services

33) Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

Staff Benefits

34) Enter the staff benefits percentage paid by the county for county employed therapy staff performing SELPA/LEA/IEP functions.

35) Enter the amount paid by the county for staff benefits by multiplying the amount in Line 6. Total, Personal Services by the staff benefits percentage.

Costs for staff benefits must be normal, reasonable, program related, and consistently applied to all employees, and must be in conformity with county policy for therapy positions.

Travel Costs

36) Enter the total amount of travel expenses incurred by therapy staff during the reporting quarter.

Allowable travel expenses are:

a. Mileage defined as travel within the county to perform job related duties, and

b. Expenses related to in-service training and State sponsored seminars. These expenses may include per diem, commercial auto rental, air travel, and private vehicle mileage costs.

All travel costs shall be supported by employee travel expense documents.

No travel outside the State of California shall be claimed without prior written State authorization.

Internal Indirect Costs

37) Enter the percentage paid by the county for internal indirect costs.

38) Enter the amount paid by the county for internal indirect costs by multiplying the total of the amounts in Line 6. Total, Personal Services and Line 7. Staff Benefits by the internal indirect costs percentage.

Total County Staff For SELPA/LEA/IEP Functions

39) Enter the total for county staff for SELPA/LEA/IEP functions by adding the amounts entered in Line 6. Total, Personal Services; Line 7. Staff Benefits; Line 8. Travel Costs; and Line 9. Internal Indirect Costs.

40) Enter the State share due county by entering the total from Line 10a.

The State share of expenditures for county staff performing SELPA/LEA/IEP functions is 100 percent.

Section IV. MTU Expenditures (Detail Document Required)

MTU Supply and Equipment Costs

41) Enter the total of MTU Supply and Equipment Costs from the MTU Expenditures –Detail Document.

MTU Conference Costs

42) Enter the total of MTU Conference Costs from the MTU Expenditures –Detail Document.

Training/Education

43) Enter the total of Training/Education from the MTU Expenditures –Detail Document.

Miscellaneous MTU Costs

44) Enter the total of Miscellaneous MTU Costs from the MTU Expenditures –Detail Document.

Total MTU Expenditures

45) Enter the total for MTU expenditures by adding the amounts entered in Line 1. MTU Supply and Equipment Costs; Line 2. MTU Conference Costs; Line 3. Training/Education; and Line 4. Miscellaneous MTU Costs.

Section V. Subtotal Therapy Expenditures

46) Enter the subtotal for therapy expenditures by adding the totals of Section I. County Employed MTU Staff; Section II. Contract Therapists; and Section IV. MTU Expenditures.

47) Enter the total State share due county by multiplying the total from Line a. by 50 percent.

Section VI. Fiscal Intermediary (FI) Paid Claims

48) Enter the amount of therapy expenditures from the MR-0-940 Report for the reporting quarter.

This amount represents the total of MR-0-940 expenditures for each of the three months within the reporting quarter.

49) Enter the amount of offset to State share due county by multiplying the amount from Line a. by 50 percent.

Section VII. Total State Share at 50% Due County

50) Enter the amount of State share due county by subtracting the amount in Section VI.b. from Section V.b. only if section V.b. is greater than Section VI.b.

Section VIII. Total County Share Due State

51) Enter the amount of county share due State by subtracting the amount in Section V.b. from Section VI.b. only if Section VI.b. is greater than Section V.b.

Section IX. Total, State Share at 100% Due County

52) Enter the amount from Section III., Line 10.b. State Share Due County (100%).

Section X. Total, Therapy Expenditures

53) Enter the total for therapy expenditures by adding the totals of Section I. County Employed MTU Staff; Section II. Contract Therapists; Section IV. MTU Expenditures; and Section VI. FI Paid Claims.

The total of Section III. County Staff for SELPA/LEA/IEP Functions is excluded in this calculation.

Section XI. MTU Medi-Cal/County Organized Health System (COHS) Paid Therapy

CMS releases a letter on a quarterly basis that indicates the amount of MTU claims billed to Medi-Cal for each county that does not use a COHS to process such claims. The letter also indicates the amount of reimbursement that each county owes the State for the MTU claims paid by Medi-Cal.

54) Enter the amount of MTU claims billed to Medi-Cal or COHS for the reporting quarter.

55) Enter the amount for county share due State by multiplying the amount in Line a. by 75 percent.

For counties that bill Medi-Cal for MTU claims, the county share due State is equal to the amount of reimbursement identified in the letter from CMS.

Section IV. MTU Expenditures

56) Open the Excel file and go to the worksheet tab labeled "Detail MTU Expenditures" (purple tab if you have Microsoft Excel 2003).

County

57) Enter the name of the county for which this invoice applies.

Quarter Ending

58) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Fiscal Year

59) Enter the state fiscal year (FY) for which this invoice applies.

MTU Supply and Equipment Costs

Item

60) List each individual supply or equipment item that is purchased.

Description

61) Provide a brief, concise description or explanation of the each item. **Be specific**.

Quantity

62) Enter the number of each item that is purchased.

