



JAN E. GRIMES, CPA
AUDITOR-CONTROLLER

**ORANGE COUNTY
AUDITOR-CONTROLLER**

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October 21, 2013

Received
October 21, 2013
Commission on
State Mandates

Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
csminfo@csm.ca.gov

Re: Additional Information Request for Incorrect Reduction Claims
11-9705-I-02, *Seriously Emotionally Disturbed (SED) Pupils; Out-of-State Mental Health Services;*
12-9705-I-03, *Handicapped and Disabled Students; Handicapped and Disabled Students II; and SED: Out of State Mental Health Services*

To the Commission on State Mandates:

The County of Orange ("the County") received your notice dated October 1, 2013 indicating the above mentioned claims were deemed to be incomplete filings and included a request for additional information.

The County has reviewed the request and per the directives provided, revised the Incorrect Reduction Claim Form to show the correct claimant and obtained the requested authorized signatures. Please find attached, the County's timely filed revision to their current IRC's which, as stated in your letter, shall maintain their original filing dates of November 17, 2011 for claim 11-9705-I-02 and March 21, 2013 for claim 12-9705-I-03.

If you have any questions regarding the County's IRC, please contact Kim Engelby, Health Care Agency Accounting, at (714) 834-5264 or via email at kengelby@ochca.com.

Sincerely,

for Jan E. Grimes
Auditor-Controller

**COMMISSION ON STATE MANDATES
INCORRECT REDUCTION CLAIM FORM**

Authorized by Government Code section 17558

GENERAL INSTRUCTIONS

- To obtain a determination that the Office of State Controller incorrectly reduced a reimbursement claim, a claimant shall file an "incorrect reduction claim" with the Commission. All incorrect reduction claims shall be filed with the Commission no later than three years following the date of the Office of State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.
- An incorrect reduction claim shall pertain to alleged incorrect reductions in a reimbursement claim(s) filed by one claimant. The incorrect reduction claim may be for more than one fiscal year.
- Type all responses.
- Complete sections 1 through 12, as indicated. Failure to complete any of these sections will result in this incorrect reduction claim being returned as incomplete.
- Please submit by either of the following methods:
 1. **E-filing**. The claimant shall electronically file the incorrect reduction claim in PDF format to the e-filing system on the Commission's website (<http://www.csm.ca.gov/dropbox.shtml>), consistent with the Commission's regulations (CCR, tit.2, § 1181.2). The requester is responsible for maintaining the paper document with original signature(s) for the duration of the claim process, including any period of appeal. ***No additional copies are required when e-filing the request.***
 2. **By hard copy**. Original incorrect reduction claim submissions shall be unbound and double-sided, without tabs, and include a table of contents. Mail, or hand-deliver, **one original and two copies** of your incorrect reduction claim submission to: Commission on State Mandates, 980 9th Street, Suite 300, Sacramento, CA 95814

Within 10 days of receipt of an incorrect reduction claim, Commission staff shall notify the claimant if the incorrect reduction claim is complete or incomplete. Incorrect reduction claims will be considered incomplete if any of the required sections are illegible or not included. Incomplete incorrect reduction claims shall be returned to the claimant. If a complete incorrect reduction claim is not received by the Commission within 30 days from the date the incomplete claim was returned to the claimant, the Commission shall deem the filing to be withdrawn.

You may download this form from our website at csm.ca.gov.

If you have questions, please contact us:

Website: www.csm.ca.gov

Telephone: (916) 323-3562

E-Mail: csminfo@csm.ca.gov

1. INCORRECT REDUCTION CLAIM TITLE

County of Orange Consolidated Handicapped and Disabled
Students (HDS), HDSII, & SEDP Pgm for FY06/07-08/09

2. CLAIMANT INFORMATION

County of Orange
Name of Local Agency or School District
Toni Smart
Claimant Contact
Manager, Financial Reporting / Mandated Costs Unit
Title
12 Civic Center Plaza
Street Address
Santa Ana, CA 92702
City, State, Zip
714-834-7480
Telephone Number
714-834-2569
Fax Number
toni.smart@ac.ocgov.com
E-Mail Address

3 CLAIMANT REPRESENTATIVE INFORMATION

Claimant designates the following person to act as its sole representative in this incorrect reduction claim. All correspondence and communications regarding this claim shall be forwarded to this representative. Any change in representation must be authorized by the claimant in writing, and sent to the Commission on State Mandates.

