**ATTACHMENT 5**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
FINANCIAL SERVICES BUREAU-REIMBURSEMENT AND AUDIT SUPPORT DIVISION

**FY 2022-23 SOURCE(S) OF INFORMATION FOR**
**MH1901 SCHEDULE B, LAC102 FORMS**
**UNITS OF SERVICE**

LE Name: _____ LE Number: _____

Please provide the source(s):

| | 701UP | FinCliamlist | Other | If Other, Please Specify |
|---|---|---|---|---|
| (1) Total Units of Service | | | | |
| (2) Medi-Cal Units of Service: | | | | |
| (a) Regular FMAP Short/Doyle Medi-Cal SD/MC | | | | |
| SD/MC_**EPSDT** | | | | |
| (b) Enhanced FMAP Short/Doyle Medi-Cal Children (CHIP) | | | | |
| Children (CHIP)_**EPSDT** | | | | |
| Other - BCCTP, Pregnancy, and Refugee | | | | |
| (c) Affordable Care Act (ACA/MCE) | | | | |
| (d) Medi-Cal Access Program (MCAP) | | | | |
| (e) State Funded Beneficiaries | | | | |
| (3) Report Run Date | | | | |

By signing below, I understand that the LE Cost Report will be subject to the State Department of Health Care Services' (DHCS) Medi-Cal Reconciliation process and/or audit. It is the LE's responsibility to resolve any discrepancies between the units of service indicated in this LE's Cost Report and the county records of DHCS' final Medi-Cal approvals within 18 months of the fiscal year ending June 30, subject to contract funding limitations. Additionally, it is the LE's responsibility to work with County, as needed, in order to facilitate payment of additional M/C UOS in order to meet CPE requirements; otherwise, such services may not be funded.

_____ _____
Responsible Official Signature Date

_____ _____
Printed Name Phone Number

_____
Position Title