Unit Cost

63) Enter the unit cost of each individual item. Unit cost must correlate to the unit of issue.

Cost Extension

64) Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue

65) Enter how each individual item is produced for sale (box, roll, kit, package, each, etc.). Unit of issue must correlate to the unit cost.

Purpose

66) Explain the purpose, provide the reason(s), and/or justify the need for each item.

Authority

67) Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. **Be specific**.

Total, MTU Supply and Equipment Costs

68) Enter the total for MTU supply and equipment costs by adding all entries in the Cost Extension column.

MTU Conference Costs

Item

69) List each individual conference cost that is incurred.

Description

70) Provide a brief, concise description or explanation of the each cost. **Be specific**.

Cost

71) Enter the cost of each item.

Purpose

72) Explain the purpose, provide the reason(s), and justify the need for each item.

Authority

73) Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. Be specific.

Total MTU Conference Costs

74) Enter the total for MTU conference costs by adding all entries in the Cost column.

Training/Education

Name

75) Enter the name of the county employed staff person registered for training/education.

Course Name and Description

76) Enter the name of the training/education course and provide a brief, concise description of the class, seminar, etc.

Cost

77) Enter the cost or registration fees for the training/education course. Do not include any travel costs here. Any expenses incurred for travel related to the training/education course should be included in Line 8. Travel Costs under Section I or III.

No. of Days

78) Enter the number of days that the staff person will be attending the training/education.

Course Date(s)

79) Provide the dates of the scheduled training/education course.

Authority

80) Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. **Be specific**.

Total Training/Education

81) Enter the total for all training/education by adding all the entries in the Cost column.

Miscellaneous MTU Costs

Item

82) List each miscellaneous item that is purchased.

Description

83) Provide a brief, concise description or explanation of the each item. **Be specific**.

Quantity

84) Enter the number of each item that is purchased.

Unit Cost

85) Enter the unit cost of each miscellaneous item. Unit cost must correlate to the unit of issue.

Cost Extension

86) Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue

87) Enter how each item is produced for sale (box, roll, kit, package, each, etc.). Unit of issue must correlate to the unit cost.

Purpose

88) Explain the purpose, provide the reason(s), and justify the need for each item.

Authority

89) Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. **Be specific**.

Total Miscellaneous MTU Costs

90) Enter the total for miscellaneous MTU costs by adding all entries in the Cost Extension column.

Total MTU Expenditures

91) Enter the total for all MTU expenditures by adding the totals for MTU Supply and Equipment Costs, MTU Conference Costs, Training/Education, and Miscellaneous MTU Costs.

COUNTY: _____ **QUARTER ENDING:** _____
MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES
FISCAL YEAR_____

MTP Caseload	
Non-Medi-Cal	
Medi-Cal	
Total	0

Per Health and Safety Code Sections 123800-123995

SECTION I. COUNTY EMPLOYED MTU STAFF (excluding staff designated as MTP liaison and for IEP attendance)

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

6. Total, Personal Services
7. Staff Benefits @ _____%
8. Travel Costs
9. Internal Indirect Costs @ _____%
10. TOTAL, COUNTY EMPLOYED MTU STAFF a. - b. State Share Due County (50%) -

SECTION II. CONTRACT THERAPISTS

1. Name	2. Job Title	3. Hourly Rate	4. Number of Hours Worked	5. Expenditures Paid for Quarter

The county certifies that it invoices the State for reimbursement of contract physical therapists (PT) and occupational therapists (OT) at the same rate it pays county employed PTs and OTs, including benefits. The difference in the higher rate of pay for contract positions will be paid 100% from county funds, unless specifically pre-approved and authorized as an area of critical need by the Sate Children's Medical Services. On a separate attachment, please notate any costs that are not reimbursed by the State.

6. TOTAL, CONTRACT THERAPISTS a. b. State Share Due County (50%) -

SECTION III. MTP COORDINATION with SELPA/LEA LIAISON ACTIVITIES and IEP ATTENDANCE by MTP STAFF

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

6. Total, Personal Services
7. Staff Benefits @ _____%
8. Travel Costs
9. Internal Indirect Costs @ _____%
10. TOTAL, COUNTY STAFF for SELPA/LEA/IEP FUNCTIONS a. - b. State Share Due County (100%) -

SECTION IV. MTU EXPENDITURES (Detail Document Required)
1. MTU Supply and Equipment Costs
2. MTU Conference Costs
3. Training/Education
4. Miscellaneous MTU Costs
5. TOTAL, MTU EXPENDITURES a. - b. State Share Due County (50%) -

SECTION V. SUBTOTAL, THERAPY EXPENDITURES
Total of Sections I, II, and IV a. - b. Total State Share Due County (50%) -

SECTION VI. FI PAID CLAIMS
MR-0-940 Expenditures including Adjustments a. b. Offset to State Share Due County (50%) -

SECTION VII. TOTAL STATE SHARE at 50% DUE COUNTY
If Section V is greater than Section VI, subtract Section VI from Section V. State Share Due County (50%) -

SECTION VIII. TOTAL COUNTY SHARE DUE STATE
If Section VI is greater than Section V, subtract Section V from Section VI. County Share Due State -

