State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Medi-Cal County Inmate Program
County Participation Form: Fiscal Year 2017-18

_____ County chooses the option selected below in
County Name

response to our interest in voluntarily participating in the Medi-Cal County Inmate Program (MCIP) from July 1, 2017 through June 30, 2018 for Fiscal Year 2017-18:

☐ **Voluntarily participating in MCIP-** By selecting this option, we are certifying our interest in voluntarily participating in the MCIP and intend on submitting a fully executed MCIP Agreement.

☐ **Not Interested in participating in MCIP**

I hereby certify, that the option selected above is the option that said county will abide by under penalty of perjury, to the best of my knowledge, is true and accurate based on the time of submission.

County Official: _____ Date: _____
Signature

County Official Title:_____

County Name: _____

Primary Contact:_____ Alternate:_____

Phone:_____ Phone:_____

Email:_____ Email:_____

Submit completed form to:
DEPARTMENT OF HEALTH CARE SERVICES
SAFETY NET FINANCING DIVISION/INMATE MEDI-CAL CLAIMING UNIT
P.O. BOX 997436, MS 4504
SACRAMENTO, CA 95899-7436
EMAIL: DHCSIMCU@dhcs.ca.gov