BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM (BH-QIP)
PROGRAM FUNDING CLAIMING FORM

Date: Fiscal Year: County Name:

BH-QIP Name:

Report Name:

Claim for Report Period Ending:

Amount Claimed:

Name of Preparer: Telephone Number:

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for administration of the County Behavioral Health Program and that I have not violated any of the provisions of Section 1090 et. seq. of the Government Code; that I am authorized to sign this certification on behalf of the county; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete and to the best of my knowledge this claim is in all respects true, correct, and in accordance with the law. The county understands that any payment to the county resulting from this claim will be paid with State funds and that any falsification or concealment of material fact may be prosecuted under State laws.

Signature: Date:

Print Name: Title: County Behavioral Health Director

I HEREBY 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 and am authorized to sign this certification on behalf of the County. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on activities necessary for claiming BH-QIP funding pursuant to all applicable requirements of the program. I understand that DHCS may deny any payment if it determines that the certification is not adequately supported for purposes of claiming BH-QIP funding. I understand that all records of funds included in this claim are subject to review and audit by DHCS.

Signature:

Date:

Print Name:

Title: County Auditor Controller or City Financial Officer

Or Check Box Below

Other Approved Designee

Title: