State Plan and DMC-ODS COUNTY
ANNUAL COUNTY MONITORING ACTIVITIES (ACMA) ATTESTATION
FISCAL YEAR (FY) 2023/2024

The Department of Health Care Services' (DHCS), State Plan or Drug Medi-Cal Organized Delivery System (DMC-ODS) County Contractor, must complete this attestation as a part of the Annual County Monitoring Activities (ACMA). The County's Chief Executive Officer (CEO)/Chief Financial Officer (CFO) or an individual who reports directly to the CEO/CFO with delegated authority to sign for the CEO/CFO, must sign the attestation to certify compliance with the requirements specified herein.

Instructions:

For the requirement(s) specified in the Attestation, the County must:

- Provide the required information for each item by listing the policy, procedure, or supporting evidence the County reviewed to verify compliance with the requirement.
- Specify the title of the document (e.g., policy and procedure), document number, and the effective date(s) (as applicable). If additional space is needed, please attach a separate document with the additional information.
- Provide supporting documents as specified for each item.

The CEO/CFO (or Designee) must sign the Attestation below, to certify the County's compliance with all requirements listed.

If the County is not able to verify compliance with the requirement, the County must submit a Corrective Action Plan (CAP) addressing any areas of non-compliance.

(42 C.F.R. § 438.606; Welf. & Inst. Code § 14197.7(b) and (d))

ATTESTATION

I, CEO/CFO (or Designee) of the _____ State Plan or DMC-ODS County, hereby attest to compliance with the federal and state laws and regulations, as well as the Intergovernmental Agreement (IA) between the Contractor and the California Department of Health Care Services (DHCS), included in this Attestation. I certify, under penalty of perjury that, based on my best information, knowledge, and belief, and to the extent indicated below, or in any required CAP, the County is currently in compliance with the specified requirements, and the information below is accurate, complete, and truthful. The County will provide to DHCS, upon request, the supporting documentation and records. I am aware that the documents and records may be requested at any time, including during or after a virtual or onsite review.

State Plan or DMC-ODS County CEO/CFO (or Designee): _____Date: _____

Print Name: _____ Print Title: _____

County Name/Address: _____

1. The County shall comply with Language and Formatting laws and regulations related to Medi-Cal beneficiaries described in Title 42 Code of Federal Regulations parts 438.10(a), 438.10(d), 438.408(d)(1)-(2), 438.408(e), 438.404(a); Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973; BHIN 18-010E; BHIN 22-070.

Document Name	Document #	Effective Date