# BEHAVIORAL INTERVENTION PLANS CLAIM FOR PAYMENT

For State Controller Use Only

(19) Program Number 00348
(20) Date Filed
(21) LRS Input

**PROGRAM 348**

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box Suite

City State Zip Code

| | | | | |
|---|---|---|---|---|
| | | **Type of Claim** | **Reimbursement Claim Data** | |
| | (03) | (09) Reimbursement ☐ | (22) FORM 1, (03) (a) | |
| | (04) | (10) Combined ☐ | (23) FORM 1, (03) (b) | |
| | (05) | (11) Amended ☐ | (24) FORM 1, (03) (c) | |
| | | | (25) FORM 1, (03) (d) | |
| | | | (26) FORM 1, (04) (a) | |
| | | | (27) FORM 1, (04) (b) | |
| | | | (28) FORM 1, (04) (c) | |
| | | | (29) FORM 1, (06) | |
| **Fiscal Year of Cost** | (06) | (12) | (30) FORM 1, (07) | |
| **Total Claimed Amount** | (07) | (13) | (31) FORM 1, | |
| Less: **10% Late Penalty** (refer to attached Instructions) | | (14) | (32) FORM 1, | |
| Less: **Prior Claim Payment Received** | | (15) | (33) FORM 1, | |
| **Net Claimed Amount** | | (16) | (34) FORM 1, | |
| **Due from State** | (08) | (17) | (35) | |
| **Due to State** | | (18) | (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 school district, county office of education or special educational local plan area 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; claimed costs are for a new program or increased level of services of an existing program; and claimed amounts do not include charter school costs, either directly or through a third party. 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 _____

E-mail Address _____

Type or Print Name and Title of Authorized Signatory

(38) Name of Agency Contact Person for Claim

Telephone Number _____

E-mail Address _____

Name of Consulting Firm / Claim Preparer

Telephone Number _____

E-mail Address _____

| PROGRAM 348 | BEHAVIORAL INTERVENTION PLANS<br>CLAIM FOR PAYMENT<br>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) If filing a combined reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(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 (11). 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. 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 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, (03) (a), means the information is located on Form 1, line (03) (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 e-mail 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 of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the agency contact person for the claim. If claim was prepared by a consultant, type or print the name of the consulting firm, the claim preparer, telephone number, and e-mail 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 348 | BEHAVIORAL INTERVENTION PLANS CLAIM SUMMARY | FORM 1 |
|---|---|---|

| (01) Claimant | (02) Fiscal Year _____/_____ |
|---|---|

| | | |
|---|---|---|
| **(03) Claim Statistics** | | |
| (a) Total number of ADA from AB 602, P2 – Special Education Local Plan Areas (SELPAs) Only | | |
| (b) Total number of ADA from comparable source – SELPAs Only | | |
| (c) Total number of ADA from AB 602, P2 – School Districts (SDs) and County Office of Education (COEs) Only | | |
| (d) Total number of ADA from a comparable source – SDs and COEs Only | | |
| **(04) Reimbursable Activities (Reasonable Reimbursement Methodology: ADA x Unit Cost Rate)** | | |
| **One-Time Activities** | | |
| (a) SELPAs Only – P's & G's § IV. A. | {(03)(a) or (b) x Unit Cost Rate for the fiscal year of claim} | |
| **On-Going Activities** | | |
| (b) SELPAs Only – P's & G's § IV. B. | {(03)(a) or (b) x Unit Cost Rate for the fiscal year of claim} | |
| (c) SDs & COEs Only – P's & G's § IV. C. | {(03)(c) or (d) x Unit Cost Rate for the fiscal year of claim} | |
| (05) Total Cost | | |
| **Cost Reduction** | | |
| (06) Less: Offsetting Revenues (Attachment A) | | |
| (07) Less: Other Reimbursements | | |
| (08) Total Claimed Amount | [Line (05) – {line (06) + Line (07)}] | |

| PROGRAM 348 | BEHAVIORAL INTERVENTION PLANS<br>CLAIM SUMMARY<br>INSTRUCTIONS | FORM 1 |
|---|---|---|

(01) Enter the name of the claimant.

