STATE OF CALIFORNIA – Health and Human Services Agency | Department of Mental Health

SHORT-DOYLE/MEDI-CAL MONTHLY CLAIM FOR REIMBURSEMENT-TREATMENT COST
MH1982 A (Rev. 07/03)

DMH ACCOUNTING ONLY

Batch ID						
Date Received						

Date	County Code	County

Fiscal Year (yy/yy)	Claim Service Period (mm/yy)

Total Number of Claim Lines: _____

		TOTAL
1	Total Expenditures	$
2	Less Revenues	
3	Subtotal	
4	Less Local H & W Trust Fund (Variable %)	
5	Federal Financial Participation (Variable %)	$

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 have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. The County agrees and shall certify 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. The County shall also certify 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. The County agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives. Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19th) birthday who were assessed or treated for a serious emotional disturbance (SED). The County also agrees that services ore offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract with the California Department of Mental Health (DMH). The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary. The services included in the claim were actually provided to the beneficiary. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the DMH. For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the DMH.

Date: _____ Signature: _____
Local Mental Health Director

Executed at _____, California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts. I further certify that claimant will provide the State's share of payment for Short-Doyle/Medi-Cal covered services included in this claim in order to satisfy matching requirements for federal financial participation pursuant to the Title XIX of the Social Security Act.

Date: _____ Signature: _____

Title: _____ Executed at _____, California
(County Auditor-Controller, City Finance Officer, or Local Mental Health Accounting Officer)

Please fax the completed form to the Department of Mental Health (DMH), Information Technology (IT) Production Support at (916) 654-3007. The original form is for your files. If you have any questions, please call DMH Information Technology help line at (916) 654-3117.

FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY