COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH CONTRACTOR CLAIMS CERTIFICATION FOR TITLE XIX SHORT-DOYLE MEDI-CAL and TITLE XXI MEDICAID CHILDREN'S HEALTH INSURANCE PROGRAM REIMBURSEMENTS

Contractor: _____

Legal Entity No.: _____

Claims for services/activities with dates of services: _____ through _____.

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of the mental health services in and for said claimant; that the amounts for which reimbursement will be claimed for Medi-Cal and Medicaid Children's Health Insurance Program (MCHIP) services to be rendered during the above indicated fiscal year and to be claimed to the County of Los Angeles Department of Mental Health will be in accordance with the terms and conditions of the Contract; and that to the best of my knowledge and belief, each claim will be in all respects true, correct, and in accordance with State and federal law and regulation. I agree and certify under penalty of perjury that all claims for services to be provided to county mental health clients will be provided to the clients by this Contractor. The services will be provided in accordance with the client's written treatment plan. I agree and certify under penalty of perjury that no services will be submitted for the Contractor nor any of its staff members who is restricted, excluded, and/or suspended from providing services under any health care program funded by the federal government, directly or indirectly, in whole or in part. This certification covers staff members who are directly included on the claim or any staff member whose time is included on the claim, but whose identifying Name and National Provider ID are not included if they were a co-practitioner in the service. This Contractor also certifies that all information submitted to the County Department of Mental Health will be accurate and complete. This Contractor and I understand that payment of these claims will be from County, State and federal funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or State laws. The Contractor agrees to keep for a minimum period of as specified in its Contract with County, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the County of Los Angeles Department of Mental Health, California Department of Health Care Services, the Medi-Cal Fraud Unit; California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The Contractor also agrees that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

FURTHER, I HEREBY CERTIFY under penalty of perjury to the following: an assessment of the beneficiary will be conducted in compliance with the requirements established in the County's Mental Health Plan (MHP) contract with the California Department of Health Care Services (State DHCS). The beneficiary will be determined to be eligible to receive Medi-Cal services at the time the services are provided to the beneficiary. The services to be included in the claims during the above indicated period will actually be provided to the beneficiary. Medical necessity will be established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services to be provided, for the timeframe in which the services will be provided. A client plan will be developed and maintained for the beneficiary that meets all client plan requirements established in the County's MHP contract with the State DHCS. For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services to be included in the claim during said period, all requirements for payment authorization for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health services will be met, and any reviews for such service or services will be conducted prior to the initial authorization and any re-authorization periods as established in the County's MHP contract with the State DHCS.

Date: _____ Signature: _____

Executed at _____ , California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts. I further certify that this claimant will provide from the eligible designated funds in the Financial Summary of the DMH Contract with County, the local share of payment for Short-Doyle/Medi-Cal and/or MCHIP covered services to be included in the claims to be submitted to County during the above referenced period in order to satisfy matching requirements for federal financial participation pursuant to the Title XIX and Title XXI of the Social Security Act.

Date: _____ Signature: _____

Executed at _____ , California