Local Educational Agency Medi-Cal Billing Option Program (LEA BOP)
Cost and Reimbursement Comparison Schedule (CRCS)

LEA Provider Name:	
Contact Name:	State Fiscal Year (SFY):
National Provider Identifier:	E-mail Address:

Certification of State Matching Funds for LEA BOP Services:

I, the undersigned, under penalty of perjury state the following:

A. LEA warrants and represents that the information on the accompanying claim form is true and correct.

B. LEA represents that its expenditures under the LEA BOP represent allowable expenditures eligible for Federal Financial Participation (FFP) pursuant to the requirements of Section 1903(w) of the Social Security Act and Subpart B of Part 433 of Title 42 of the Code of Federal Regulations.

C. LEA will maintain documentation supporting the expenditures claimed on the accompanying claim form. This documentation must include all fiscal records required for Medi-Cal audits.

D. LEA certifies that all expenditures reported within the Medi-Cal Cost and Reimbursement Comparison Schedule are in compliance with the Office of Management and Budget (OMB) Super-Circular (2 CFR 200). To the extent that reporting is not governed by OMB Super-Circular, LEA certifies that Generally Accepted Accounting Principles have been applied.

E. LEA's expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medi-Cal or any other program.

F. LEA acknowledges that the information is to be used by the Department of Health Care Services (DHCS) for filing of a claim with the federal government for federal funds and understands that misrepresentation of information constitutes violation of federal and state law.

G. LEA acknowledges that all records of funds expended are subject to review and audit by DHCS and the Federal Centers for Medicare and Medicaid Services.

H. LEA understands that DHCS must deny payment of any claim if it is determined that the certification and/or claim form is not adequately supported for purposes of FFP.

As a public administrator, a public officer or other public individual duly authorized as having authority to sign on behalf of the LEA, I am authorized or designated to make this Certification and declare that this Certification and claim form documents attached hereto are true and correct. I understand that the filing of a false or fraudulent claim or making of false statements in support of a claim may violate the Federal False Claims Act or other applicable statute and federal law and may be punishable thereunder.

Summary of Overpayments/(Underpayments):	**Enter amount below:**
Total Overpayment/(Underpayment) For LEA BOP Services (From Excel Certification Worksheet, enter Underpayment as a negative number)	

Name:	Title:
Signature:	Date: