JEB BUSH
GOVERNOR

CHRISTA CALAMAS
SECRETARY

Permissible Expenditures Certification Form

for the Florida Low Income Pool

_____

(provider name)

Provider name and address (include county):

Prepared by:

Contact Phone:

Contact email:

Medicaid Provider Number

Reporting Period: From_____ To: _____

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF _____

(Provider Type)

I Hereby Certify That I Have Examined The Accompanying Data (Permissible Expenditures) For The Reporting Period Beginning _____ and Ending _____ And That To The Best Of My Knowledge And Belief It Is A True, Correct And Complete Statement Prepared From The Books And Records Of The _____ (provider name) In Accordance With Applicable Instructions, Except As Noted:

I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services and expenditures identified in this report were provided in compliance with such laws and regulations.

_____

Signature of Officer or Adminstrator

_____

Title

_____

Date