SECTION IX. TOTAL, STATE SHARE at 100% DUE COUNTY
Section III, State Share Due County (100%) State Share Due County (100%) -

SECTION X. TOTAL THERAPY EXPENDITURES
Total of Sections I, II, IV, and VI -

SECTION XI. MTU MEDI-CAL/COHS PAID THERAPY
MTU Claims Paid by Medi-Cal or COHS Paid Therapy a. b. County Share Due State (75%) -

Revised April 2010

COUNTY: **QUARTER ENDING:**
MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

FISCAL YEAR_____

ADDITIONAL STAFF PERSONS PAGE

Per Health and Safety Code Sections 123800-123995

SECTION I. COUNTY EMPLOYED MTU STAFF (excluding staff designated as MTP liaison and for IEP attendance)

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

SECTION II. CONTRACT THERAPISTS

1. Name	2. Job Title	3. Hourly Rate	4. Number of Hours Worked	5. Expenditures Paid for Quarter

The county certifies that it invoices the State for reimbursement of contract physical therapists (PT) and occupational therapists (OT) at the same rate it pays county employed PTs and OTs, including benefits. The difference in the higher rate of pay for contract positions will be paid 100% from county funds, unless specifically pre-approved and authorized as an area of critical need by the Sate Children's Medical Services . On a separate attachment, please notate any costs that are not reimbursed by the State.

SECTION III. MTP COORDINATION with SELPA/LEA LIAISON ACTIVITIES and IEP ATTENDANCE by MTP STAFF

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

Revised June 2011

COUNTY: **QUARTER ENDING:**
MONTH/DAY/YEAR

CCS QUARTERLY REPORT OF THERAPY EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

FISCAL YEAR: _____

SECTION IV. MTU EXPENDITURES - DETAIL DOCUMENT

1. MTU Supply and Equipment Costs

Item	Description	Quantity	Unit Cost	Cost Extension	Unit of Issue	Purpose	Authority

Total, MTU Supply and Equipment Costs $ -

2. MTU Conference Costs

Item	Description	Cost	Purpose	Authority

Total, MTU Conference Costs $ -

3. Training/Education

Name	Course Name and Description	Cost	No. of Days	Course Date(s)	Authority

Total, Training/Education $ -

4. Miscellaneous MTU Costs

Item	Description	Quantity	Unit Cost	Cost Extension	Unit of Issue	Purpose	Authority

Total, Miscellaneous MTU Costs $ -

5. TOTAL, MTU EXPENDITURES $ -

Revised June 2011

CCS Claims for Reimbursement Cover Page Instructions

This worksheet was developed to calculate the amount of reimbursement due to the state or due to the county from the two separate worksheets „Part I DX Trtmnt" (yellow tab) and „Part II Therapy" (blue tab). The only entries the county will make are below.

Instructions

1) Open the Excel file and go to the worksheet tab labeled: "Claim for Reimb" (green tab if you have Microsoft Excel 2003).

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx – September 30, 20xx	September 30, 20xx
2	October 1, 20xx – December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 – March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 – June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Certification

5) Provide the contact name, e-mail address and telephone number with area code of the county staff who is responsible for processing the invoice form.

6) The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

7) Print or type the name and the title of the official who signed the invoice.

Submission

8) **Submit all invoices with original signatures**. Signature stamps are not acceptable. Additional copies are not necessary.

9) Send the original signed copy of the "Claim for Reimbursement" and Parts I and II, including the required attachments, to:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS DIAGNOSTIC/TREATMENT/THERAPY QUARTERLY EXPENDITURE REPORTING

FISCAL YEAR: _____

(EXPENDITURES INCURRED PURSUANT TO SECTIONS 123800-123995 OF THE HEALTH AND SAFETY CODE, AND RELATED LEGISLATION)

PART I **DIAGNOSTIC AND TREATMENT** ('*amount from Lines*' are from the "CCS DIAGNOSTIC AND TREATMENT EXPENDITURE REPORTING, PART I"

Positive amount = due State; negative (-)amount = due County. Except line 11&12 display as a positive, the amount due County (line 11) or due State (line 12).

1.	DIAGNOSTIC - (*amount from Line 1. f.*)	$0	
	1.a. County Share (50% of line 1. above or adjusted for relief)		$0
2.	TREATMENT - (*amount from Line 2. f.*)	$0	
	2.a. County Share (50% of line 2. above or adjusted for relief)		$0
3.	Subtotal COUNTY SHARE Diagnostic & Treatment (line 1.a.+ line 2.a.) positive amount = amount due State, negative (-) amount = amount due County		$0
4.	TOTAL Fees Collected	$0	
	4.a. County Share (50% of line 4. above)		$0
5.	**TOTAL PART I (line 3. + line 4.a.)** positive amount = amount due State, negative (-) amount = amount due County		$0

PART II **MEDICAL THERAPY PROGRAM (amounts are from CCS QUARTERLY REPORT OF EXPENDITURES, PART II)**

6.	Total County Share (amount from Section VII or Section VIII)	$0
7.	Total 100% Reimbursable to County *(from Section IX, as applicable)*	$0
8.	Total Medi-Cal /COHS due State *(amount from Section XI)*	-
9.	**TOTAL PART II (sum of lines 6, 7, & 8)**	$0

PART III **TOTAL CLAIM FOR REIMBURSEMENT**

10.	**TOTAL OF PART I and PART II (Line 5 + Line 9)**	$0
11.	**AMOUNT DUE COUNTY**	$0
	or	
12.	**AMOUNT DUE STATE**	$0

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date | Area Code/Telephone Number

Authorized Signature | Date | Print or Type Name and Title of Signer

Revised June 2011

CCS Bone Marrow Invoice Instructions

Information pertaining to CCS Bone Marrow can be found in Numbered Letter 01-0185.

