

Office of the State Controller  
State-Mandated Costs Claiming Instructions No. 2016-04  
Immunization Records – Mumps, Rubella, and Hepatitis B – Program No. 368  
June 28, 2016  
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 costs incurred for state-mandated cost programs. This document contains claiming instructions and forms that eligible claimants must use for filing claims for the Immunization Records – Mumps, Rubella, and Hepatitis B program (formerly known as Immunization Records – Hepatitis B, Program 230). 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 the CSM’s website.

On August 24, 2000, CSM adopted a Statement of Decision finding that the test claim legislation imposes a reimbursable state-mandated program upon school districts within the meaning of article XIII B, section 6 of the California Constitution and GC section 17514.

On March 25, 2016, CSM adopted a new test claim decision, finding that Chapter 434, Statutes of 2010 amended Health and Safety Code section 120335(c), eliminating the condition that pupils be fully immunized against hepatitis B before a school district may advance a pupil into the seventh grade. As a result, the reimbursable activities for this program have been modified, beginning July 1, 2013. The Ps & Gs have been amended in accordance with the new test claim decision.

### **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 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**). 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 will only be filed in the combined form 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 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. Pursuant to GC section 17561(d)(2), SCO has the authority to audit the application of an reasonable reimbursement method (RRM).

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 RRM and 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 RRM and 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 – MUMPS, RUBELLA, AND HEPATITIS B CLAIM FOR PAYMENT FORM</b>		For State Controller Use Only (19) Program Number 00368 (20) Date Filed (21) LRS Input		<b>Program 368</b>
(01) Claimant Identification Number		Reimbursement Claim Data		
(02) Claimant Name		(22)	FORM 1, (03)	
County of Location		(23)	FORM 1, (04) (b)	
Street Address or P.O. Box and Suite		(24)	FORM 1, (04) (c)	
City, State, and Zip Code		(25)	FORM 1, (05)	
(03)	Type of Claim	(26)	FORM 1, (07) D. 2. (f)	
(04)	(09) Reimbursement	(27)	FORM 1, (09)	
(05)	(10) Combined	(28)	FORM 1, (10)	
(06)	(11) Amended	(29)	FORM 1, (12)	
(07)	(12) Fiscal Year of Cost	(30)	FORM 1, (13)	
(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>368</b>	<b>IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B 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>368</b>	IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B CLAIM FOR PAYMENT INSTRUCTIONS (CONTINUED)	<b>FORM FAM-27</b>
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- (22) to (30) Bring forward the cost information as specified on the left-hand column of lines (22) through (30) for the reimbursement claim, e.g., Form 1, (04) (b) means the information is located on Form 1, line (04), column (b). 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.
- (31) 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, the 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>PROGRAM</b> <b>368</b>	IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B CLAIM SUMMARY	<b>FORM</b> <b>1</b>
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(01) Claimant	(02) Fiscal Year 20 ___ /20 ___
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**Claim Statistics**

(03) Total number of new entrants in the school district	
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**Uniform Cost Allowance:** for reimbursable activities A. through C., D.1., and D.3. through D.5., listed on pages 3 through 5 of the amended Parameters and Guidelines (Ps & Gs)

(a) Name of School	(b) Kindergarten Entrants	(c) Out-of-State Transfers	(d) Total

(04) Total New Entrants	
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(05) New Entrant Reimbursement Rate	[Refer to Claim Summary Instructions]
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(06) Total Cost for New Entrants	[Line (04)(d) times line (05)]
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**Direct Costs:** for reimbursable activity D.2. only, listed on page 5 of the amended Ps & Gs

(07) Reimbursable Activity	Object Accounts					
	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Contract Services	(d) Fixed Assets	(e) Travel	(f) Total

**D. Documentation and Reporting Requirements**

2. Maintain records, which have already been received, relating to the hepatitis B immunization or lawful exemption for pupils advancing into 7 <sup>th</sup> grade, formerly required by Health and Safety Code section 120335(c), in each pupil's permanent file.						
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(08) Total Direct Costs	
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**Indirect Costs:** applies only to reimbursable activity D.2.

(09) Indirect Cost Rate	[See Claim Summary Instructions]
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(10) Total Indirect Costs	[Line (08)(f) minus line (08)(d) minus \$ <input type="text"/> ] times line (09)]
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(11) Total Direct and Indirect Costs	[Line (08)(f) + line (10)]
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**Cost Reduction**

(12) Less: Offsetting Revenues	
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(13) Less: Other Reimbursements	
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(14) Total Claimed Amount	[Line (06) + line (11) minus {line (12) + line (13)}]
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<b>PROGRAM</b>  <b>368</b>	IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B CLAIM SUMMARY INSTRUCTIONS	<b>FORM</b>  <b>1</b>
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- (01) Enter the name of the claimant.
- (02) Enter the fiscal year in which costs were incurred.
- (03) Enter the total number of new entrants (kindergarten entrants and out-of-state transfers) in the school district.  
  
