

Office of the State Controller  
State-Mandated Costs Claiming Instructions No. 2009-15  
Immunization Records – Program No. 32  
Revised September 1, 2020

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 state-mandated cost programs. This document contains claiming instructions and forms that eligible claimants must use for filing claims for the Immunization Records program. 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 an integral part of the claiming instructions and are located on CSM's website.

Chapter 415, Statutes of 1995 added Health and Safety Code sections 120335 through 120380, formerly 3380 through 3390, which provides uniform requirements for immunizations of students prior to entering private or public elementary, secondary school, or other specific institutions. In addition, the governing authority of the school or specified institution is required to maintain immunization records on each student and file a written report on the immunization status of new entrants to the school or institution with the State Department of Public Health at times and on forms prescribed by the Department.

On June 20, 1979, CSM determined that reimbursement of Chapter 1176, Statutes of 1977, and costs will be pursuant to the State Mandate Apportionment System (SMAS).

### **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 school district, as defined in GC section 17519, with the exception of community college districts, is eligible to claim reimbursement for increased cost incurred as a result of this mandate. Charter schools and block grant recipients are not eligible to claim for reimbursement.

### **Types of Claims**

#### **A. Entitlement Claims**

This program has been included in SMAS, a process in which a claimant receives an annual apportionment, reflective of the program's costs, without further filing of reimbursement claims. A claimant is eligible to be included in the process after having established a SMAS base-year entitlement for the program. SCO determines a base-year entitlement by averaging the claimant's actual costs for any three consecutive fiscal years. The actual costs are first adjusted according to any change in the implicit price deflator. With an established base-year, the claimant will receive annual payments adjusted by changes in the implicit price deflator. When the claimant has filed three consecutive fiscal years of costs, no further claims need to be filed. For programs included in SMAS after January 1, 1988, the annual payments are adjusted

by changes in the implicit price deflator and changes in the school's average daily attendance (ADA).

A claimant, who has not established a base-year entitlement, may file claims as described in the following instructions to complete three consecutive fiscal years of actual costs. If a claimant incurred three consecutive fiscal years of costs, and had not previously claimed those costs, the claimant may file an Entitlement Claim, FAM-43 for each of those fiscal years beginning with 1989-90 or any subsequent three consecutive fiscal years. An Entitlement Claim is for the sole purpose of establishing a base-year entitlement and not for claiming reimbursement.

Entitlement claims should be filed with SCO by February 15. After the claims are approved and a base-year entitlement amount is determined, the claimant will receive an apportionment of the current fiscal year.

## **B. Reimbursement Claims**

If an eligible claimant does not have three consecutive fiscal years of costs for Chapter 1176, Statutes of 1977, to qualify for inclusion in SMAS, the claimant may file a reimbursement claim.

A reimbursement claim is defined in GC section 17522 as any claimed filed with SCO by a school district for reimbursement of costs incurred for which an appropriation is made for the purpose of paying the claim.

### **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**). However, a county superintendent of schools may submit a combined claim on behalf of school districts within their county if the combined claim exceeds **\$1,000**, even if the individual school district's claim does not each exceed **\$1,000**. If the total costs for a given fiscal year do not exceed \$1,000, no reimbursement will be allowed except as otherwise allowed by GC section 17564. The county superintendent of schools will determine if the submission of the combined claim is economically feasible and be responsible for disbursing the funds to each school district. These combined claims may be filed only when the county superintendent of schools is the fiscal agent for the districts. A combined claim must show the individual claim costs for each eligible school district. All subsequent claims based upon the same mandate must be filed in the combined form only unless a school district provides a written notice of its intent to file a separate claim to the county superintendent of schools and to SCO at least 180 days prior to the deadline for filing the claim.

## **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 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 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 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 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 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 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 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 SCO 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 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.

Use the following mailing addresses:

If delivered by U.S. Postal Service:

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

If delivered by other delivery services:

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

For more information, contact the Local Reimbursements Section by [email](#), by telephone at (916) 324-5729, or by writing to the address above.