CCS Healthy Families (HF) Quarterly Report of Expenditures Instructions

Instructions

1) Open the Excel file CCS HF Invoice.

County

2) Enter the name of the county for which this invoice applies.

Quarter Ending

3) Enter the dates of the quarter for which the invoice applies.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Fiscal Year

4) Enter the state fiscal year (FY) for which this invoice applies.

Healthy Families Treatment

5) Enter on line **1.a** the total amount of HF Treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports applicable**. **(If the amount is negative, enter as a negative.)**

6) Enter on line **1.b the sum of the three MR-O-163(M) Monthly CCS Financial Reports,** CCS HF FUNDED TOTALS, **(Aid Codes 9K/OC, 9K/9H, 9U/OC, 9U/9H)**, Net Paid Amount. **(If the amount is negative, enter as a negative.)**

7) Enter on line **1.c** the total amount of approved HF Treatment expenditure **Adjustments** (***only adjustments of FI paid claims, MR-0-940 corrections can be entered****; **approval documentation must be attached***). The amount entered must be entered as **a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.

8) Enter the amount of county paid HF treatment expenditures on line **1.d** (this includes county paid dental, also). ***(Pre-approval by CMS must be attached or on file in the CMS Administration Unit***).

9) Line **1.e** will calculate the total HF Treatment expenditures.

Healthy Families Therapy

Healthy Families Therapy expenditures are payments to vendors, and are provided in lieu of the County MTP for HF. HF therapy expenditures should only be coded and paid from this fund source when services have been provided to HF clients.

10) Enter on line **2.a** the total amount of HF therapy expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**

11) Enter on line **2.b** the total amount of approved HF therapy expenditure **adjustments** *(**only adjustments of FI paid claims, MR-0-940 corrections can be entered**; **approval documentation must be attached**)*. The amount entered must be entered as **a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.

12) Enter on line **2.c** the amount of County Paid HF Therapy expenditures (***pre-approval by CMS must be attached or on file in the CMS Administration Unit***).

13) Line **2.d** calculates the total HF Therapy expenditures.

Total Healthy Families Expenditures

14) Formula will calculate from the entries made in HF Treatment and HF Therapy. This amount is rounded to the nearest dollar.

Funding Sources

15) The funding sources for **4.a** Total HF expenditures and adjustments; **4.b** Total County Paid; and **4.c** Total HF Expenditure Funding Sources are formula driven.

Amount Due

16) Amount due is formula driven and calculates the **Amount due State or Amount due County**.

Certification

17) Provide the contact name, e-mail address and telephone number with area code of the county staff who is responsible for processing the invoice form.

18) The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

19) Print or type the name and the title of the official who signed the invoice.

Submission

20) **Submit all invoices with original signatures**. Signature stamps are not acceptable. Additional copies are not necessary.

21) Send the original signed copy of the "CCS HEALTHY FAMILIES QUARTERLY REPORT OF EXPENDITURES" including required attachments, to:

Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING** MONTH/DAY/YEAR

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: _____

(Per H&S Code, Sections 123800-123995 and related legislation)

1. HF TREATMENT

a. MR-0-940	$ _____	
b. MR-0-163 (M) Delta Dental Report **[Aid Codes 9K/OC, 9K/9H, 9U/OC, 9U/9H]**	_____	
* c. Treatment Adjustments (fiscal intermediary related, MR-0-940 only)	_____	
d. County Paid HF Treatment	_____	
e. Total HF Treatment (a. + b. + c. + d.)		$0

* Approval documentation must be attached, or on file with CMS Administration Unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.

2. HF THERAPY

a. MR-0-940	$ _____	
* b. Therapy Adjustments (fiscal intermediary related, MR-0-940 only)	_____	
c. County Paid HF Therapy	_____	
d. Total HF Therapy (a.+ b.+ c.)		$0

* Adjustments of FI paid claims only, documentation must be attached, or on file with CMS Administration Unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.

3. TOTAL HEALTHY FAMILIES EXPENDITURES ***(Total is rounded to nearest dollar)*** $0

4. FUNDING SOURCES

	Federal Title XXI	State	County
a. Total MR-0-940 and Adjustments	$0	$0	$0
b. Total County Paid	$0	$0	$0
c. Total HF Expenditure Funding Sources	$0	$0	$0

5. AMOUNT DUE (formula will calculate) :

Amount due STATE	$0
or	
Amount due COUNTY	$0

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date | Area Code/Telephone No.