(02) Enter the fiscal year of costs.

(03) (a) Enter the number of ADA from AB 602, P2 – SELPAs only during the fiscal year of claim.

(b) Enter the number of ADA from a comparable source – SELPAs only during the fiscal year of claim.

(c) Enter the total Number of ADA from AB 602, P2 – SDs and COEs Only during the fiscal year of claim.

(d) Enter the total Number of ADA from a comparable source – SDs and COEs Only during the fiscal year of claim.

(04) (a)(b)(c) Multiply the applicable AB 602, P2 Average Daily Attendance (ADA) or a comparable source, lines (03)(a) through (d), with the Unit Cost Rate below for the fiscal year of claim.

| Fiscal Year | (a)<br>SELPAs Only –<br>One-Time Activities | (b)<br>SELPAs Only –<br>On-going Activities-Training | (c)<br>SDs AND COEs Only -<br>On-going Activities |
|---|---|---|---|
| 1993-94 | $ 0.21043 | $ 0.76111 | $ 6.06376 |
| 1994-95 | $ 0.21683 | $ 0.78428 | $ 6.24838 |
| 1995-96 | $ 0.22181 | $ 0.80229 | $ 6.39188 |
| 1996-97 | $ 0.22628 | $ 0.81844 | $ 6.52051 |
| 1997-98 | $ 0.22986 | $ 0.83140 | $ 6.62376 |
| 1998-99 | $ 0.23514 | $ 0.85051 | $ 6.77601 |
| 1999-00 | $ 0.24532 | $ 0.88730 | $ 7.06913 |
| 2000-01 | $ 0.25518 | $ 0.92299 | $ 7.35351 |
| 2001-02 | $ 0.25998 | $ 0.94035 | $ 7.49176 |
| 2002-03 | $ 0.26958 | $ 0.97505 | $ 7.76826 |
| 2003-04 | $ 0.27859 | $ 1.00767 | $ 8.02813 |
| 2004-05 | $ 0.29426 | $ 1.06434 | $ 8.47963 |
| 2005-06 | $ 0.31248 | $ 1.13024 | $ 9.00463 |
| 2006-07 | $ 0.32818 | $ 1.18702 | $ 9.45701 |
| 2007-08 | $ 0.34798 | $ 1.25863 | $ 10.02751 |
| 2008-09 | $ 0.35678 | $ 1.29048 | $ 10.28126 |
| 2009-10 | $ 0.35830 | $ 1.29597 | $ 10.32501 |
| 2010-11 | $ 0.36978 | $ 1.33748 | $ 10.65576 |
| 2011-12 | $ 0.38083 | $ 1.37746 | $ 10.97426 |

(05) Enter the total calculated costs using Reasonable Reimbursement Methodology: ADA x Unit Cost Rate, lines (04)(a) through (c).

(06) If applicable, enter any revenue received by the claimant for this mandate from any state or federal source. Complete Attachment A detailing the reimbursement sources. Refer to the P's and G's. Section VII, Offsetting Revenues and Other Reimbursements for more information.

(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, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(08) Subtract the sum of Offsetting Revenues, line (06), and Other Reimbursements, line (07), from Total Cost, line (05) and carry the amount forward to Form FAM-27, line (13) for the Reimbursement Claim.

| PROGRAM 348 | BEHAVIORAL INTERVENTION PLANS<br>DETAILED SUMMARY OF OFFSETTING REVENUES | ATTACHMENT A |
|---|---|---|

| (01) Claimant | (02) Fiscal Year<br>_____/_____ |
|---|---|

| (03) FUNDING SOURCES (Refer to the P's & G's Section VII, Offsetting Revenues and Other Reimbursements) | |
|---|---|
| A. Federal Program | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| B. State Program | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| C. Other Source Funds | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| **(04) TOTAL OFFSETTING REVENUES** | |