CLAIMS CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am an official responsible for the administration of Mental Health Services for: "Org Provider Name", hereinafter referred to as "Provider"; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this/these claim(s) is/are in all respects true and correct, and in accordance with the law. Provider agrees and shall certify under penalty of perjury that all claims for services provided to Fresno County mental health clients have been provided to the clients by Provider. The services were, to the best of my knowledge, provided in accordance with the client's written treatment plan. I shall also certify that all information submitted to Fresno County is accurate and complete. I understand that payment of these claims will be from Federal and/or State funds and any falsification or concealment of a material fact may be prosecuted under Federal and/or State Laws. Provider agrees to keep for a minimum period of seven (7) years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Provider agrees to furnish these records and any information regarding payments received for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives. Amounts claimed herein for the Healthy Families program are only for children between the ages of one (1) year old to their nineteenth (19) birthday who were assessed or treated for a serious emotional disturbance (SED). Provider also agrees that services were offered and provided without discrimination based on race, religion, color, national or ethnic origin, gender, age or physical or mental disability.

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the Mental Health Plan (MHP) contract with the California Department of Mental Health (DMH);the beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary; the services included in the claim(s) were actually provided to the beneficiary;. medical necessity was established for the beneficiary as defined under Title 9 California Code of Regulations, Division 1, Chapter 11, for the service or services provided for the timeframe in which the services were provided; a client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the DMH; for each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the DMH.

Attached claim(s) are for these month(s) of service _____

Total amount of attached claim(s): $_____Total Units: s:_____

Name (Print):

_____

Signature:_____ Date: _____

Title:_____

(Must be the CEO, CFO, Administrator or Clinical Director)

PROVIDER MUST COMPLETE THIS FORM AND ATTACH IT TO EACH CLAIM OR BATCH OF CLAIMS SUBMITTED FOR PAYMENT TO THE FRESNO COUNTY MENTAL HEALTH PLAN.