CHILD HEALTH AND DISABILITY PREVENTION PROGRAM DIRECTOR/DEPUTY DIRECTOR TRAINING - SECTION X

Quarterly Invoicing/Property Management

Section revised 10/21/15

GENERAL INFORMATION

References

Instructions for completing invoices can be found in Section 7 (Expenditure Claims and Property Management) – from the Children's Medical Services (CMS) Plan and Fiscal Guidelines (PFG) unless otherwise indicated.

Be advised that information may change. Refer to the most current version of the Plan and Fiscal Guidelines (PFG) for the latest information.

- The quarterly expenditure invoice forms contain the same five line items used in the budgets.
- Counties/Cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices; however justification of how expenditure amounts were derived must be maintained for audit purposes.
- Invoices must be supported by time studies and maintained at the county/city level for audit purposes.

- Tools for using time study information to allocate personnel services and benefits expenses are included in the PFG, Section 9, References
- Overhead costs on the invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller 10 Federal Guidelines. External costs invoiced must be based on the plan approved by the State Controller's Office.
- Invoices must list actual expenditures approved in the budget justification worksheet with the exception of indirect costs, staff benefits and certain goods.

- Goods (e.g., equipment, printing, videos, etc.) that are supported by a purchase order, for which funds are encumbered, might not be received until the following fiscal year. These costs may be included on the fourth quarter invoice or submitted on a supplemental invoice for the fiscal year in which they were encumbered.
- Refer to PFG Section 6 Budget Instructions for questions concerning the appropriate line item usage for an expense.
- Headings on invoices must contain program name (i.e. CHDP), name of county or city, fiscal year of invoicing period and quarter ending date.

- Invoices that exceed budgeted funding sources, or do not compute, will be returned for corrections.
- Agencies are responsible for federal audit exceptions and must notify the State in the event any exceptions are found.

QUARTERLY INVOICES

- Quarterly invoices for expenditures authorized in Children Medical Services budgets shall be submitted no later than 60 days after the end of each quarter. All quarterly invoices are paid on a cash basis, therefore it is important to submit invoices in a timely manner.

NOTE: It is imperative that the Director/Deputy Director work closely with fiscal services in the preparation and submission of the quarterly invoices, as the Director/Deputy Director is ultimately responsible for the accuracy of the information submitted.

Types of Quarterly Invoices

- CHDP Quarterly Administrative Expenditure Initial Invoice
  - No County/City Match
  - County/City Match*
- Health Care Program for Children in Foster Care (HCPCFC) Quarterly Administrative Expenditure Invoice
- CHDP Foster Care Administrative Expenditure Invoice*
- CHDP Quarterly Administrative Expenditure - Supplemental Invoice Parts A and B (This Invoice will be discussed in the Supplemental Invoice section.)

*These are optional, depending on local program funding.

Initial Invoice
No County/City Match

The Initial Invoice (No County/City Match) includes:

A. Category/Line Items

1. Total Personnel Expenses
2. Total Operating Expenses
3. Total Capital Expenses
4. Total Indirect Expenses
5. Total Other Expenses
6. Expenditure Grand Total

B. Source of Funds

1. State
2. Federal (Title 19 matching funds)
    a. Enhanced State/Federal
    b. Non-Enhanced State/Federal
    c. Total Funds

    (No local funds involved)

C. Certification and Signatures

Invoice Form
No County/City Match

State of California - Health & Human Services Agency

_____COUNTY/CITY

Department of Health Care Services - Children's Medical Services

QUARTER ENDING: _____
MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE

(No County / City Match)

FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES (COLUMNS 2 + 3)	TOTAL CHDP *Non Medi-Cal*	TOTAL MEDI-CAL (COLUMNS 4 + 5)	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	1	2	3	4	5
I. TOTAL PERSONNEL EXPENSE	0		0		
II. TOTAL OPERATING EXPENSE	0		0		
III. TOTAL CAPITAL EXPENSE	0		0		
IV. TOTAL INDIRECT EXPENSE	0		0		
V. TOTAL OTHER EXPENSE	0		0		
EXPENDITURE GRAND TOTAL	0	0	0	0	0

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS	0	0			
MEDI-CAL FUNDS:					
STATE	0		0	0	
FEDERAL (TITLE XIX)	0		0	0	
EXPENDITURE GRAND TOTAL	0	0	0	0	0

Prepared By | E-mail Address | Date | Area Code / Telephone No.

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director | Date

Type or Print Name of Signer

Revision Date: January 2009

Initial Invoice
County/City Match

The Initial Invoice (County/City Match) is completed for local programs that use the optional budget.

Local county/city funds may be matched with federal funds (Title 19) for this budget. No State general funds are used in this budget.

