DIRECT PROVIDER CERTIFICATION

for Drug Medi-Cal for Fiscal Year 2011-2012
Year-End Claim for Reimbursement

Name and Address of Direct Contract Provider: ______________________________
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ADP Contract Number: ________________ County Name: __________________________

I, HEREBY CERTIFY under penalty of perjury that I am the official person responsible for the administration of 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: ______________________________ DATE: ____________________
Contract Administrator

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: ____________________