Authorized Signature | Title | Date

Revised June 2011

CCS PEDIATRIC PALLIATIVE CARE INVOICE INSTRUCTIONS

The following are instructions for the completion of the California Children's Services (CCS) Pediatric Palliative Care (PPC) invoice. The PPC invoice is prepared on a quarterly basis.

County

1) Enter the name of the county for which this invoice applies.

Quarter Ending

2) Enter the date for which the quarter ends using the chart below.

Quarter	Time Period of Quarter	Quarter End Date
1	July 1, 20xx –September 30, 20xx	September 30, 20xx
2	October 1, 20xx –December 31, 20xx	December 31, 20xx
3	January 1, 20xx+1 –March 31, 20xx+1	March 31, 20xx+1
4	April 1, 20xx+1 –June 30, 20xx+1	June 30, 20xx+1

Quarterly invoices shall be submitted no later than 60 days after the end of each quarter.

Fiscal Year

3) Enter the State fiscal year (FY) for which this invoice applies.

Expenditures

Column A –Category

4) The PPC invoice has three categories of expenditures, which are:

- Personnel Expenses,
- Operating Expenses, and
- Indirect Costs

Total Category Expenditures is comprised of all categories of expenditures.

Column B –Total Expenditures

5) Enter the total of all expenditures charged during the quarter to each category listed in Column A.

6) Enter the amount for Total Category Expenditures by adding all entries in Column B.

For each category, the amounts entered in Column B must equal the total of respective amounts in Columns C and D.

Column C – Medi-Cal Enhanced Funds State/Federal (25/75)

7) Enter the amount of Medi-Cal enhanced expenditures charged during the quarter to Personnel Expenses and Operating Expenses.

The amount of expenditures charged to Personnel Expenses is based on time studies for:

a. Skilled Professional Medical Personnel (SPMP) who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and

b. Clerical staff that directly support and are supervised by the SPMP.

The amount of expenditures allowed for Operating Expenses is only training and travel costs for SPMP.

Medi-Cal enhanced does not allow expenditures for indirect costs.

8) Enter the amount for Total Category Expenditures by adding all entries in Column C.

Column D – Medi-Cal Non-Enhanced Funds State/Federal (50/50)

9) Enter the amount of Medi-Cal non-enhanced expenditures charged during the quarter to each category listed in Column A.

The amount of expenditures charged to each category includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; ancillary staff; clerical staff not providing direct support to, or supervised by SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, shall be charged at the non-enhanced rate.

The amount of Medi-Cal non-enhanced expenditures for each category listed in Column A is determined by subtracting the entries in Column C from the corresponding entries in Column B.

10) Enter the amount for Total Category Expenditures by adding all entries in Column D.

Source of Funds

The columns for Sources of Funds need to be completed in reverse order. First, complete Column H –Medi-Cal Non-Enhanced. Second, complete Column G –Medi-Cal Enhanced Funds. And lastly, complete Column F –Total Funds.

Column E –Sources of Funds

11) The PPC Program has two sources of funds, which are:

- State General Funds; and
- Federal Funds, e.g., Medi-Cal Title XIX.

Total Sources of Funds is comprised of all sources of funds.

Column H –Medi-Cal Non-Enhanced Funds

12) Enter the amounts of State and federal funds that were used to pay Medi-Cal non-enhanced expenditures.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent State funds and 50 percent federal funds.

The amount of State funds is determined by multiplying the Total Category Expenditures in Column D by 50 percent.

The amount of Federal Funds (Title XIX) is determined by multiplying the Total Category Expenditures in Column D by 50 percent.

13) Enter Total Sources of Funds by adding all entries in Column H.

Column G –Medi-Cal Enhanced Funds

14) Enter the amounts of State and federal funds that were used to pay Medi-Cal enhanced expenditures.

The funding distribution for Medi-Cal Enhanced expenditures is 25 percent State funds and 75 percent federal funds.

The amount of State funds is determined by multiplying the Total Category Expenditures in Column C by 25 percent.

The amount of Federal Funds (Title XIX) is determined by multiplying the Total Category Expenditures in Column C by 75 percent.

15) Enter Total Sources of Funds by adding all entries in Column G.

Column F – Total Funds

16) Enter the amounts for Total Funds by adding the respective amounts in Columns G and H for each funding source listed in Column E.

17) Enter the amount for Total Sources of Funds by adding all entries in Column F.

For each source of funds, the amounts entered in Column F must equal the total of respective amounts in Columns G and H.

Certification

18) Type or print the name of the contact person.

19) Enter the e-mail address of the contact person.

20) Enter the date the invoice was prepared by the contact person.

21) Enter the telephone number with the area code of the contact person.

22) Affix the signature of the CCS Administrator or an official who is authorized to sign in place of the CCS Administrator. **Original signature is required. Signature stamps are not acceptable**.

23) Type or print the name of the authorized official.

24) Enter the date that the authorized official signed the invoice.

