_____ (County Name)

PROVIDER CERTIFICATION

Mental Health Cost Report
Year-End Claim for Reimbursement
Fiscal Year 2018-19

I HEREBY CERTIFY *under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services and the Mental Health Services Act (MHSA) in and for said claimant; that I have not violated any of the provisions of Section 1090 et. seq. of the Government Code and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete. With respect to MHSA funding, I certify that the County is in compliance with California Code of Regulations, Title 9, Division 1, Chapter 14, Article 4, Section 3410, Non-Supplant and Article 5, Section 3500, Non-Supplant Certification and Reports; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5, Section 5891 of the Welfare and Institutions Code (W&I Code). I understand that any payment to me resulting from this report will be paid with state, federal, and local county funds and that any falsification or concealment of material fact may be prosecuted under federal, state, and/or local laws. I further certify that, to the best of my knowledge and belief, the information in this report is in all respects true, correct, and in accordance with the state, federal, and local law.*

DATE: _____ PRINTED NAME: _____

SIGNATURE: _____

TITLE: _____

EXECUTED AT _____, CALIFORNIA