<b>IMMUNIZATION RECORDS CLAIM FOR PAYMENT FORM</b>		For State Controller Use Only (19) Program Number 00032 (20) Date Filed (21) LRS Input		<b>Program 032</b>
(01) Claimant Identification Number		Reimbursement Claim Data		
(02) Claimant Name		(22)	FORM 1, (03)	
County of Location		(23)	FORM 1, (04)(d)	
Street Address or P.O. Box and Suite		(24)	FORM 1, (05)	
City, State, and Zip Code		(25)	FORM 1, (07)	
(03)	Type of Claim	(26)	FORM 1, (08)	
(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 school district or county office of education 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	
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 <b>032</b>	<b>IMMUNIZATION RECORDS CLAIM FOR PAYMENT INSTRUCTIONS</b>	<b>FORM FAM-27</b>
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- (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 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 (11). 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 <b>032</b>	IMMUNIZATION RECORDS CLAIM FOR PAYMENT INSTRUCTIONS (CONTINUED)	<b>FORM FAM-27</b>
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- (22) to (26) Bring forward the cost information as specified in the left-hand column of lines (22) through (26) for the reimbursement claim, e.g., Form 1, (04)(d), means the information is located on Form 1, line (04), column (d). 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., 7.548% should be shown as 8. Completion of this data block will expedite the process.
- (27) 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 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, 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  
Local Government Programs and Services Division  
P.O. Box 942850  
Sacramento, CA 94250**

***Address, if delivered by other delivery service:***

**Office of the State Controller  
Attn: Local Reimbursements Section  
Local Government Programs and Services Division  
3301 C Street, Suite 700  
Sacramento, CA 95816**

<b>IMMUNIZATION RECORDS CLAIM FOR PAYMENT FORM</b>				For State Controller Use Only (19) Program Number 00032 (20) Date Filed (21) LRS Input	<b>Program 032</b>
(01) Claimant Identification Number				Entitlement Claim	
(02) Claimant Name				(22)	Form 1, (03)
County of Location				(23)	Form 1, (04) (d).
Street Address or P.O. Box and Suite				(24)	Form 1, (05)
City, State, and Zip Code				(25)	Form 1, (07)
<b>Base Year</b>	<b>Fiscal Years</b>	<b>FAM-27</b>	<b>Amount</b>	(26)	Form 1, (08)
First	(03)	(06) <input type="text"/>	(09)	(27)	
Second	(04)	(07) <input type="text"/>	(10)	(28)	
Third	(05)	(08) <input type="text"/>	(11)	(29)	
				(30)	
				(31)	
				(32)	
				(33)	
				(34)	
				(35)	
				(36)	

**(37) CERTIFICATION OF CLAIM**

In accordance with the provisions of Article 5 (commencing with Section 17615) of Chapter 4 of Part 7 of Division 4 of Title 2 of the Government Code, I certify that I am the officer authorized by the school district to file claims with the State of California for costs mandated by Chapter 1253, Statutes of 1975; and certify under penalty of perjury that I have not violated any of the provisions of Government Code sections 1090 through 1096 inclusive.

I further certify that there was no application for any grant or payment received, other than from the claimant, for costs contained herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1253, Statutes of 1975.

The amount of Entitlement Claim 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 <b>032</b>	IMMUNIZATION RECORDS CERTIFICATION CLAIM FORM INSTRUCTIONS	<b>FORM                  FAM-43</b>
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Note: Chapter 1534, Statutes of 1985, established the State Mandates Apportionment System (SMAS), a method of paying designated mandated programs as apportionments. This program is included in the SMAS. A claimant who has established a base year entitlement for this program will receive an annual payment by January 15 from the State Controller's Office (SCO). A base-year entitlement is determined for each district by averaging their approved claims, (i.e., actual costs) fiscal years 1981-82, 1982-83, and 1983-84 or any three consecutive fiscal years thereafter. If a claimant has incurred costs for three consecutive fiscal years, but has not filed a claim for each of those years, the claimant may file an entitlement claim with the SCO. An entitlement claim is filed solely for the purpose of establishing a base-year cost and may be filed for any or all of the three fiscal years. Once a base-year entitlement has been established, no additional claim needs to be filed by the claimant. Submit a separate Form FAM-43 for each fiscal year that is needed to complete the three consecutive fiscal years.

