_____ (County Name)

_____ (Provider Name)

PROVIDER CERTIFICATION

Prevention and Treatment of Non-Drug Medi-Cal Cost Report
Year-End Claim for Reimbursement
Fiscal Year 2017-18

PART I: I HEREBY CERTIFY *under penalty of perjury that I am the official responsible for the administration of Department of Health Care Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1096 of the California Government Code; that the amount for which reimbursement is claimed herein is in accordance with Division 10.5, Part 2, Chapter 4 and Chapter 13 of the California Health and Safety Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law.*

DATE: _____ PRINTED NAME: _____

SIGNATURE: _____

TITLE: _____

EXECUTED AT _____, CALIFORNIA
