

OFFICE OF THE STATE CONTROLLER
STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2012-05
HEALTH FEE ELIMINATION

NOVEMBER 15, 2010

REVISED JULY 1, 2015

In accordance with Government Code (GC) sections 17560 and 17561, eligible claimants may submit claims to the State Controller's Office (SCO) for reimbursement of costs incurred for state-mandated cost programs. This document contains claiming instructions and forms that eligible claimants must use for filing claims for the Health Fee Elimination (HFE) program. The SCO issues these claiming instructions subsequent to the Commission on State Mandates (CSM) adopting the program's Parameters and Guidelines (Ps & Gs). The Ps & Gs are included as an integral part of the claiming instructions.

Chapter 1118, Statutes of 1987 amended Education Code section 72246 to require any community college district that provided health services in the 1986-87 fiscal year to maintain health services at that level in the 1986-87 fiscal year and each fiscal year thereafter. Chapter 8, Statutes of 1993, has revised the numbering of sections 72246 to 76355.

On April 27, 1989, the CSM adopted a Statement of Decision finding that the test claim legislation imposes a reimbursable state-mandated program on community college districts within the meaning of article XIII B, section 6 of the California Constitution and GC section 17514.

On January 29, 2010, the CSM approved the amendments to the Ps & Gs to clarify the source documentation requirements and record retention language, as requested by the SCO.

Exception

There will be no reimbursement for any period in which the Legislature has suspended the operation of a mandate pursuant to state law.

Eligible Claimants

Any community college district, as defined in Government Code section 17519, that incurs increased costs as a result of this mandate is eligible to claim for reimbursement. Block grant recipients are not eligible to claim for reimbursement.

Reimbursement Claim Deadline

Claims for the **2014-15** fiscal year may be filed by **February 16, 2016**, without a late penalty. **Claims filed more than one year after the filing date will not be accepted.**

Penalty

- **Initial Claims**

When filed within one year of the initial filing deadline, claims are assessed a late penalty of 10% of the total amount of the initial claim without limitation pursuant to GC section 17561, subdivision (d)(3).

- **Annual Reimbursement Claim**

When filed within one year of the annual filing deadline, claims are assessed a late penalty of 10% of the claim amount, not to exceed \$10,000, pursuant to GC section 17568.

Minimum Claim Cost

GC section 17564, subdivision (a), provides that no claim may be filed pursuant to sections 17551 and 17561, unless such a claim exceeds one thousand dollars (**\$1,000**).

Reimbursement of Claims

To be eligible for mandated cost reimbursement for any fiscal year, only actual costs may be claimed. These costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, training packets, and declarations. Declarations must include a certification or declaration stating: "I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5.

Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise in compliance with local, state, and federal government requirements. However, these documents cannot be substituted for source documents.

Audit of Costs

All claims submitted to the SCO are subject to review to determine if costs are related to the mandate, are reasonable and not excessive, and if the claim was prepared in accordance with the SCO's claiming instructions and the Ps & Gs adopted by the CSM. If any adjustments are made to a claim, the claimant will be notified of the amount adjusted, and the reason for the adjustment.

On-site audits will be conducted by the SCO as deemed necessary. Pursuant to GC section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a claimant is subject to audit by the SCO no later than three years after the date the actual reimbursement claim was filed or last amended, whichever is later. However, if no funds were appropriated or no payment was

made to a claimant for the program for the fiscal year for which the claim was filed, the time for the SCO to initiate an audit will commence to run from the date of initial payment of the claim.

All documents used to support the reimbursable activities must be retained during the period subject to audit. If an audit has been initiated by the SCO during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings. Supporting documents must be made available to the SCO on request.

Record Retention

All documentation to support actual costs claimed must be retained for a period of three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated or no payment was made at the time the claim was filed, the time for the Controller to initiate an audit will be from the date of initial payment of the claim. Therefore, all documentation to support actual costs claimed must be retained for the same period, and must be made available to the SCO on request.

Claim Submission

Submit a signed original Form FAM-27 and one copy with required documents. **Please sign the Form FAM-27 in blue ink and attach the copy to the top of the claim package.**

Mandated costs claiming instructions and forms are available online at the SCO's website: **www.sco.ca.gov/ard_mancost.html**.

Use the following mailing addresses:

If delivered by
U.S. Postal Service:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

If delivered by
other delivery services:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 700
Sacramento, CA 95816

For more information, contact the Local Reimbursements Section by email at LRSDAR@sco.ca.gov, by telephone at (916) 324-5729, or by writing to the address above.