- (01) Enter the payee number assigned by the SCO.
- (02) Enter your official name, county of location, street or P.O. Box, city, state, and zip code.
- (03) to (05) Enter the three consecutive fiscal years that comprise the base year.
- (06) to (08) If a Form FAM-27 was filed for any fiscal year, enter an "x" in the box for that fiscal year.
- (09) to (11) Enter the amount from Form 1, line (12) that corresponds to the fiscal year for this Entitlement Claim. Only one amount should appear on lines (09) through (11). Complete a separate Form FAM-43 for each entitlement claim. Do not enter an amount for the fiscal year in which a Form FAM-27 was previously filed as indicated in the checked box.
- (12) to (18) n/a.
- (19) to (21) Leave blank.
- (22) to (26) Bring forward cost information as specified in the left-hand column of lines (22) through (26) for the reimbursement claim, e.g., Form 1, (04)(d) means the information is located on Form 1, line (04), column (d). Enter the information in the left-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.
- (27) to (36) Leave blank.

Program <b>032</b>	IMMUNIZATION RECORDS CERTIFICATION CLAIM FOR PAYMENT INSTRUCTIONS (CONTINUED)	<b>FORM FAM-43</b>
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- (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 a signed certification. (Please sign the Form FAM-43 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, claim preparer, telephone number, and email address.

**SUBMIT A SIGNED ORIGINAL FORM FAM-43 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  
Local Government Programs and Services Division  
P.O. Box 942850  
Sacramento, CA 94250**

***Address, if delivered by other delivery service:***

**Office of the State Controller  
Attn: Local Reimbursements Section  
Local Government Programs and Services Division  
3301 C Street, Suite 700  
Sacramento, CA 95816**

<b>PROGRAM</b> <b>032</b>	<b>IMMUNIZATION RECORDS</b> <b>CLAIM SUMMARY</b>			<b>FORM</b> <b>1</b>
(01) Claimant		(02)		Fiscal Year 20__/20__
<b>Claim Statistics</b>				
(03) Number of new entrants for each school in the district				
(a) Name of School	(b) Kindergarten Entrants	(c) Out-of-State Transfers	(d) Total	
(04) Total New Entrants				
(05) New Entrant Reimbursement Rate		[Refer to Claim Summary Instructions]		
(06) Total Costs		[Line (04)(d) times line (05)]		
<b>Cost Reduction</b>				
(07) Less: Offsetting Revenues				
(08) Less: Other Reimbursements				
(09) Total Claimed Amount		[Line (06) minus {line (07) + line (08)}]		

<b>PROGRAM</b> <b>032</b>	<b>IMMUNIZATION RECORDS CLAIM SUMMARY INSTRUCTIONS</b>	<b>FORM</b> <b>1</b>
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- (01) Enter the name of the claimant.
- (02) Enter the fiscal year of costs.
- (03) Number of new entrants for each school in the district. List in column (a), the name of the school, in column (b), enter the number of kindergarten entrants, and in column (c), enter the number of out-of-State transfers. Total each row.
- (04) Add columns (b), (c), and (d).
- (05) Enter the specified reimbursement rate for the fiscal year of claim. Please visit the SCO's [website](#) for the current rate.  
  
[(Current Year Index divided by Base Year Index) times Base Year Actual Unit Cost equals Current Year Actual Unit Cost]
- (06) Enter the product of Total New Entrants, line (04)(d) and multiply it by the appropriate New Entrant Reimbursement Rate, line (05).
- (07) 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.
- (08) 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.
- (09) From Total Costs, line (06), subtract the sum of Offsetting Revenues, line (07), and Other Reimbursements, line (08). Enter the remainder on this line and carry the amount forward to Form FAM-27, line (13) of the Reimbursement Claim.