Local Educational Agency (LEA) Medi-Cal Billing Option Program
Certification of Zero Reimbursements for LEA Services
Fiscal Year 2016-2017 (July 1, 2016-June 30, 2017)

1. **LEA Identification:** Identify the primary LEA employee who can be contacted to answer questions about information submitted in the Medi-Cal CRCS.

LEA Provider Name:_____ National Provider Identifier: _____

LEA Contact Name: _____ Provider Number/CDS Code: _____

Phone:_____ Title: _____

Fax:_____ E-mail Address: _____

Address 1:_____ City: _____

Address 2:_____ State: CA Zip Code:_____

2. **Certification of Zero Reimbursements for LEA Services:** The LEA employee that completed or supervised the completion of the Medi-Cal CRCS should read, sign, and date this certification statement under penalty of perjury. The contact in Section 1 may be different than the signatory responsible for certification in Section 2.

I certify under penalty of perjury that the Local Educational Agency (LEA) did not receive reimbursement for **services that were provided in State Fiscal Year 2016-17** and that there are no expenditures to report.

Summary of Matching Funds

Total Reimbursement Received: $ _____

I, the undersigned, state the following: As a public administrator, a public officer or other public individual duly authorized by the LEA as having authority to sign on behalf of the LEA, I am authorized or designated to make this certification on behalf of the Public Entity for

LEA: _____

and declare that this Certification and CRCS form documents attached hereto are true and correct. I understand that making false statements, or the filing of a false or fraudulent claim is punishable under Welfare and Institutions Code sections 14107, 14107.11, and other applicable provisions of law.

Print Name	Title
Signature	Date

Instructions for Completing Certification:

Section 1- LEA Identification: Report the LEA Provider's full name, Medi-Cal Provider Identifier and Provider Number/CDS Code. Identify the primary LEA employee who can be contacted to answer questions about information submitted in the Medi-Cal CRCS, as well as their title, phone number, fax number, e-mail address and mailing address.

Section 2- Certification of State Matching Funds for LEA Services: Indicate that a total of zero reimbursements were received for LEA services, and identify the LEA for which this certification is binding to. Provide (print) name, title, and signature of the person who is authorized by the LEA, and the date.