Adopted: 8/27/87
Amended: 5/25/89
Amended: 1/29/10

AMENDMENT TO PARAMETERS AND GUIDELINES

Statutes 1984, 2nd E.S., Chapter 1
Statutes 1987, Chapter 1118

Health Fee Elimination
05-PGA-69 (CSM-4206)

This amendment is effective beginning with the claims filed for the
July 1, 2005 through June 30, 2006 period of reimbursement

I. SUMMARY OF MANDATE

Chapter 1, Statutes of 1984, 2nd E.S. repealed Education Code Section 72246 which had authorized community college districts to charge a health fee for the purpose of providing health supervisions and services, direct and indirect medical and hospitalization services, and operation of student health centers. This statute also required that health services for which a community college district charged a fee during the 1983-84 fiscal year had to be maintained at that level in the 1984-85 fiscal year and every year thereafter. The provisions of this statute would automatically repeal on December 31, 1987, which would reinstate the Community colleges districts' authority to charge a health fee as specified.

Chapter 1118, Statutes of 1987, amended Education Code section 7246 to require any community college district that provided health services in 1986-87 to maintain health services at the level provided during the 1986-87 fiscal year in 1987-88 and each fiscal year thereafter.

II. COMMISSION ON STATE MANDATES DECISION

At its hearing on November 20, 1986, the Commission on State Mandates determined that Chapter 1, Statutes of 1984, 2nd E.S. imposed a "new program" upon community college districts by requiring any community college district which provided health services for which it was authorized to charge a fee pursuant to former section 72246 in the 1983-84 fiscal year to maintain health services at the level provided during the 1983-84 fiscal year in the 1984-85 fiscal year and each fiscal year thereafter. This maintenance of effort requirement applies to all community college districts which levied a health services fee in the 1983-84 fiscal year, regardless of the extent to which the health fees collected offset the actual costs of providing health services at the 1983-84 fiscal year level.

At its hearing of April 27, 1989, the Commission determined that Chapter 1118, Statutes of 1987, amended this maintenance of effort requirement to apply to all community college districts which provided health services in fiscal year 1986-87 and required then to maintain that level in fiscal year 1987-88 and each fiscal year thereafter.

III. ELIGIBLE CLAIMANTS

Community college districts which provided health services in 1986-87 fiscal year and continue to provide the same services as a result of this mandate are eligible to claim reimbursement of those costs.

IV. PERIOD OF REIMBURSEMENT

This amendment is effective beginning with the claims filed for the July 1, 2005 through June 30, 2006 period of reimbursement.

Chapter 1, Statutes of 1984, 2nd E.S., became effective July 1, 1984. Section 17557 of the Government Code states that a test claim must be submitted on or before November 30th following a given fiscal year to establish for that fiscal year. The test claim for this mandate was filed November 27, 1985; therefore, costs incurred on or after July 1, 1984, are reimbursable. Chapter 1118, Statutes of 1987, became effective January 1, 1988. Title 2, California Code of Regulations, section 1185.3(a) states that a parameters and guidelines amendment filed before the deadline for initial claims as specified in the Claiming Instructions shall apply to all years eligible for reimbursement as defined in the original parameters and guidelines; therefore, costs incurred on or after January 1, 1988, for Chapter 1118, Statutes of 1987 are reimbursable.

Actual cost for one fiscal year should be included in each claim. Estimated costs for the subsequent year may be included on the same claim if applicable. Pursuant to section 17561 (d)(3) of the Government Code, all claims for reimbursement of costs shall be submitted within 120 days of notification by the state controller of the enactment on the claims bill.

If the total costs for a given fiscal year do not exceed \$200, no reimbursement shall be allowed, except as otherwise allowed by Government Code Section 17564.

V. REIMBURSABLE COSTS

To be eligible for mandated cost reimbursement for any fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, training packets, and declarations. Declarations must include a certification or declaration stating, "I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct based upon personal knowledge." Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Increased cost is limited to the cost of an activity that the claimant

is required to incur as a result of the mandate. In addition, the claimant must maintain documentation for the fiscal year 1986-87 program to substantiate a maintenance of effort.

A. Scope of Mandate

Eligible community college districts shall be reimbursed for the costs of providing a health services program. Only services provided in 1986-87 fiscal year may be claimed.

