Office of the State Controller
State-Mandated Costs Claiming Instructions No. 2012-42
Medi-Cal Beneficiary Probate – Program No. 43
Revised October 1, 2025

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 Medi-Cal Beneficiary Probate program. SCO issues these claiming instructions subsequent to the Commission on State Mandates (CSM) adopting the program's Parameters and Guidelines (Ps & Gs). The amended Ps & Gs are an integral part of the claiming instructions and are located on the CSM's website.

On December 2, 1982, CSM (formerly the State Board of Control) adopted a Statement of Decision finding that the test claim legislation imposed a reimbursable state-mandated program on local agencies within the meaning of Article XIII B, section 6 of the California Constitution and GC section 17514.

On January 29, 2010, CSM approved the amendments to the Ps & Gs to clarify source documentation requirements and record retention language, as requested by 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 county, as defined in GC section 17515, that incurs increased costs as a result of this mandate is eligible to claim for reimbursement.

Reimbursement Claim Deadline

Pursuant to GC section 17560(a), annual reimbursement claims may be filed by **February 15** following the fiscal year in which costs were incurred. If the deadline falls on a weekend or holiday, claims are due the following business day. Claims filed after the deadline must be reduced by a late penalty. **Claims filed more than one year after the deadline will not be accepted.**

Penalty

- **Initial Reimbursement 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(d)(3).

- **Annual Reimbursement Claims**

  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(a) states 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 and 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(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.

Record Retention

All documentation to support actual costs claimed must be retained during the period subject to audit and made available to the SCO upon request. The period subject to audit is at a minimum, three years after the date that the actual reimbursement claim is filed or last amended, whichever is later, or, 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, three years after the date of initial payment of the claim. 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.

Claim Submission

Electronic submissions of the signed Form FAM-27, all other forms, and supporting documentation are accepted through an online file transfer protocol called the **Data Exchange Portal (DEP).** All information regarding **DEP** is available on the SCO's website.

For more information, contact the Local Reimbursements Section by email.

MEDI-CAL BENEFICIARY PROBATE CLAIM FOR PAYMENT FORM	For State Controller's Office Use Only (19) Program Number 00043 (20) Date Filed (21) LRS Input	**PROGRAM 043**

(01) Claimant Identification Number		Reimbursement Claim Data			
(02) Claimant Name		(22)	FORM 1, (05) (e)		
County of Location		(23)	FORM 1, (06)		
Street Address or P.O. Box and Suite		(24)	FORM 1, (07)		
City, State, and Zip Code		(25)			
(03)	Type of Claim	(26)			
(04)	(09) Reimbursement ☐	(27)			
(05)	(10) Combined ☐	(28)			
(06)	(11) Amended ☐	(29)			
(07)	(12) Fiscal Year of Cost	(30)			
(08)	(13) Total Claimed Amount	(31)			
(14) Less: 10% Late Penalty		(32)			
(15) Less: Prior Claim Payment Received		(33)			
(16) Net Claimed Amount		(34)			
(17) Due from State		(35)			
(18) Due to State		(36)			

(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 local agency 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 for 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	
Type or Print Name and Title of Authorized Signatory	Email Address	

(38) Name of Agency Contact Person for Claim	Telephone Number	
	Email Address	
Name of Consulting Firm/Claim Preparer	Telephone Number	
	Email Address	

PROGRAM 043	MEDI-CAL BENEFICIARY PROBATE 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 in 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 (08). The total claimed amount must exceed $1,000; minimum claim must be $1,001.

(14) Initial reimbursement claims must be filed as specified in the claiming instructions. Annual reimbursement claims must be filed by **February 15,** or as specified in the claiming instructions following the fiscal year in which costs were incurred. Claims filed after the specified date must be reduced by a late penalty. Enter zero if the claim was filed on time. Otherwise, enter the result from the following penalty calculation formula:

- Late Initial Reimbursement 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.