Submission

25) Submit the invoice that has the original signature. **Signature stamps are not acceptable**. No additional copies are required.

26) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services
Program Support Section – Administration Unit
P.O. Box 997413 MS 8104
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

Quarter	Due Date
1st	November 30, 20xx
2nd	February 28, 20xx+1
3rd	May 31, 20xx+1
4th	August 31, 20xx+1

Supplemental invoices shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2011-12 ends June 30, 2012. Supplemental Invoices for FY 2011-12 are due no later than December 31, 2012.

State of California - Health and Human Resources Agency | Department of Health Care Services - Children's Medical Services

COUNTY: **QUARTER ENDING:**

MONTH/DAY/YEAR

CCS PEDIATRIC PALLIATIVE CARE QUARTERLY INVOICE
FISCAL YEAR _____

CATEGORY	TOTAL EXPENDITURES	Enhanced Funds State/Federal (25/75)	Non-Enhanced Funds State/Federal (50/50)
A	*B = C + D*	*C*	*D*
Personnel Expenses	0		
Operating Expenses	0		
Indirect Costs	0		
EXPENDITURES GRAND TOTAL	0	0	0

SOURCE OF FUNDS	TOTAL FUNDING	Enhanced Funds State/Federal (25/75)	Non-Enhanced Funds State/Federal (50/50)
E	*F = G + H*	*G*	*H*
State Funds	0	0	0
Federal Funds (Title XIX)	0	0	0
EXPENDITURES GRAND TOTAL	0	0	0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date | Area Code/Telehone Number

CCS Administrator (Signature) | Date | Print or Type Name of Signer

Revised June 2011

Management of Equipment Purchased with State Funds

I. County/City Guidelines for Equipment

All equipment purchased with funds furnished in whole or in part by the State under the terms of this agreement shall be the property of the State and shall be subject to the following provisions.

A. The county/city shall use its own procurement process when purchasing equipment. The cost of equipment includes the purchase price plus all costs to acquire, install, and prepare equipment for its intended use. Examples of items may include computers, printers, photocopiers, etc.

B. All equipment purchased under this agreement shall be used only to conduct business related to programs funded by Children's Medical Services (CMS).

C. The county/city shall maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of State property to assure its full availability and usefulness.

D. The county/city shall forward to CMS regional office a list of all new equipment purchased on the "Contractor Equipment Purchased with DHCS Funds" form (DHCS 1203). This form can be found at:

http://www.dhcs.ca.gov/publications/forms/pdf/dhcs1203.pdf

The regional office will forward the DHCS 1203 to the CMS's Administration Unit, Program Support Section. The Administration Unit will contact the Department's Asset Management for identification tags. Asset Management is responsible for inventory and control of equipment. Asset Management staff will determine which type of tag should be applied to the pieces of equipment. Each piece of equipment will retain the same tag number for its duration. All equipment must have State identification tags affixed to the front left-hand corner. Identification tags will be forwarded to the contact person on the DHCS 1203.

E. Invoices for budgeted equipment purchases are to be submitted with their quarterly invoice only after the equipment is received.

II. County/City Required Annual Inventory and Final Disposition

The county/city shall submit an annual inventory of State-purchased equipment on the form entitled "Inventory/Disposition of DHCS-Funded Equipment" (DHCS 1204). The form can be found at:

http://www.DHCS.ca.gov/publications/forms/pdf/dhcs1204.pdf

This form has a dual purpose; it serves to provide an inventory to Asset Management of the Department's assets and to notify Asset Management when disposal of those assets is needed.

Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report (STD 152).

Management of all county/city equipment purchased with State funds shall be coordinated through the CMS Administrative Consultant in accordance with the procedures described in Section II below.

III. Tagging and Disposal of State Purchased Equipment

A. Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602, as all equipment with a unit cost of $5,000 or more and a life expectancy of more than four years that is used to conduct State business.

B. In response to the DHCS 1203 received from the county/city, CMS Administrative Consultant forwards State tag(s) to the county/city with an equipment identification tag transmittal letter.

C. State-purchased equipment used by counties/cities in performance of CMS program obligations must be disposed of according to DHCS procedures. Disposition occurs when funding is terminated; the useful life of the equipment is expended; the equipment is determined by the State to be obsolete for purpose for which it was intended; or any other reason deemed by the State to be in its own best interest.

1. The county/city representative submits a written request to CMS Regional Administrative Consultant to dispose of equipment, or CMS Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.

