

DIRECT PROVIDER CERTIFICATION
for Drug Medi-Cal for Fiscal Year 2012-13
Year-End Claim for Reimbursement

Name and Address of Direct Contract Provider: _____

DHCS Contract Number: _____

County Name: _____

I, HEREBY CERTIFY under penalty of perjury that I am the official person responsible for the administration of Drug Medi-Cal alcohol and drug program services in and for said program; that I have not violated any of the provisions of Section 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Division 10.5, Part 2, Chapter 4 and Chapter 13 of the California Health and Safety Code; and that to the best of my knowledge and belief this claim is in all aspects true, correct, and in accordance with the law.

SIGNATURE: _____
 Contract Administrator

DATE: _____

EXECUTED AT _____, California

FOR STATE USE ONLY

Drug Medi-Cal Funds

- 1. Claim for Reimbursement _____
- 2. Advances Paid to Date <_____>
- 3. Less State Admin. <_____>
- 4. Less Share of Cost <_____>
- 5. Net Reimbursement _____

DHCS APPROVAL SIGNATURE: _____

DATE: _____