State of California – Health and Human Services Agency
Department of Health Care Services

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – FREE TEXT (FY)
Payment Invoice for FREE TEXT (Month, Day, Year) to FREE TEXT (Month, Day, Year)

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

FREE TEXT (Facility Name)
FREE TEXT (Facility Address)
FREE TEXT (Facility City, State, Zip Code

Office of Statewide Health Planning and Development Number: [Blank]
National Provider Identifier (NPI): [Blank]
Due Date: FREE TEXT (Date) [Blank]
Amount Remitted: $ [Blank]

Index: 5650
Object Detail: 000
Agency Object: 00
BLK: H
Source: 125600
Agency Source: 31
PCA: 85214
FFY: Free Text (FFY)
Fund: 0001

Total Resident Days [Blank] Multiply by FREE TEXT (Fee Amount) = Amount Due [Blank]
Original Signature: [Blank]
Date: [Blank]
Print Name: [Blank]
Phone Number: [Blank]
E-Mail: [Blank]

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF
Payment Invoice Instructions:
Total Resident Days –
Enter the Total Resident Days for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service,

Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due –
Multiply the Total Resident Days by FREE TEXT (Fee Amount) and enter that amount in the space provided for the Amount Due.

Amount Remitted –
Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the Amount Due.

Original Signature –
Sign in the space provided. Please use ink.

Date –
Enter the date you completed this payment invoice.

Phone Number/E-Mail –
Enter your area code, daytime phone number, and E-Mail address.
Payment invoices are available online at:
http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the Amount Due to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the NPI on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

DHCS 9116 (Rev. 03-10)