B. Reimbursable Activities

For each eligible claimant, the following cost items are reimbursable to the extent they were provided by the community college district in fiscal year 1986-87:

ACCIDENT REPORTS

APPOINTMENTS

- College Physician – Surgeon
 - Dermatology, Family Practice, Internal Medicine
- Outside Physician
- Dental Services
- Outside Labs (X-ray, etc.)
- Psychologist, full services
- Cancel/Change Appointments
- R.N.
- Check Appointments

ASSESSMENT, INTERVENTION, COUNSELING

- Birth control
- Lab Reports
- Nutrition
- Test Results (office)
- VD
- Other Medical Problems
- CD
- URI
- ENT
- Eye/Vision
- Derm./Allergy
- GYN/Pregnancy Services
- Neuro
- Ortho
- GU
- Dental
- GI
- Stress Counseling
- Crisis Intervention
- Child Abuse Reporting and Counseling
- Substance Abuse Identification and Counseling
- Aids
- Eating Disorders

Weight Control
Personal Hygiene
Burnout

EXAMINATIONS (Minor Illnesses)

Recheck Minor Injury

HEALTH TALKS OR FAIRS – INFORMATION

Sexually Transmitted Disease
Drugs
Aids
Child Abuse
Birth Control/Family Planning
Stop Smoking
Etc.
Library = videos and cassettes

FIRST AID (Major Emergencies)

FIRST AID (Minor Emergencies)

FIRST AID KITS (Filled)

IMMUNIZATIONS

Diphtheria/Tetanus
Measles/Rubella
Influenza
Information

INSURANCE

On Campus Accident
Voluntary
Insurance Inquiry/Claim Administration

LABORATORY TESTS DONE

Inquiry/ Interpretation
Pap Smears

PHYSICALS

Employees
Students
Athletes

MEDICATIONS (dispensed OTC for misc. illnesses)

Antacids
Antidiarrhial
Antihistamines
Aspirin, Tylenol, etc.
Skin rash preparations

Misc.
Eye drops
Ear drops
Toothache – Oil cloves
Stingkill
Midol – Menstrual Cramps

PARKING CARDS/ELEVATOR KEYS

Tokens
Return card/key
Parking inquiry
Elevator passes Temporary handicapped parking permits

REFERRALS TO OUTSIDE AGENCIES

Private Medical Doctor
Health Department
Clinic
Dental
Counseling Centers
Crisis Centers
Transitional Living Facilities (Battered/Homeless Women)
Family Planning Facilities
Other Health Agencies

TESTS

Blood Pressure
Hearing
Tuberculosis
 Reading
 Information
Vision
Glucometer
Urinalysis
Hemoglobin
E.K.G.
Strep A testing
P.G. testing
Monospot
Hemacult
Misc.

MISCELLANEOUS

Absence Excuses/PE waiver
Allergy Injections
Band-aids
Booklets/Pamphlets
Dressing Change

Rest
Suture Removal
Temperature
Weigh
Misc.
Information
Report/Form
Wart Removal

COMMITTEES

Safety
Environmental
Disaster Planning

SAFETY DATA SHEETS

Central file

X-RAY SERVICES

COMMUNICABLE DISEASE CONTROL

BODY FAT MEASUREMENTS

MINOR SURGERIES

SELF-ESTEEM GROUPS

MENTAL HEALTH CRISIS

AA GROUP

ADULT CHILDREN OF ALCOHOLICS GROUP

WORKSHOPS

Test Anxiety
Stress Management
Communication Skills
Weight Loss
Assertiveness Skills

VI. CLAIM PREPARATION

Each claim for reimbursement pursuant to this mandate must be timely filed and set forth a list of each item for which reimbursement is claimed under this mandate.

A. Description of Activity

1. Show the total number of full-time students enrolled per semester/quarter
2. Show the total number of full-time students enrolled in the summer program.
3. Show the total number of part-time students enrolled per semester/quarter.
4. Show the total number of part-time students enrolled in the summer program.

B. Actual Costs of Claim Year for Providing 1986-87 Fiscal Year Program Level of Service.

Claimed costs should be supported by the following information:

1. Employees Salaries and Benefits

Identify the employee, (s), show the classification of the employee, (s), involved, describe the mandated functions performed and specify the actual number of hours devoted to each function, the productive hourly rate, and the related benefits. The average number of hours devoted to each function may be claimed if supported by a documented time study.

2. Services and Supplies

Only expenditures which can be identified as a direct cost of the mandate can be claimed. List cost of materials which have been consumed or expended specifically for the purpose of this mandate.

3. Allowable Overhead Cost

Indirect costs may be claimed in the manner described by the State Controller in his claiming instructions.