**Note:** The uniform cost allowance covers all the direct and indirect costs of performing reimbursable activities A. through C., activity D.1., and activities D.3. through D.5, for “new entrants”, listed on pages 3 through 5 of the amended Parameters and Guidelines (Ps & Gs).
  - (a) Enter the name of each school.
  - (b) Enter the number of kindergarten entrants.
  - (c) Enter the number of out-of-state transfer students.
  - (d) Enter the sum of columns (b) and (c) for each school listed.
- (04) Enter the totals of columns (b), (c), and (d).
- (05) Enter the specified reimbursement rate for the fiscal year of claim.  
Please visit 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 the Total New Entrants, line (04)(d), multiplied by the appropriate New Entrant Reimbursement Rate, line (05).
- (07) For reimbursable activity, D.2., listed on page 5 of the amended Ps & Gs, enter the total from Form 2, line (05), columns (d) through (h) to Form 1, block (07), columns (a) through (e). Total each row.  
  
**Note:** Reimbursement for activity D.2, is based on actual cost claiming.
- (08) Total columns (a) through (f), for reimbursable activity D.2.
- (09) Indirect Costs apply **only** to reimbursable activity D.2. Enter the approved indirect cost rate from the California Department of Education for the year that funds are expended.
- (10) From the Total Direct Costs, line (08)(f), deduct the total Fixed Assets, line (08)(d), and any other item excluded from the indirect cost distribution base in accordance with the California School Accounting Manual, Procedure 915. Enter zero if there are no exclusions. Multiply the result by the Indirect Cost Rate, line (09).
- (11) Enter the sum of the Total Direct Costs, line (08)(f), and the Total Indirect Costs, line (10).
- (12) If applicable, enter any offsetting revenue received by the claimant for this mandate from any other state or federal source. Submit a schedule detailing the revenue sources and amounts.
- (13) 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.
- (14) Take the sum of the Total Cost for New Entrants, line (06), and the Total Direct and Indirect Costs, line (11), and subtract the sum of Offsetting Revenues, line (12), and Other Reimbursements, line (13). Enter the remainder on this line [line (14)] and carry the amount forward to Form FAM-27, line (13) of the Reimbursement Claim.

<b>PROGRAM</b> <b>368</b>	IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B ACTIVITY COST DETAIL	<b>FORM</b> <b>2</b>
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(01) Claimant	(02) Fiscal Year 20__ / 20__
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(03) Reimbursable Activity:

D. Documentation and Reporting Requirements

2. Maintain records, which have already been received, relating to the hepatitis B immunization or lawful exemption for pupils advancing into 7<sup>th</sup> grade, formerly required by Health and Safety Code section 120335(c), in each pupil's permanent file.

(04) Description of Expenses			Object Accounts				
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Contract Services	(g) Fixed Assets	(h) Travel

(05) Total <input type="checkbox"/> Subtotal <input type="checkbox"/> Page: ___ of ___						
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<b>PROGRAM</b> <b>368</b>	<b>IMMUNIZATION RECORDS – MUMPS, RUBELLA, AND HEPATITIS B ACTIVITY COST DETAIL INSTRUCTIONS</b>	<b>FORM</b> <b>2</b>
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- (01) Enter the name of the claimant.
- (02) Enter the fiscal year in which costs were incurred.
- (03) Costs incurred for this activity are to be detailed on Form 2.
- (04) The following table identifies the type of information required to support reimbursable costs. To itemize costs for the activity specified in block (03), enter each employee name, job classification, a brief description of the activities performed, productive hourly rate, actual time spent, fringe benefits, supplies used, contract services, fixed assets, and travel expenses. The descriptions required in column (04)(a) must be of sufficient detail to explain the cost of activities or items being claimed.

Object Accounts	Columns								Submit Supporting Documents with the Claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	
<b>Salaries and Benefits</b>	Employee Name and Job Classification	Hourly Rate	Hours Worked	Salaries equal Hourly Rate times Hours Worked					
	Activities Performed	Benefit Rate		Benefits equal Benefit Rate times Salaries					
<b>Materials and Supplies</b>	Description of Supplies Used	Unit Cost	Quantity Used		Costs equal Unit Cost times Quantity Used				
<b>Contract Services</b>	Name of Contractor and Specific Tasks Performed	Hourly Rate	Hours Worked and Inclusive Dates of Service			Costs equal Hourly Rate times Hours Worked or Total Contract Cost			Copy of Contract and Invoices
<b>Fixed Assets</b>	Description of Equipment Purchased	Unit Cost times Quantity	Usage				Costs equal Total Cost times Usage		Copy of Contract and/ or Invoices
<b>Travel</b>	Purpose of Trip, Name and Title, Destination, Departure Date, and Return Date	Per Diem Rate, Mileage Rate, and Travel Cost	Days, Miles, and Travel Mode					Costs equal Rate times Days or Miles	

- (05) Total line (04), columns (d) through (h) and enter the sums on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail activity costs, number each page. Enter totals from line (05), columns (d) through (h) on Form 1, block (07), columns (a) through (e) in the appropriate row.