Quarterly Certification of Expenditures by County

Agency for Health Care Administration
Medicaid Services
Behavioral Health Unit
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308-5403

Attn.: Certification of Match for Substance Abuse Services

County Medicaid#:_____

I, as financial officer of the _____, am charged
(Name of County)

with the duties of supervising the administration of the provision of, and billing for, the substance abuse services provided under Title XIX (Medicaid) of the Social Security Act. I hereby certify that the county has expended public, non-federal funds as required to seek reimbursement for the federal share of medical claims billed to the state Medicaid agency for substance abuse services. I further certify that the services were provided to eligible Medicaid recipients during the quarter checked below.

Check the applicable box, and enter the 3-month period and year of the quarter for which this filing applies.

☐ 1st Quarter ☐ 3rd Quarter

☐ 2nd Quarter ☐ 4th Quarter

Beginning _____,20____ and ending_____,20 ____
(Month/Year Certified)

These expenditures, reported by provider, are as follows:

Provider of Service	Medicaid #	Dates of Services	Amount Paid for Medicaid Eligible

I also certify that the County's certified expenditures were incurred in accordance with provisions of Florida's policies for the services. These certified expenditures are separately identified and supported in our accounting system.

_____
Name (please print)

_____
Signature

_____
Title

_____
Date