VII. RECORD RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter¹ is subject to the initiation of an audit by the Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. In any case, an audit shall be completed not later than two years after the date that the audit is commenced. All documents used to support the reimbursable activities, as described in Section V, must be retained during the period subject to audit. If the Controller has initiated an audit during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VIII. OFFSET SAVINGS AND OTHER REIMBURSEMENTS

Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed. In addition, reimbursement for this mandate received from any source, e.g., federal, state, etc., shall be identified and deducted from this claim. This shall include the amount of \$7.50 per full-time student per semester, \$5.00 per full-time student for summer school. Or \$5.00 per full-time student per quarter, as authorized by education code section 72246(a). This shall also include payments (fees) received from

¹ This refers to Title 2, division 4, part 7, chapter 4 of the Government Code.

individuals other than students who are not covered by Education Code 72246 for health services.

IX. REQUIRED CERTIFICATION

The following certification must accompany the claim:

I DO HEREBY CERTIFY under penalty of perjury:

THAT the foregoing is true and correct:

THAT Section 1090 to 1096, inclusive, of the Government Code and other applicable provisions of the law have been complied with:

And

THAT I am the person authorized by the local agency to file claims for funds with the State of California.

HEALTH FEE ELIMINATION CLAIM FOR PAYMENT	For State Controller Use Only	PROGRAM 234
	(19) Program Number 00234	
	(20) Date Filed	
	(21) LRS Input	

(01) Claimant Identification Number			Reimbursement Claim Data	
(02) Claimant Name			(22) FORM 1, (04)(a)	
County of Location			(23) FORM 1, (05)(e)	
Street Address or P.O. Box		Suite	(24) FORM 1, (06)(e)	
City	State	Zip Code	(25) FORM 1, (07)(e)	
		Type of Claim	(26) FORM 1, (08)(e)	
	(03)	(09) Reimbursement <input type="checkbox"/>	(27) FORM 1, (09)(e)	
	(04)	(10) Combined <input checked="" type="checkbox"/>	(28) FORM 1, (10)(e)	
	(05)	(11) Amended <input type="checkbox"/>	(29) FORM 1, (11)(e)	
Fiscal Year of Cost	(06)	(12)	(30) FORM 1, (16)	
Total Claimed Amount	(07)	(13)	(31) FORM 1, (17)	
Less: 10% Late Penalty (refer to attached Instructions)		(14)	(32) FORM 1, (18)	
Less: Prior Claim Payment Received		(15)	(33) FORM 1, (19)	
Net Claimed Amount		(16)	(34) FORM 1, (20)	
Due from State	(08)	(17)	(35) FORM 2A, (4)(d)	
Due to State		(18)	(36) FORM 2B, (4)(d)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code Sections 17560 and 17561, I certify that I am the officer authorized by the community college district to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Article 4, Chapter 1 of Division 4 of Title 1 of the Government Code.

I further certify that there was no application other than from the claimant, nor any grant(s) or payment(s) received, for reimbursement of costs claimed herein; and claimed costs are for a new program or increased level of services of an existing program. All offsetting revenues and reimbursements set forth in the parameters and guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amount of this reimbursement is hereby claimed from the State for payment of actual costs set forth on the attached statements.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer

Date Signed _____

Telephone Number _____

Email Address _____

Type or Print Name and Title of Authorized Signatory

(38) Name of Agency Contact Person for Claim _____ Telephone Number _____

Email Address _____

Name of Consulting Firm / Claim Preparer _____ Telephone Number _____

Email Address _____

PROGRAM
234

**HEALTH FEE ELIMINATION
CLAIM FOR PAYMENT
INSTRUCTIONS**

**FORM
FAM-27**

- (01) Enter the claimant identification number assigned by the State Controller's Office.
- (02) Enter claimant official name, county of location, street or postal office box address, city, State, and zip code.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) Not applicable.
- (11) If filing an amended reimbursement claim, enter an "X" in the box on line (11) Amended.
- (12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate Form FAM-27 for each fiscal year.
- (13) Enter the amount of the reimbursement claim as shown on Form 1, line (21). The total claimed amount must exceed \$1,000; minimum claim must be \$1,001.
- (14) Initial claims must be filed as specified in the claiming instructions. Annual reimbursement claims must be filed by **February 15**, or otherwise specified in the claiming instructions, following the fiscal year in which costs were incurred or the claims must be reduced by a late penalty. Enter zero if the claim was filed on time. Otherwise, enter the penalty amount as a result of the calculation formula as follows:
- Late Initial Claims: Form FAM-27 line (13) multiplied by 10%, without limitation; or
 - Late Annual Reimbursement Claims: Form FAM-27, line (13) multiplied by 10%, late penalty not to exceed \$10,000.
- (15) Enter the amount of payment, if any, received for the claim. If no payment was received, enter zero.
- (16) Enter the net claimed amount by subtracting the sum of lines (14) and (15) from line (13).
- (17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.
- (18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.
- (19) to (21) Leave blank.
- (22) to (36) Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., Form 1, (04)(a), means the information is located on Form 1, line (04), column (a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 7.548% should be shown as 8. **Completion of this data block will expedite the process.**
- (37) Read the statement of Certification of Claim. The claim must be dated, signed by the agency's authorized officer, and must type or print name, title, date signed, telephone number, and email address. **Claims cannot be paid unless accompanied by an original signed certification. (Please sign the Form FAM-27 in blue ink and attach the copy to the top of the claim package.)**
- (38) Enter the name, telephone number, and email address of the agency contact person for the claim. If the claim was prepared by a consultant, type or print the name of the consulting firm, the claim preparer, telephone number, and email address.