PROGRAM 043	MEDI-CAL BENEFICIARY PROBATE CLAIM FOR PAYMENT INSTRUCTIONS (CONTINUED)	FORM FAM-27

(22) to (24) Bring forward the cost information as specified in the left-hand column of lines (22) through (24) for the reimbursement claim, e.g., Form 1, (05)(e), means the information is located on Form 1, line (05), column (e). 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. The indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. Completion of this data block will expedite the process.

(25) to (36) Leave blank.

(37) Read the statement of Certification of Claim. The claim must be signed and dated by the agency's authorized officer, and include their typed or printed name, title, 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 or electronic signature. If submitting by U.S. Postal Service or by other delivery service, attach a copy of the FAM-27 to the top of the claim.

(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, claim preparer, telephone number, and email address.

(39) Electronic submissions of the signed Form FAM-27, all other forms, and supporting documentation are accepted through an online file transfer protocol called the Data Exchange Portal (DEP). All information regarding DEP is available on the SCO's website.

For more information, contact the Local Reimbursements Section by email.

PROGRAM 043	MEDI-CAL BENEFICIARY PROBATE CLAIM SUMMARY	FORM 1

(01) Claimant	(02) Fiscal Year 20___/20___
(03) Department	

(04) Computation of Claimable Increased Costs

(a) Case Number or Name of Decedents	(b) Cost of Providing the Required Information	(c) Cost of All County Services Provided to the Estate	(d) Reimbursement Received by County from the Estate	(e) Claimable Increased Costs Col. (b) minus [{Col. (b) divide Col. (c)} times Col. (d)]
(05) Claimable Increased Costs Total ☐ Subtotal ☐ Page: ____of____				

Cost Reduction

(06) Less: Offsetting Revenues	
(07) Less: Other Reimbursements	
(08) Total Claimed Amount [Line (05) minus {line (06) plus line (07)}]	

PROGRAM 043	MEDI-CAL BENEFICIARY PROBATE CLAIM SUMMARY INSTRUCTIONS	FORM 1

(01) Enter the name of the claimant.

(02) Enter the fiscal year of claim.

(03) If more than one department has incurred costs for this mandate, give the name of each department. A separate Form 1 must be completed for each department.

(04) Computation of Claimable Increased Costs. Enter information as follows:

Column (a), the case number or name of the decedents.

Column (b), the county's customary charge per case for providing the required information to the Director of Health Services. **(Attach a worksheet detailing the costs stated in column (b))**.

Note: Compensation for indirect costs is eligible for reimbursement and may be included within the calculation of the amount stated in column (b). Claimants have the option of using the flat rate in accordance with the Office of Management and Budget Circular, Code of Federal Regulations, title 2, section 200.414(f) of direct labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) for the department if the indirect cost rate exceeds the flat rate. If more than one department is claiming indirect costs for the mandated program, each department must have its own ICRP. An officially approved ICRP must be submitted with the claim when the indirect cost rate exceeds the flat rate.

Column (c), the county's customary charge per case for providing all county services to the estate of the decedent. **(Attach a worksheet detailing the costs for those cases which are significantly different than the customary rate.)**

Column (d), the amount of reimbursement the county has received from the estate of the decedent for the cost of services rendered.

Column (e), the formula for computing the claimable increased costs:

Claimable Increased Costs equal Column (b) minus [{Column (b) divide Column (c)} times Column (d)]

(05) Enter the sum of the Claimable Increased Costs for all the deceased Medi-Cal recipients. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed, number each page.

(06) If applicable, enter any offsetting revenue received by the claimant for this mandate from any state or federal source. Submit a schedule detailing the revenue sources and amounts.

(07) If applicable, enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds that reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(08) From Increased Costs, line (05), subtract the sum of Offsetting Revenues, line (06), and Other Reimbursements, line (07). Enter the total on this line and carry the amount forward to Form FAM-27, line (13) of the Reimbursement Claim.