Quality Assurance Fee – Quarterly Payment
Designated Intermediate Care Facility

Facility Information	Payment Information
Facility Name:	**Rate Year:**
Street Address:	**Full Year Reconciliation: Yes ☐ No ☐**
City:	**Quarterly Reporting:**
State:	**Amount Due:**
Zip Code:	**Due Date:**
NPI:	
Vendor Number:	
Phone:	

Fiscal Year	Reporting Structure	Account	App Ref	Service Location
	4260KB0B	4129200	980	84005
Activity	**Program**	**Alt Account**	**Fund**	**Project**
	9990	4129200016	3213	

Gross receipts do not include: return of overpayments, uncollected debts, vendor rebates received by the DICF, charitable contributions, grants, and any other contributions to the DICF that are not fees for services provided to a Medi-Cal beneficiary.

Gross Receipts for this Quarter:	
1. Medi-Cal fee-for-service (including share of costs):	
2. Medi-Cal Managed Care (e.g. Cal-Optima, Molina, etc.):	
3. Other non-Medi-Cal (e.g. private pay):	
4. Total of gross receipts (sum of lines 1, 2, and 3):	
5. Multiply line 4 by 6.0% [.06]:	
6. Enter license fee (or credit from previous quarter): (Leave blank if the entire fee has already been deducted for the fiscal year)	
7. Subtract line 6 from line 5. If line 6 is blank, enter total from line 5. This is your QAF:	

Payment Instructions:

Please visit http://dhcs.ca.gov/epay and use invoice number **ICF12345678** to pay via EFT, the preferred method of payment. To pay by mail, please submit payment and form to: Department of Health Care Services, Accounting Section/Cashiers Unit, Mail Stop 1101, 1501 Capitol Avenue, Suite 71.2048, P.O. Box 997415, Sacramento, CA 95899-7415.

Submitter Information:	
Name:	**Email:**
Original Signature:	**Date:**
I am an administrator, officer, or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is *true, correct,* and *complete*.	