The Initial Invoice (County/City Match) includes:

A. Category/Line Items

1. Total Personnel Expenses
2. Total Operating Expenses
3. Total Capital Expenses
4. Total Indirect Expenses
5. Total Other Expenses
6. Expenditure Grand Total

B. Source of Funds

1. County/City Funds
2. Federal (Title XIX matching funds)
    a. Enhanced
    b. Non-Enhanced
    c. Total Funds

(No State Funds Involved)

C. Certification and Signatures

Invoice Form
County/City Match

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

_____COUNTY/CITY

QUARTER ENDING: _____
MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INITIAL INVOICE

(County / City Match)

FISCAL YEAR_____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES (COLUMNS 2 + 3)	ENHANCED STATE/FEDERAL (25/75)	NON-ENHANCED STATE/FEDERAL (50/50)
COLUMN	1	2	3
I. TOTAL PERSONNEL EXPENSE	0		
II. TOTAL OPERATING EXPENSE	0		
III. TOTAL CAPITAL EXPENSE	0		
IV. TOTAL INDIRECT EXPENSE	0		
V. TOTAL OTHER EXPENSE	0		
EXPENDITURE GRAND TOTAL	0	0	0

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL (25/75)	NON-ENHANCED COUNTY/FEDERAL (50/50)
COLUMN	1	2	3
COUNTY/CITY MATCH	0	0	
FEDERAL (TITLE XIX)	0	0	
GRAND TOTAL	0	0	0

Prepared By | E-mail Address | Date | Area Code / Telephone No.

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director | Date

Type or Print Name of Signer

Revision Date: January 2009

Health Care Program for Children in Foster Care Invoice

The Health Care Program for Children in Foster Care Invoice (No County/City Match) includes:

A. Category/Line Items

1. Total Personnel Expenses
2. Total Operating Expenses
3. Total Indirect Expenses
4. Expenditure Grand Total

B. Source of Funds

1. State
2. Federal (Title XIX matching funds)
    a. Enhanced State/Federal
    b. Non-Enhanced State/Federal
    c. Expenditure Grand Total

C. Certification and Signatures

Health Care Program for Children in Foster Care Invoice Form

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services Branch

QUARTER ENDING: _____
MONTH/DAY/YEAR

HCPCFC Quarterly Administrative Expenditure Invoice
Fiscal Year _____
County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense			
II. Total Operating Expense			
III. Total Capital Expense			
IV. Total Indirect Expense			
V. Total Other Expense			
Expenditure Grand Total			

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds			
Federal Funds (Title XIX)			
Expenditure Grand Total			

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter to which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date / Area Code /Telephone Number

CHDP Director or Deputy Director (Signature) | Date | Area Code /Telephone Number

CHDP Foster Care Invoice

The Foster Care Administrative (County/City Match) invoice form is completed when the local program uses the optional budget to fund Public Health Nurse and Supervising Public Health Nurse staff working in support of children and youth in out-of-home placement or foster care.

Local county/city funds may be matched with Federal funds (Title XIX) for this budget. No State general funds are used in this budget or included on the Foster Care Administrative Expenditure Invoice.

The Foster Care Quarterly Administrative Invoice Form (County/City Match) includes:

A. Category/Line Items

1. Total Personnel Expenses
2. Total Operating Expenses
3. Total Indirect Expenses
4. Expenditure Grand Total

B. Source of Funds

1. County/City Funds
2. Federal Funds (Title XIX)
    a. Enhanced Funds
    b. Non-Enhanced Funds
    c. Total Funds

C. Certification and Signatures

CHDP Foster Care Invoice Form

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services Branch

QUARTER ENDING: _____
MONTH/DAY/YEAR

CHDP Foster Care Quarterly Administrative Expenditure Invoice
Fiscal Year _____
County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense			
II. Total Operating Expense			
III. Total Capital Expense			
IV. Total Indirect Expense			
V. Total Other Expense			
Expenditure Grand Total			

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
County-City Funds			
Federal Funds (Title XIX)			
Expenditure Grand Total			

Source County-City Funds: _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By | E-Mail Address | Date / Area Code /Telephone Number

CHDP Director or Deputy Director (Signature) | Date | Area Code /Telephone Number

SUPPLEMENTAL INVOICE PARTS A AND B

Supplemental Invoice

A supplemental Invoice identifies the differences between the expenditures and funding amounts previously submitted on the Initial Invoice and the expenditures and funding amounts that are currently true, correct, and accurately reflect the actual spending pattern for a particular quarter.

A supplemental invoice is comprised of the following two parts:

- Supplemental Invoice – Part A, Approved Invoice Plus Changes
- Supplemental Invoice – Part B, Amounts of Changes

Part A, Approved Invoice Plus Changes – represents the Initial Invoice that has been approved by CMS and any changes that update the information previously reported on the Initial Invoice.

Part B, Amounts of Changes – represents the difference between the Initial Invoice and the Supplemental Invoice Part A.

