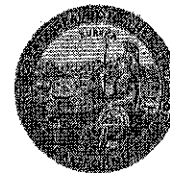




State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

**Medi-Cal County Inmate Program
County Participation Form: Fiscal Year 2016-17 Quarter 4**

San Mateo

County Name

County chooses the option selected below in

response to our interest in voluntarily participating in the Medi-Cal County Inmate Program (MCIP) for a three month period from April 1, 2017 through June 30, 2017 for Fiscal Year 2016-17:



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: _____

Signature

Date: 1/6/17

County Official Title: _____

Health System Chief

County Name: _____

San Mateo

Primary Contact: Carlos Morales

Alternate: Peter Shih

Phone: 650-363-7830

Phone: 650-573-5094

Email: cmorales@smcgov.org

Email: pshih@smcgov.org

Submit completed form to:

DEPARTMENT OF HEALTH CARE SERVICES

SAFETY NET FINANCING DIVISION/INMATE MEDI-CAL CLAIMING UNIT

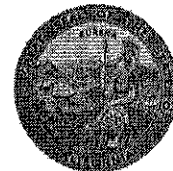
P.O. BOX 997436, MS 4504

SACRAMENTO, CA 95899-7436

EMAIL: DHCSIMCU@dhcs.ca.gov



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



EDMUND G. BROWN JR.
GOVERNOR

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

San Mateo

County Name

County chooses the option selected below in

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: _____

Signature

Date: 1/6/17

County Official Title: _____

Health System Chief

County Name: _____

San Mateo

Primary Contact: _____

Carlos Morales

Alternate: _____

Peter Shih

Phone: _____

650-363-7830

Phone: _____

650-573-5094

Email: _____

cmorales@smcgov.org

Email: _____

pshih@smcgov.org

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