SUBMIT A SIGNED ORIGINAL FORM FAM-27 AND ONE COPY WITH ALL OTHER FORMS TO:

Address, if delivered by U.S. Postal Service:

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

Address, if delivered by other delivery service:

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 700
Sacramento, CA 95816**

PROGRAM 234	HEALTH FEE ELIMINATION CLAIM SUMMARY	FORM 1
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(01) Claimant	(02) Fiscal Year 20__/20__
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(03) Indicate the level at which health services were provided during the fiscal year (FY) of reimbursement in comparison to the FY 1986-87. If the "Less" box is checked, **STOP**, do not complete the form. **No reimbursement is allowed.**

LESS **SAME** **MORE**

(04) Indirect Cost Rate [FAM-29C] [Apply Indirect Cost Rate to Salaries and Benefits]	(a)	(b)	(c)	(d)	(e)
	%	Salaries & Benefits	Materials & Supplies	Indirect Costs	Total
(05) Cost of employee and athlete physicals for the fiscal year of claim					
(06) Less: Cost of employee and athlete physicals that exceed services provided in FY 1986-87					
(07) Less: offsetting revenues and reimbursements attributable to employee and athlete physicals provided in both FY 1986-87 and the fiscal year of claim					
(08) Current year costs of employee and athlete physicals provided in FY 1986-87 [Line (05) - Line (06) - Line (07)]; If less than \$0, enter \$0.					
(09) Cost of health services for the fiscal year of claim, excluding costs reported on Line (05)					
(10) Less: Costs to provide current year services that exceed services of FY 1986-87 (exclude athlete and employee physicals)					
(11) Current year cost of services provided in FY 1986-87, excluding employee and athlete physicals [Line (09) - Line (10)]					

School Term	(a)	(b)	(c)	(d)	(e)	(f)
	Number of Students Enrolled [see instructions]	Students Exempt per EC 76355(c)(1)	Students Exempt per EC 76355(c)(2) [see instructions]	Number of Students Subject to Health Fee [(a) - (b) - (c)]	Authorized Health Fee Rate Per EC 76355	Authorized Student Health Fees [(d) x (e)]
(12) Summer Semester						
(13) Fall Semester or First Quarter						
(14) Winter Intersession or Second Quarter						
(15) Spring Semester or Third Quarter						

(16) Authorized Health Service Fees [Line (12f) + Line (13f) + Line (14f) + Line (15f)]	
(17) Subtotal [Line (11) - Line (16)]; If less than \$0, enter \$0	
(18) Less: Offsetting revenues and reimbursements attributable to health services excluding employee and athlete physicals	
(19) Subtotal [Line (17) - Line (18)]; If less than \$0, enter \$0	
(20) Current year costs of employee and athlete physicals provided in FY 1986-87 [Line (08)]	
(21) Total Claimed Amount [Line (19) + Line (20)]	