Supplemental Invoice Form Part A

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

_____COUNTY/CITY

QUARTER ENDING: _____
MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART A

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE / FEDERAL	NON ENHANCED STATE / FEDERAL
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE / FEDERAL 25% / 75%	NON ENHANCED STATE / FEDERAL 50% / 50%
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					
GRAND TOTAL					

Prepared By/Contact Person | E-mail Address | Date | ( ) Telephone Number

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director | Date | Type or Print Name of Signer | Title

Supplemental Invoice Form Part B

State of California - Health & Human Services Agency

Department of Health Care Services - Children's Medical Services

_____COUNTY/CITY

QUARTER ENDING: _____

MONTH/DAY/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR _____

SUPPLEMENTAL INVOICE - PART B

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE / FEDERAL	NON ENHANCED STATE / FEDERAL
a	*b = c + d*	*c*	*d = b - c*	*e*	*f = d - e*
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP Non MEDI-CAL	TOTAL MEDI-CAL	ENHANCED STATE / FEDERAL 25% / 75%	NON ENHANCED STATE / FEDERAL 50% / 50%
g	*h = i + j*	*i*	*j = h - i*	*k*	*l = j - k*
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					
GRAND TOTAL					

Prepared By/Contact Person | E-mail Address | Date | ( ) Telephone Number

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director | Date | Type or Print Name of Signer | Title

Supplemental Invoices for Foster Care

- Currently there is no specific supplemental invoice form for the CHDP County Match Quarterly Invoice, HCPCFC Quarterly Expenditure Invoice or CHDP Foster Care Quarterly Expenditure Invoice.
- If a supplemental invoice is required for these programs, contact your Regional Administrative Consultant for direction.

Submission of Invoices

All invoices are to be submitted with original

signatures. Signature stamps are not acceptable.

- Quarterly invoices shall be submitted no later than 60 days after the end of each quarter
- Supplemental invoices shall be submitted no later than December 31st after the end of the fiscal year

Submission of Invoices Timeline

- First quarter invoice (time period of July 1 through September 30) is due by November 30.
- Second quarter invoice (time period of October 1 through December 31) is due by February 28.
- Third quarter invoice (time period of January 1 through March 31) is due by May 31.
- Fourth quarter invoice (time period of April 1 through June 30) is due by August 31.

Invoices Submitted

Invoices should be submitted to:

California Department of Health Care Services

Children's Medical Services Branch

Administration Unit

P.O. Box 997413 MS 8104

Sacramento, CA 95899-7413

PROPERTY MANAGEMENT

Equipment Purchased with State Funds

All equipment purchased with funds furnished in whole or in part by the State shall be the property of the State and shall be subject to the following provisions:

- The county/city shall use its own procurement process when purchasing equipment.
- All equipment purchased shall be used only to conduct business related to programs funded by Children Medical Services.
- The county/city shall maintain a program for the utilization, maintenance, repair, protection, and preservation of State property.

New Equipment Purchase

- The county/city shall forward to the Children Medical Services regional office a list of all new equipment purchased on the “Contractor Equipment Purchased with Department of Health Care Services Funds” form (DHCS 1203). This form can be found in the PFG, Section 7.
- State Asset Management staff will provide identification tags and is responsible for inventory and control of equipment. Equipment will retain the same tag number for its duration.
- All equipment must have State identification tags affixed to the front left-hand corner. The tags will be forwarded to the contact person on the DHCS 1203

Major Equipment

- Major Equipment
  - Tangible items having a base unit cost of $5,000 or more
  - These items are issued green numbered State/ Department of Health Care Services property tags

Minor Equipment

- Minor Equipment
  - Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000
  - These items are issued green unnumbered “BLANK” State/ Department of Health Care Services property tags

Exceptions are PDA, PDA/cell phone combination, laptops, desktop personal computers, LAN servers, routers, and switches, which require numbered tags.

Equipment Inventory and Disposal

- The county/city shall submit an annual inventory of State-purchased equipment on the form entitled "Inventory/Disposition of Department of Health Care Services -Funded Equipment" DHCS 1204).

- The DHCS 1204 serves to provide an inventory to Asset Management of the Department's assets and to notify Asset Management when disposal of those assets is needed.

- The form can be found in the Plan and Fiscal Guidelines, Section 7.

Equipment Disposal

- Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report (STD 152).
- Management of all equipment purchased with State funds shall be coordinated through the Regional Administrative Consultant.

Tagging and Disposal of Equipment Summary

- Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602.
- In response to the DHCS 1203 received from the county/city, the Regional Administrative Consultant forwards State tag(s) to the county/city with an equipment identification tag transmittal letter.
- State-purchased equipment used in performance of Children's Medical Program obligations must be disposed of according to Department of Health Care Services procedures.

- The county/city representative submits a written request to the Regional Administrative Consultant to dispose of equipment, or the Consultant may notify the county/city in writing that certain equipment is scheduled for disposition.
- The Regional Administrative Consultant notifies the Department of Health Care Services Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Property Survey Report (STD 152).
- The STD 152 will describe how the County/City will dispose of the equipment, or the State will provide some other correspondence to describe direction to take.