2. CMS Regional Administrative Consultant notifies the DHCS Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Property Survey Report (STD 152).

   http://www.documents.dgs.ca.gov/osp/pdf/std152.pdf

Contractor Equipment Purchased With DHCS Funds Form (DHCS 1203)

State of California—Health and Human Services Agency

Department of Health Care Services

Exhibit _____

CONTRACTOR EQUIPMENT PURCHASED WITH DHCS FUNDS

Current Contract Number: _____

Previous Contract Number (if applicable): _____

Contractor's Name: _____

_____

Contractor's Complete Address: _____

_____

Contractor's Contact Person: _____

Contact's Telephone Number: _____

Date Current Contract Expires: _____

DHCS Program Name: _____

DHCS Program Contract Manager: _____

DHCS Program Address: _____

_____

DHCS Program Contract Manager's Telephone Number: _____

Date of this Report: _____

(THIS IS NOT A BUDGET FORM)

STATE/DHCS PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	DHCS PURCHASE ORDER (STD 65) NUMBER	DATE PURCHASED	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL* *PROGRAM USE ONLY*
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				

DHCS 1203 (12/07)

Instructions for DHCS 1203 Form

(PLEASE READ CAREFULLY)

The information on this form will be used by the Department of Health Care Services (DHCS) Asset Management (AM) to tag contract equipment and/or property (see definitions A and B) which is purchased with DHCS funds and is used to conduct state business under this contract. After the Standard Agreement has been approved and each time state/ DHCS equipment and/or property has been received, the DHCS Program Contract Manager is responsible for obtaining the information from the Contractor and submitting this form to DHCS AM. The DHCS Program Contract Manager is responsible for ensuring the information is complete and accurate. (See *Health Administrative Manual (HAM),* Section 2-1060 and Section 9-2310.)

Upon receipt of this form from the DHCS Program Contract Manager, AM will fill in the first column with the assigned state/ DHCS property tag, if applicable, for each item (see definitions A and B). AM will return the original form to the DHCS Program Contract Manager, along with the appropriate property tags. The DHCS Program Contract Manager will then forward the property tags and the original form to the Contractor and retain one copy until the termination of this contract. The Contractor should place property tags in plain sight and, to the extent possible, on the item's front left hand corner. The manufacturer's brand name and model number are not to be covered by the property tags.

If the item was shipped via the DHCS warehouse and was issued a state/ DHCS property tag by warehouse staff, fill in the assigned property tag. If the item was shipped directly to the Contractor, leave the first column blank.

Provide the quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of:

A. Major Equipment:

Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.

Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video).

These items are issued green numbered state/ DHCS property tags.

B. Minor Equipment/Property: Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. **These items are issued green** unnumbered "BLANK" state/**DHCS property tags** with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers, and switches. NOTE: It is DHCS policy not to tag modular furniture. (See your Federal rules, if applicable.)

Provide the DHCS Purchase Order (STD 65) number if the items were purchased by DHCS.

If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHCS Vehicle Services. (See HAM, Section 2-10050.)

If all items being reported do not fit on one form, make copies and write the number of pages being sent in the upper right-hand corner (e.g., "Page 1 of 3.") The DHCS Program Contract Manager should retain one copy and send the original to: Department of Health Care Services, Asset Management, MS 1405, P.O. Box 997413, 1501 Capitol Avenue, Sacramento, CA 95899-7413.

Property tags that have been lost or destroyed must be replaced. Replacement property tags can be obtained by contacting AM at (916) 650-0150.

Use the version on the DHCS Intranet forms site. The DHCS 1203 consists of one page for completion and one page with information and instructions.

Inventory/Disposition of DHCS-Funded Equipment Form (DHCS 1204)

State of California—Health and Human Services Agency

Department of Health Care Services

Exhibit _____

INVENTORY/DISPOSITION OF DHCS-FUNDED EQUIPMENT

Current Contract Number: _____

Previous Contract Number (if applicable): _____

Contractor's Name: _____

_____

Contractor's Complete Address: _____

_____

Contractor's Contact Person: _____

Contact's Telephone Number: _____

Date Current Contract Expires: _____

DHCS Program Name: _____

DHCS Program Contract Manager: _____

DHCS Program Address: _____

_____

DHCS Program Contract Manager's Telephone Number: _____

Date of this Report: _____

(THIS IS NOT A BUDGET FORM)

STATE/ DHCS PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	DHCS ASSET MGMT. USE ONLY DHCS Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				
			$				

DHCS 1204 (12/07)

Instructions for DHCS 1204 Form

(PLEASE READ CAREFULLY)

The information on this form will be used by the Department of Health Care Services (DHCS) Asset Management (AM) to; (a) conduct an inventory of DHCS equipment and/or property (see definitions A and B) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items' ages, per number 1 below, purchased with DHCS funds and used to conduct state business under this contract. (See *Health Administrative Manual (HAM),* Section 2-1060 and Section 9-2310.)

The DHCS Program Contract Manager is responsible for obtaining information from the Contractor for this form. The DHCS Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

Inventory: List all DHCS tagged equipment and/or property on this form and submit it within 30 days prior to the three-year anniversary of the contract's effective date, if applicable. **The inventory should be based on previously submitted** DHCS **1203s**, "Contractor Equipment Purchased with DHCS Funds." AM will contact the DHCS Program Contract Manager if there are any discrepancies.

Disposal: *(Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).)* The DHCS 1204 should be completed, along with a "Property Survey Report" (STD. 152) or a "Property Transfer Report" (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the DHCS Program Contract Manager to arrange for the appropriate disposal/transfer of the items.

List the state/ DHCS property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;

A. Major Equipment: (These items were issued green numbered state/ DHCS property tags.)

Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.

Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)

B. Minor Equipment/Property:

Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. The minor equipment and/or property items were issued green unnumbered "BLANK" state/DHCS property tags with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers, and switches.

