State of California
Health and Human Services Agency

Department of Health Care Services

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Adult Subacute Nursing Facility (FS ASA/NF-B), Freestanding Pediatric Subacute, Level-B (FS PSA/NF-B) Quality Assurance Fee

Facility Information:	**Payment Details:**
Facility Name:	**Rate Year:**
Address:	**Full Year Reconciliation:** Yes ◯ No ◯
NPI:	**Month Reporting:**
OSHPD:	**Amount Due: $**
Phone:	**Due Date:**

Fiscal Year	**Reporting Structure**	**Account**	**App Ref**	**Service Location**
	4260KB0B	4129200	980	84005
Activity	**Program**	**Alt Account**	**Fund**	**Project**
	9990	4129200015	3213	

Resident days are the number of days in which a patient resides at the SNF. This includes, **but is not limited to**: bed hold days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, private pay, other insurance, charity, and hospice. **The QAF Rate for Rate Year is $ for less than 100,000 resident days, and $ for 100,000 or more resident days.**

Amount Due:	
Total # of Resident Days:	
QAF Rate:	
Amount Due = Total # of Resident Days x QAF Rate:	

Payment Instructions:

Please visit http://dhcs.ca.gov/epay and use invoice number **SNF12345678** to pay via EFT, the preferred method of payment. To pay by mail, please submit payment and form to: 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.

Submitter Information:	
Name:	**Email:**
Original Signature:	**Date:**
I am an administrator, officer, or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is *true, correct,* and *complete*.	