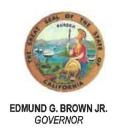


## State of California—Health and Human Services Agency Department of Health Care Services



## Medi-Cal County Inmate Program County Participation Form: SFY 2020 through SFY 2023

San Francisco	county Name	y chooses the option selected below in
response to ou	r interest in voluntarily par	ticipating in the Medi-Cal County Inmate Program 30, 2023, for State Fiscal Years 2020-23:
X	Voluntarily participating in MCIP- By selecting this option, we are certifying our interest in voluntarily participating in the MCIP and intend on submitting a fully executed Provider Participation Agreement and Administrative Agreement.	
	Not Interested in partic	ipating in MCIP
I hereby certify, that the option selected above is the option that said county will abide by under penalty of perjury, to the best of my knowledge, is true and accurate based on the time of submission.		
County Official:	Signature	Date: 3/3//20
County Official	Title: Director of Health	
County Name:	San Francisco	
Primary Contac	t: Grant Colfax	Alternate: Yvonne Uyeki
Phone:_	(415)554-2600	Phone:(628)206-6686
Email:	grant.colfax@sfdph.org	Email:yvonne.uyeki@sfdph.org
	Health Care Services ental Financing Division/Ir	nmate Medi-Cal Claiming Unit

Sacramento, CA 95899-7436 EMAIL: DHCSIMCU@dhcs.Ca.Gov