Attestation: Medi-Cal Specialty Mental Health Services Quarterly Claim for Reimbursement - Administrative Cost

Date:		County Code:		County:		Quarter:	
Fiscal Year:		Claim for Quarter Ending:			Mark "X" if Replacement Claim:		
BHSA Federal Financial Participation Calculated:				BHSA SGF Calculated:			
Total SGF Calculated (MCHIP):				Total SGF Calculated (Other):			
Total FFP Calculated (MCHIP):				Total FFP Calculated (Other):			

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Section 1090 et sec. of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; that the claim is based on actual, total-funds expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county mental health clients have been provided to the clients by the County; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing services, on request, within the State of California to the California Department of Health Care Services (DHCS), the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, or physical or mental disability.

Date: Print Name:

Local Mental Health Director

Executed at: Signature:

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Section 1090 et sec. of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; that the claim is based on actual, total-funds expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county mental health clients have been provided to the clients by the County; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing services, on request, within the State of California to the California Department of Health Care Services (DHCS), the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, or physical or mental disability.

Date: Print Name:

County Auditor Controller or City Financial Officer

Executed at: Signature:

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Instructions

Refer to DMH Letter No. 11-01 for descriptions of administrative activities.

Heading Instructions:

County: From dropdown Selection, select the County Name
County Code: From dropdown selection, select the County Code
Date: Enter the date the claim form is submitted
Fiscal Year: From dropdown selection, select Fiscal Year in which costs were incurred
Claim for Quarter Ending: From dropdown selection, select the quarter ending date Month/Day for the costs incurred
in Quarter: From the dropdown selection, select the quarter the costs incurred
BHSA Federal Financial Participation Calculated: Enter Line 14 amount from MC 1982B
BHSA SGF Calculated : Enter Line 15 amount from MC 1982B
Total SGF Calculated MCHIP: Enter Line 16 amount from MC 1982B
Total FFP Calculated MCHIP: Enter Line 17 amount from MC 1982B

After completing and signing this attestation, combine with the completed SMHS Other Admin 1982 (b) claim workbook and send this claim to: 1982BClaim@dhcs.ca.gov