PROGRAM 234	HEALTH FEE ELIMINATION CLAIM SUMMARY INSTRUCTIONS	FORM 1
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- (01) Enter the name of the claimant. Only a community college district may file a claim with the State Controller's Office (SCO) on behalf of its colleges.
- (02) Enter the fiscal year of costs.
- (03) Use Form 3 to compare the level of services provided during the fiscal year entered on line (02) to the services provided during FY 1986-87. Indicate the result by checking the appropriate box. If the "Less" box is checked, STOP and do not file a claim with SCO. No reimbursement is forthcoming.
- (04) Only the indirect cost rate from the Form FAM-29C is allowed. Submit the Form FAM-29C with the claim.
- (05) Enter the actual costs of employee and/or athlete physicals provided during the fiscal year of the claim. Enter the costs for salaries and benefits, and materials and supplies, from Form 2A, lines (04) columns (d), and (e).
- (06) Enter the current year costs of employee and/or athlete physicals provided that exceed services provided by the district in fiscal year 1986-1987.
- (07) Enter the total of claim year offsetting revenues and other reimbursements that are attributable to employee and/or athlete physical services that the district provided in both fiscal year 1986-87 and fiscal year of claim.
- (08) From line (05), subtract both line (06) and line (07). If the result is less than \$0, enter \$0.
- (09) Enter the actual costs for salaries and benefits, and services and supplies, excluding costs attributable to employee and athlete physicals provided. Enter the amounts from Form 2B, lines (04) columns (d) and (e). **If the sum of line (05) and line (09) differ from total costs that the district reported on its Community College Annual Financial and Budget Report (CCFS-311), EDP Code 6440, columns (2) and (3), provide a detailed schedule that reconciles the difference.**
- (10) Enter the costs of current year services provided (excluding employee and athlete physicals) that exceed services provided by the district in fiscal year 1986-87. Submit a detailed schedule that identifies each excess service and associated costs.
- (11) Subtract line (10) from line (09).
- (12) - (15) Complete columns (a) through (f). Enrollment data should agree with data reported to the California Community Colleges Chancellor's Office (CCCCO). For column (a), the number of students enrolled should be based on CCCCCO MIS Data Element STD7, Codes A through G, after excluding duplicate entries for the same student (See Attachment 1). For column (c), the number of apprenticeship program enrollees should be based on CCCCCO MIS Data Element STD7, Codes A through G, and MIS Data Element SB23, Code 1, after excluding duplicate entries for the same student (See Attachment 2). Effective with the Summer 2011 session, the authorized health service fees are \$19 per semester, and \$16 for summer sessions, quarters, or inter-sessions of at least four weeks.
- (16) Enter the sum of line (12) column (f) through line (15) column (f).
- (17) Subtract line (16) from line (11) column (e). If the result is less than \$0, enter \$0.
- (18) Identify any revenue received for this mandate from any state or federal source and other reimbursements received from any source (i.e., federal, other state programs, etc.). Exclude revenue and other reimbursements attributable to employee and/or athlete physicals. Submit a detailed schedule of offsetting revenue and other reimbursements with the claim.
- (19) From the subtotal on line (17), subtract the offsetting revenues and other reimbursements, line (18). If the result is less than \$0, enter \$0.
- (20) Enter the amount from line (08).
- (21) Total claimed amount. Enter the sum of line (19) and line (20). Carry the amount from line (21) forward to Form FAM-27, line (13) of the reimbursement claim.

PROGRAM 234	HEALTH FEE ELIMINATION ACTIVITY COST DETAIL EMPLOYEE AND ATHLETE PHYSICALS	FORM 2A
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(01) Community College District	(02)	Fiscal Year 20___/20___
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(03) Description of Expenses – Employee and Athlete Physicals			Object Accounts	
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies
(04) Total <input type="checkbox"/> Subtotal <input type="checkbox"/> Page: ___ of ___				

PROGRAM 234	HEALTH FEE ELIMINATION ACTIVITY COST DETAIL – EMPLOYEE AND ATHLETE PHYSICALS INSTRUCTIONS	FORM 2A
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- (01) Enter the name of the community college district.
- (02) Enter the fiscal year in which costs were incurred.
- (03) Description of Expenses – Employee and Athlete Physicals. Include costs attributable to employee and athlete physicals only.

The following table identifies the type of information required to support reimbursable costs. Enter the employee names, job classification, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, and materials and supplies used. **The descriptions required in line (3) column (a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than **three years after the date the claim was filed or last amended**, whichever is later. If no funds were appropriated or no payment was made at the time the claim was filed, the time for the Controller to initiate an audit will be from the date of initial payment of the claim. For audit purposes, all supporting documents must be retained by the claimant while the claim is subject to audit and must be made available to the SCO on request. If the SCO has initiated an audit, the retention period is extended until the ultimate resolution of any audit findings.

Object/ Sub object Accounts	Columns					Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	
Salaries and Benefits	Employee Name and Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked		
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used	

- (04) Total line (03), columns (d), and (e), and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the activity costs, number each page. Enter totals from line (04), columns (d), and (e), to Form 1, line (05) columns (b), and (c). Carry the amount from line (04), column (d) to form FAM-27, line (35) for the reimbursement claim.