Kimberly Engelby
Claimant Representative Name
Accounting Manager
Title
Auditor-Controller / Health Care Agency
Organization
405 W. 5th Street, 7th Floor
Street Address
Santa Ana, CA 92701
City, State, Zip
714-834-5264
Telephone Number
714-834-5506
Fax Number
kengelby@ochca.com
E-Mail Address

<i>For CSM Use Only</i>	
Filing Date:	RECEIVED March 8, 2013 COMMISSION ON STATE MANDATES REVISED October 21, 2013
IRC #:	12-9705-I-03

4. IDENTIFICATION OF STATUTES OR EXECUTIVE ORDERS

Please specify the statute or executive order that claimant alleges is not being fully reimbursed pursuant to the adopted parameters and guidelines.

California Government Code Sections 7570 et seq.
(AB3632)

5. AMOUNT OF INCORRECT REDUCTION

Please specify the fiscal year and amount of reduction. More than one fiscal year may be claimed.

<u>Fiscal Year</u>	<u>Amount of Reduction</u>
2006/07	\$1,539,558.00
2007/08	\$1,922,515.00
2008/09	\$275,972.00
TOTAL:	\$3,738,045.00

6. NOTICE OF INTENT TO CONSOLIDATE

Please check the box below if there is intent to consolidate this claim.

Yes, this claim is being filed with the intent to consolidate on behalf of other claimants.

Sections 7 through 11 are attached as follows:

7. Written Detailed Narrative: pages 1 to 9.
8. Documentary Evidence and Declarations: Exhibit A.
9. Claiming Instructions: Exhibit B.
10. Final State Audit Report or Other Written Notice of Adjustment: Exhibit C.
11. Reimbursement Claims: Exhibit D.

Sections 7 through 11 shall be included with each incorrect reduction claim submittal.

7. WRITTEN DETAILED NARRATIVE

Under the heading "7. Written Detailed Narrative," please describe the alleged incorrect reduction(s). The narrative shall include a comprehensive description of the reduced or disallowed area(s) of cost(s).

8. DOCUMENTARY EVIDENCE AND DECLARATIONS

If the narrative describing the alleged incorrect reduction(s) involves more than discussion of statutes or regulations or legal argument and utilizes assertions or representations of fact, such assertions or representations shall be supported by testimonial or documentary evidence and shall be submitted with the claim under the heading "8. Documentary Evidence and Declarations." All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based upon the declarant's personal knowledge or information or belief.

9. CLAIMING INSTRUCTIONS

Under the heading "9. Claiming Instructions," please include a copy of the Office of State Controller's claiming instructions that were in effect during the fiscal year(s) of the reimbursement claim(s).

10. FINAL STATE AUDIT REPORT OR OTHER WRITTEN NOTICE OF ADJUSTMENT

Under the heading "10. Final State Audit Report or Other Written Notice of Adjustment," please include a copy of the final state audit report, letter, remittance advice, or other written notice of adjustment from the Office of State Controller that explains the reason(s) for the reduction or disallowance.

11. REIMBURSEMENT CLAIMS

Under the heading "11. Reimbursement Claims," please include a copy of the subject reimbursement claims the claimant submitted to the Office of State Controller.

12. CLAIM CERTIFICATION

*Read, sign, and date this section and insert at the end of the incorrect reduction claim submission.**

This claim alleges an incorrect reduction of a reimbursement claim filed with the State Controller's Office pursuant to Government Code section 17561. This incorrect reduction claim is filed pursuant to Government Code section 17551, subdivision (d). I hereby declare, under penalty of perjury under the laws of the State of California, that the information in this incorrect reduction claim submission is true and complete to the best of my own knowledge or information or belief.

Toni Smart

Print or Type Name of Authorized Local Agency
or School District Official

Manager, Financial Reporting/Mandated Costs Unit

Print or Type Title



Signature of Authorized Local Agency or
School District Official

10-15-13

Date

** If the declarant for this Claim Certification is different from the Claimant contact identified in section 2 of the incorrect reduction claim form, please provide the declarant's address, telephone number, fax number, and e-mail address below.*