AMENDMENT TO THE AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND THE CITY OF REDWOOD CITY AS FISCAL AGENT FOR REDWOOD CITY 2020

THIS AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____ , 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and THE CITY OF REDWOOD CITY as fiscal agent for REDWOOD CITY 2020, hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, it is necessary and desirable that Contractor be retained for the purpose of providing Differential Response services.

WHEREAS, the parties entered into an Agreement on January 1, 2006 wherein the City of Redwood City, as fiscal agent for Redwood City 2020, agreed to provide Differential Responses to Path One and Path Two families in Redwood City for the term of January 1, 2006 through June 30, 2008 for a maximum payment amount of $907,537; and

WHEREAS, the parties wish to amend the Agreement for Contractor to hire, train and supervise one Mental Health Clinician to work with Differential Response Team in Redwood City and to add $100,000 for FY 2005-08, for a new total maximum obligation of $1,007,537 and

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Exhibits A, B, and C, and Attachment I are hereby deleted and replaced in their entirety with Exhibits A1, B1, C1, and Attachment I1 and Section 1 (“Exhibits and Attachments”) shall be amended to read as follows:

The following exhibits and attachments are included hereto and incorporated by reference herein:

Exhibit A1—Program/Project Description (03/06)
Exhibit B1—Payment Schedule (03/06)
Exhibit C1— Program Monitoring (03/06)
Attachment I – Differential Response Referral Process (03/06)
Attachment II – 504 Compliance
Attachment III – Fingerprinting
Attachment IV – Equal Benefits Ordinance

2. Section 2 (“Services To Be Performed By Contractor”) shall be amended to read as follows:

In consideration of the payments set forth herein and in Exhibit “B1,” Contractor shall perform services for County in accordance with the terms, conditions and specifications set forth herein and in Exhibit “A1.”

3. Section 3 (“Payments”) shall be amended to read as follows:

In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A1," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B1" The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County’s total fiscal obligation under this Agreement exceed **ONE MILLION SEVEN THOUSAND FIVE HUNDRED THIRTY SEVEN DOLLARS ($1,007,537).**

4. The parties acknowledge and agree that with respect to services provided on or after the effective date of this Amendment, all references to Exhibits A, B, and C, and Attachment I shall be construed to refer to Exhibits A1, B1, and C1, and Attachment I1.

5. **Section 11 (“Non-Discrimination”) shall be amended to add subsection G as follows:**

G. ***Compliance with Contractor Employee Jury Service Ordinance.*** **Contractor shall comply with the County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from the contractor, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received for such jury service with the contractor or that the contractor deduct from the employees regular pay the fees received for jury service.**

6. All other terms and conditions of the Agreement dated January 1, 2006 shall remain in full force and effect.

7. This Amendment, including the exhibits attached hereto and incorporated herein by reference constitutes the entire understanding of the parties hereto with respect to the amendment to the parties' Agreement dated January 1, 2006, and correctly states the rights, duties, and obligations of each party as of this document's date. Any prior understandings, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. Any modifications to this amendment shall be in writing and signed by the parties.

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representatives, have affixed their hands.

COUNTY OF SAN MATEO

By:_____
Jerry Hill, President, Board of Supervisors,
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

Ed Everett, City Manager
City of Redwood City

_____
Contractor's Signature

Date:_____

Tajel Shah, Executive Director
Redwood City 2020

_____
Contractor's Signature

Date:_____

ATTACHMENT I1 (03/06)

DIFFERENTIAL RESPONSE REFERRAL PROCESS

I. SCREENING AND PATH ASSIGNMENT

A. Children and Families Services (CFS) Phone Screener:

1. Receives calls from the public.

2. Gathers referral information including information from additional questions.
    a) Screener determines if a referral should be generated, i.e. does the allegation address child maltreatment according to statutory and state operational definitions.
    b) Screener determines if the child is in immediate danger.
    c) Screener gathers names, locations, telephone numbers, family members, schools children attend.
    d) Screener documents reporter information.
    e) Screener determines if the report concerns a vulnerable population, i.e. child 0-5 years, substance abusing parent, homelessness, chronic neglect, special needs.
    f) Screens for prior reports.
    g) Screener completes Comprehensive Assessment Tool (CAT)