PROGRAM 234	HEALTH FEE ELIMINATION ACTIVITY COST DETAIL – ALL HEALTH SERVICES EXCLUDING EMPLOYEE AND ATHLETE PHYSICALS	FORM 2B
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(01) Community College District	(02) Fiscal Year 20__/20__
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(03) Description of Expenses – All Health Services Excluding Employee and Athlete Physicals	Object Accounts
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(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies

(04) Total <input style="width: 30px;" type="text"/> Subtotal <input style="width: 30px;" type="text"/> Page: ___ of ___	
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PROGRAM 234	HEALTH FEE ELIMINATION ACTIVITY COST DETAIL – ALL HEALTH SERVICES EXCLUDING EMPLOYEE AND ATHLETE PHYSICALS INSTRUCTIONS	FORM 2B
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- (01) Enter the name of the community college district.
- (02) Enter the fiscal year in which costs were incurred.
- (03) Description of Expenses – All Health Services Excluding Employee and Athlete Physicals. Include costs of all health services, excluding costs of employee and athlete physicals.

The following table identifies the type of information required to support reimbursable costs. Enter the employee names, job classification, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, and materials and supplies used. **The descriptions required in line (3) column (a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than **three years after the date the claim was filed or last amended**, whichever is later. If no funds were appropriated or no payment was made at the time the claim was filed, the time for the Controller to initiate an audit will be from the date of initial payment of the claim. For audit purposes, all supporting documents must be retained by the claimant while the claim is subject to audit and must be made available to the SCO on request. If the SCO has initiated an audit, the retention period is extended until the ultimate resolution of any audit findings.

Object/ Sub object Accounts	Columns					Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	
Salaries and Benefits	Employee Name and Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked		
	Activities Performed	Benefit Rate		Benefits = Benefit Rate x Salaries		
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used	

- (04) Total line (03), columns (d), and (e), and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the activity costs, number each page. Enter totals from line (04), columns (d), and (e), to Form 1, line (09), columns (b), and (c). Carry the amount from line (04), column (d) to form FAM-27, line (36) for the reimbursement claim.

PROGRAM 234	HEALTH FEE ELIMINATION HEALTH SERVICES PROVIDED	FORM 3
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(01) Claimant:	(02) Fiscal Year 20__/20__	
(03) Place an "X" in columns (a) or (b), as applicable; to indicate which health services were provided by student health service fees for the indicated fiscal years. Provide a detailed explanation if column (a) differs from any previous claim submitted by the district.	(a) 1986-87	(b) FY of Claim
Accident Reports		
Appointments		
College Physician, Surgeon, Dermatology, Family Practice, Internal Medicine		
Outside Physician		
Dental Services		
Outside Labs, (X-ray, etc.)		
Psychologist, full services		
Cancel/Change Appointments		
Registered Nurse		
Check Appointments		
Assessment, Intervention and Counseling		
Birth Control		
Lab Reports		
Nutrition		
Test Results, Office		
Venereal Disease		
Communicable Disease		
Upper Respiratory Infection		
Ear, Nose, and Throat		
Eye/Vision		
Dermatology/Allergy		
Gynecology/Pregnancy Service		
Neurology		
Orthopedic		
Genito/Urinary		
Dental		
Gastro-Intestinal		
Stress Counseling		
Crisis Intervention		
Child Abuse Reporting and Counseling		
Substance Abuse Identification and Counseling		
Acquired Immune Deficiency Syndrome (AIDS)		

PROGRAM 234	HEALTH FEE ELIMINATION HEALTH SERVICES PROVIDED	FORM 3
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(01) Claimant:	(02)	Fiscal Year: 20___/20___
(03) Place an "X" in columns (a) or (b), as applicable, to indicate which health services were provided by student health service fees for the indicated fiscal years. Provide a detailed explanation if column (a) differs from any previous claim submitted by the district.	(a) 1986-87	(b) FY of Claim
Assessment, Intervention and Counseling (Continued)		
Eating Disorders		
Weight Control		
Personal Hygiene		
Burnout		
Other Medical Problems, list		
Examinations (Minor Illnesses)		
Recheck Minor Injury		
Health Talks or Fairs, Information		
Sexually Transmitted Disease (STD)		
Drugs		
Acquired Immune Deficiency Syndrome (AIDS)		
Child Abuse		
Birth Control/Family Planning		
Stop Smoking		
Library, Videos and Cassettes		
First Aid (Major Emergencies)		
First Aid (Minor Emergencies)		
First Aid Kits (Filled)		
Immunizations		
Diphtheria/Tetanus		
Measles/Rubella		
Influenza		
Information		
Insurance		
On Campus Accident		
Voluntary		
Insurance Inquiry/Claim Administration		
Laboratory Tests Done		
Inquiry/Interpretation		
Pap Smears		
Physical Examinations		

