1982 A: SHORT-DOYLE/MEDI-CAL MONTHLY CLAIM FOR REIMBURSEMENT-
TREATMENT COST

Date (mm/dd/yyyy)	County Code	County	Total Actual Expenditures of Services Rendered $

Claim File Name	Revised Claim File Name

CERTIFICATION FOR SERVICES RENDERED:

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. seq. 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 (W&I) 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 law. The County 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; that 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. The County agrees, pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), to keep for a minimum of three years after the 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 the 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, Managed Risk Medical Insurance Board or their duly authorized representatives. The County further certifies under penalty of perjury that the 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) and that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I FURTHER 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 DHCS; 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 DHCS; for each beneficiary with day rehabilitation, day treatment intensive, or Early and Periodic Screening, Diagnosis and Treatment (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 DHCS.

Date:_____ Signature:_____
Local Mental Health Director

Executed at:_____ **,** California

CERTIFICATION FOR ACTUAL EXPENDITURES MADE BY COUNTY:

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; that I am authorized to sign this certification on behalf of the County; and that the information is to be used for filing a claim with the federal government for federal funds pursuant to Section 430.30 of Title 42, CFR. I understand that misrepresentation of any information constitutes a violation of federal and state law. I FURTHER CERTIFY under penalty of perjury that this claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of federal law, including Section 433.51 of Title 42, CFR, and that the expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program (unless these claims are being resubmitted after correction). I understand that the Department must deny payment of any claim submitted if it determines that the certification is not adequately supported for purposes of claiming FFP. I acknowledge that all records of funds expended are subject to review and audit by DHCS and/or the federal government and that, pursuant to Section 433.32 of Title 42, CFR, all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum of three years after the 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.

Date:_____ Signature: _____
(County Auditor-Controller, City Finance Officer,or
Local Mental Health Accounting Officer)

Title: _____ Executed at: _____ **,** California

The signed original of this form must be retained by the county mental health plan and presented upon request. This form must be converted to a PDF and transmitted along with the claim file referenced above. If you have any questions, please call the DHCS Medi-Cal Claims Customer Service Office at (916) 651-3283.