If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to DHCS Vehicle Services. (See HAM, Section 2-10050.)

If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right- hand corner (e.g. "Page 1 of 3.")

The DHCS Program Contract Manager should retain one copy and send the original to: Department of Health Care Services, Asset Management, MS 1405, P.O. Box 997413, 1501 Capitol Avenue, Sacramento, CA 95899-7413.

Use the version on the DHCS Intranet forms site. The DHCS 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 650-0150.

Property Survey Report Form (STD 152)

Print Clear

STATE OF CALIFORNIA
PROPERTY SURVEY REPORT
STD. 152 (REV. 9-2003c)

Record as of disposition data (lost, stolen or destroyed property--record as of the date such determination was made).

RETURN TO:

REPORTING DEPARTMENT/AGENCY	ATTENTION	DOCUMENT NUMBER
RETURN ADDRESS	IMS CODE	DATE
CITY	ZIP CODE	REPLACEMENTS: SEE PURCHASE ESTIMATE NUMBER

Authority is requested to dispose of the following State property:

FUND OWNED BY	CONTACT PERSON	TELEPHONE NUMBER

ATTACHED

ITEM--DESCRIPTION, MODEL NUMBER, SERIAL NUMBER, ETC.	STATE IDENT. NO. (1)	DATE PURCHASED	ORIGINAL COST	LOCATION (CITY)	PRESENT CONDITION	DISP. CODE*	PRICE OFFERED (2)	PRICE RECEIVED (3)	RECEIPT NUMBER
1.									
2.									
3.									
4.									
5.									
6.									
7.									

(1) PROPERTY TAG NUMBER OR VIN NUMBER FOR VEHICLE (2) DO NOT OBTAIN BIDS ON TRADE-INS. ESTIMATE PRICE OFFERED (3) AMOUNT ALLOWED IF TRADED IN OR SOLD

***DISPOSITION CODE**
1. TRADE-IN
2. SALE (INCLUDING JUNK SALE)
3. JUNK - VALUELESS
4. LOST**
5. STOLEN**
6. DESTROYED (AS BY FIRE, ETC.)** } DEPARTMENT OF GENERAL SERVICES REVIEW NOT REQUIRED
7. TO BE SALVAGED
8. PROPERTY REUTILIZATION--GENERAL SERVICES, SURPLUS PROPERTY

**IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 8643 FOR INSTRUCTIONS.

EXPLANATION--REASONS FOR PROPOSED DISPOSITION OF EACH ITEM

APPROVED BY PROPERTY SURVEY BOARD

(A minimum of two signatures is required)

The above statements regarding state property are true and correct; culpable negligence (check appropriate box)

☐ was ☐ was not

involved in loss, theft, or damage; the disposition proposed is best for the public interest.

SIGNATURE	DATE SIGNED
1.	
2.	
3.	

CERTIFICATION OF DISPOSITION

The above described property was disposed of as follows: (specify if no consideration was received)

MANNER OF DISPOSAL

DISPOSAL DATE

SIGNATURE (Officer Supervising Disposal of the Property)

TITLE

REVIEWED BY DEPT. OF GENERAL SERVICES

FOR DGS REVIEW, SEND TO: Department of General Services, State Agency for Surplus Property

NORTH: 1700 National Drive, Sacramento, CA 95834
SOUTH: 701 Baming Tree Road, Fullerton, CA 92833

FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO:

Department of General Services, Office of Fleet Administration, 602 Q Street, Sacramento, CA 95814

SIGNATURE

DATE SIGNED

(DO NOT USE HALF SHEETS OR STAPLES)

152PRT.FRP

Equipment Identification Tag Transmittal Letter and Form CMSB-A-2

Date

County/City Program

Address

City, State Zip Code

Dear _____:

EQUIPMENT IDENTIFICATION TAG TRANSMITTAL

In accordance with State requirements for equipment management, this equipment identification tag transmittal is being issued in response to your request dated _____ and detailed on the "Contractor Equipment Purchased with DHCS Funds" form (DHCS 1203). The enclosed Department of Health Care Services Equipment identification tag(s) is/are to be affixed by County/City staff to the equipment as follows:

ITEM DESCRIPTION	**STATE ID NUMBER**
1.	
2.	
3.	
4.	

All tags must be placed on the front left-hand corner of the item. Manufacturer's marks must be left intact.

If you have any questions regarding the instructions in this letter or the appropriate procedures for affixing the enclosed tag(s), please contact me at (____) _____-_____.

Sincerely,

(State CMS Staff Name)
Administrative Consultant
Children's Medical Services

State of California - Health and Human Services
Department of Health Care Services

Systems of Care
Children's Medical Services

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County/City Name: Date of Report:

Complete Address: CMS Administrative Consultant:

Consultant's Address:

Program Name: Consultant's Telephone No.:

Program Contract Telephone No.:

Program Contract E-Mail Address:

DHCS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1 Include Manufacturer's name, model no./(type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHCS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, list VIN No.)
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Revised: March 2008
CMSB A-2 (7/01)

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