PROGRAM 234	HEALTH FEE ELIMINATION HEALTH SERVICES PROVIDED	FORM 3
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(01) Claimant:	(02) Fiscal Year: 20__/20__	
(03) Place an "X" in columns (a) or (b), as applicable, to indicate which health services were provided by student health service fees for the indicated fiscal years. Provide a detailed explanation if column (a) differs from any previous claim submitted by the district.	(a) 1986-87	(b) FY of Claim
Physical Examinations (Continued)		
Students		
Athletes		
Employees		
Medications (Dispensed over the counter for miscellaneous illnesses)		
Antacids		
Antidiarrheal		
Antihistamines		
Aspirin, Tylenol, etc.		
Skin Rash Preparations		
Eye Drops		
Ear Drops		
Toothache, Oil cloves		
Stingkill		
Midol, Menstrual Cramps		
Other, list		
Parking Cards/Elevator Keys		
Tokens		
Return Card/Key		
Parking Inquiry		
Elevator Passes		
Temporary Handicapped Parking Permits		
Referrals to Outside Agencies		
Private Medical Doctor		
Health Department		
Clinic		
Dental		
Counseling Centers		
Crisis Centers		
Transitional Living Facilities (Battered/Homeless Women)		
Family Planning Facilities		
Other Health Agencies		

PROGRAM 234	HEALTH FEE ELIMINATION HEALTH SERVICES PROVIDED	FORM 3
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(01) Claimant:	(02)	Fiscal Year 20___/20___	
(03) Place an "X" in columns (a) or (b), as applicable, to indicate which health services were provided by student health service fees for the indicated fiscal years. Provide a detailed explanation if column (a) differs from any previous claim submitted by the district.	(a) 1986-87	(b) FY of Claim	
	Tests		
	Blood Pressure		
	Hearing		
	Tuberculosis		
	Reading		
	Information		
	Vision		
	Glucometer		
	Urinalysis		
	Hemoglobin		
	EKG		
	Strep A Testing		
	PG Testing		
	Monospot		
	Hemacult		
	Others, list		
	Miscellaneous		
	Absence Excuses/PE Waiver		
	Allergy Injections		
	Band-aids		
	Booklets/Pamphlets		
	Dressing Change		
	Rest		
	Suture Removal		
	Temperature		
	Weight		
Information			
Report/Form			
Wart Removal			
Others, list			

PROGRAM 234	HEALTH FEE ELIMINATION HEALTH SERVICES PROVIDED	FORM 3	
(01) Claimant:		(02)	Fiscal Year: 20___/20___
(03) Place an "X" in columns (a) or (b), as applicable, to indicate which health services were provided by student health service fees for the indicated fiscal years. Provide a detailed explanation if column (a) differs from any previous claim submitted by the district.		(a) 1986-87	(b) FY of Claim
Committees			
Safety			
Environmental			
Disaster Planning			
Safety Data Sheets			
Central File			
X Ray Services			
Communicable Disease Control			
Body Fat Measurements			
Minor Surgeries			
Self Esteem Groups			
Mental Health Crisis			
Alcohol Anonymous Group			
Adult Children of Alcoholics Group			
Workshops			
Test Anxiety			
Stress Management			
Communication Skills			
Weight Loss			
Assertiveness Skills			

**California Community College District Enrollment
Academic Year 2014-15**

<u>District Name</u>	<u>Term Name</u>	<u>District Enrollment</u>
BARSTOW CCD	2014 Summer term	1441
BARSTOW CCD	2014 Fall term	1974
BARSTOW CCD	2015 Spring term	1875
GAVILAN CCD	2014 Summer term	2373
GAVILAN CCD	2014 Fall term	6439
GAVILAN CCD	2015 Spring term	7004
VICTOR VALLEY CCD	2014 Summer term	4905
VICTOR VALLEY CCD	2014 Fall term	12038
VICTOR VALLEY CCD	2015 Winter term	3424
VICTOR VALLEY CCD	2015 Spring term	11662
EL CAMINO (INCLUDE COMPTOM) CCD	2014 Summer term	14737
EL CAMINO (INCLUDE COMPTOM) CCD	2014 Fall term	30563
EL CAMINO (INCLUDE COMPTOM) CCD	2015 Spring term	28191

Source: Tonia Lu, MIS Specialist
California Community Colleges Chancellor's Office
11-Dec-15

Enrollment Criteria:
CCCCO MIS data element STD7, Codes A through G
Duplicate students excluded based on student SSN