Specialty Mental Health Services Progress Reports Claim Form
Reimbursement of County Expenditures
Katie A. Subclass

1) Date _____
2) County Code _____
3) County Name _____
4) Date Report Submitted _____
5) Total Actual Expenditures _____

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administraton of Community Mental Health Services and for said claimant; that I am authorized to sign this certification form 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 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 further 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; the services were, to the best of the County's knoweldge, 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 State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees 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, the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County further certifies under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

Date: _____ Signature: _____
Local Mental Health Director

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official, as delegated by the Board of Supervisors, of the herein claimant responsible for the examination and settlement of accounts and that I am authorized to sign the certification on behalf of the County. I understand that misrepresentation of any information herein constitutes a violation of state and federal laws. I further certify that the claim is based on actual, total-funds expenditures necessary for claiming Federal Financial Participation (FFP) pursuant to all applicable requirements of state and federal law including, but not limited, to Sections 430.30 and 433.51 of Title 42, Code of Federal Regualtions (CFR). I understand that DHCS may deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds included in this claim are subject to review and audit by DHCS and/or the federal government and that, pursuant to Section 433.32, Title 42, CFR all records of funds 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 peiod if audit findings have not been resolved.

Date: _____ Signature: _____

Title: _____
County Auditor-Controller or Local Mental Health Accounting Officer

FOR STATE DEPARTMENT OF HEALTH CARE SERVICES USE ONLY

County Claim for Reimbursement $ _____

Signature: _____ Date: _____
Accounting Officer

Schedule Number: _____

INSTRUCTIONS FOR COMPLETING THE SPECIALTY MENTAL HEALTH SERVICES PROGRESS REPORTS CLAIM FORM

Line 1) Please enter the date the claim form is being prepared.

Line 2) Please enter the county code for the county claiming reimbursement.

Line 3) Please enter the name of the county for the county claiming reimbursement.

Line 4) Please enter the date the Katie A. implementation progress report was submitted to DHCS.

Line 5) Please enter the total expenditures for which this claim is being submitted. The total expenditures claimed for the two semi-annual reports may not exceed the amount shown in column C of enclosure 1 to MHSUD IN No.

Send a .pdf of the completed claim form to: 1982CClaim@dhcs.ca.gov