State of California
Health and Human Services Agency

Department of Health Care Services

2015-2016 Certification of Compliance

Federal Deficit Reduction Act of 2005

I, _____, as the _____
(Name) *(Title)*

of _____, under provider number(s) _____,
(Name of Entity) *(NPI Number/s)*

and Taxpayer Identification Number (TIN) _____, located at
(TIN)

_____, do hereby certify that the above entity:
(Address/es)

1. Has read and understood the federal law (Title 42, United States Code § 1396a(a)(68)) and the state law (Welfare & Institutions Code § 14115.75), regarding employee education on false claims recovery;
2. Has been in compliance with the following requirements, as of January 1, 2016:
   a. Established written policies for **all** employees, including management, and applicable contractor(s) or agent(s) consistent with CMS FAQs 23-26 (March 30, 2007). These written policies provide detailed information about the following:
      i. Federal False Claims Act, including administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38.
      ii. State laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protection under such laws; and the role of these laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.
   b. These written policies include details about the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
   c. If applicable, the employee handbook includes specific discussion of the laws about false claims and statements, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
      ****NOTE: You are not required to create an employee handbook if one does not already exist.**
3. Will continue to be in compliance for each calendar year thereafter, if the five million dollar ($5,000,000) threshold is met.
4. Understands that failure to comply may result in suspension or termination of provider status.

_____ _____ _____
(Signature) *(Date)* *(Telephone)*

Sworn to before me this _____ day of _____, 20___. _____
(Notary Public)

Return to:
Department of Health Care Services, Provider Enrollment Division
P.O. Box 997412, MS 4704, Sacramento, CA 95819-7412