EXHIBIT B: Quarterly Certification of State (Non-Federal) Matching Funds
YH21-0007 MEDICAID SCHOOL-BASED CLAIMING

Sample document for submitting a QUARTERLY CERTIFICATION OF STATE (NON-FEDERAL) MATCHING FUNDS
BY LOCAL EDUCATIONAL AGENCIES

Certification for the Year: __________ Quarter Ending:__________________

Based on the total quarterly expenditures of $__________ for qualified covered services and $ __________ for the TPA administrative fee; (________ Insert Name of the LEA ________) is required to certify the expenditure of at least $ __________ in total state/local matching funds for the same quarter by signing and returning this form to the AHCCCS contracted Third Party Administrator.

___________________________________________________________________________

As a condition of participation in the AHCCCS Medicaid Schools-Based Claiming Programming, I hereby certify that:

* The LEA expended the state / local matching funds (as noted above) in an amount sufficient to provide the non-federal share of the expenditures being claimed for federal financial participation.

* The state and/or local matching funds were not obligated to match other federal funds for any federal program and that these matching funds are not federal funds.

* The expenditures were incurred in accordance with provisions of AHCCCS policies for the services and that the state / local matching funds are separately identified and supported in the LEAs accounting system.

* I understand that payment of the claims subject to this certification is from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

<table>
<thead>
<tr>
<th>NAME OF LOCAL EDUCATIONAL AGENCY:</th>
<th>SIGNATURE OF AUTHORIZED REPRESENTATIVE:</th>
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<tbody>
<tr>
<td>STREET ADDRESS:</td>
<td>TYPED NAME:</td>
</tr>
<tr>
<td>CITY, STATE  ZIP</td>
<td>TITLE:</td>
</tr>
<tr>
<td>AHCCCS GROUP BILLER NUMBER:</td>
<td>DATE:</td>
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</tbody>
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