3. Inputs referral into CWS/CMS.

4. Assigns path to referral. Documents path decision in CWS/CMS, Special Projects.
    a) Path One- referral meets the statutory definition of maltreatment but there are no safety issues identified and the risk to the child is low.
    b) Path Two- referral meets the statutory definition of maltreatment and there is an identified concern of safety for the child and the risk to the child is low or moderate.
    c) Path Three- referral meets the statutory definition of maltreatment and there is a safety issue identified that presents a danger of severe harm to the child.
    d) Evaluates out.

5. Sends referral to Regional ER Supervisor for assignment and cross-reports to police as necessary.

B. CFS Emergency Response (ER) Supervisor:

1. Receives ER referrals.

2. Reviews path assignments:
    a) Reviews referral information
    b) Contacts collaterals for information if appropriate

3. Determines if joint family response is indicated or if Social Worker will contact child alone first with a joint family response to follow.

Criteria for determining Response Type

Joint Assessment Response

- Child does not receive proper supervision from a parent, guardian, custodian, or caretaker.
- Child does not receive proper care from a parent, guardian, custodian, or caretaker, such as lack of food, clothing, or shelter.
- Child does not receive proper discipline from a parent, guardian, custodian, or caretaker.
- Child is not provided necessary medical care.
- Child lives in an environment injurious to his/her welfare.
- Child is in need of assistance or placement because he/she has no parent, guardian, or custodian responsible for the juvenile's care or supervision; or
- Child's parent, guardian, or custodian is unable to provide for care or supervision and lacks an appropriate alternative child care arrangement.

ER Investigative Assessment Response (joint response would follow_)

- Parent/caretaker creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means.
- Parent/caretaker uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior.
- Parent/caretaker commits, permits, or encourages the commission of sexual offense against a child.
- Parent/caretaker creates or allows to be created serious emotional damage to the juvenile.

4. If ER Supervisor determines referral to be Path One, Supervisor closes the referral in CWS/CMS and the case information is downloaded overnight into the CARE system.

a. On a daily basis, the DR Liaison will review new referral information in CARE for:

- Path designation
- Service needs
- DR case history

The Liaison will also check Cal-WIN for existing self-sufficiency case(s). Liaison will contact HSA self-sufficiency case manager (IESS, SAS or ET) to find out what services are currently being offered.

The Liaison may also call the Phone Screener if clarification is needed on any of the information in CARE.

b) Liaison will print two hard copies from CARE for MDT.

c) Liaisons will facilitate an MDT at designated time and location with community partner staff.

d) Liaison will obtain sign-off on "Case Referred To Community" form by community partner staff.

e) Liaison will release information in CARE to community partner.

5. If ER Supervisor determines referral to be Path Two, a Social Worker is assigned and information is downloaded

overnight into CARE system.

a) On a daily basis, the DR Liaison will review new referral information in CARE for:
   - Path designation
   - Name/phone number of assigned Social Worker
   - Service needs
   - DR case history

b) The Liaison will also check Cal-WIN for existing self-sufficiency case(s). Liaison will contact HSA self-sufficiency case manager (IESS, SAS or ET) to find out what services are currently being offered.

c) The Liaison may also call the Phone Screener if clarification is needed on any of the information in CARE.

d) Liaison will print two hard copies from CARE for MDT.

e) Liaisons will facilitate an MDT at designated time and location with community partner staff.

f) Liaison will obtain sign-off on "Case Referred To Community" form by community partner staff.

g) Liaison will release information in CARE to community partner.

h) Community partner case manager will contact Social Worker to arrange joint home visit.

6. If ER Supervisor determines referral to be Path Two, a Social Worker is assigned and a determination is made for a joint response with FRC staff. The meeting/conference between the Social Worker and the FRC representative(s) will constitute a MDT thus allowing for the sharing of referral information.

    a) Meeting may be done through teleconferencing but must occur at a formal time specifically scheduled to conduct a MDT.

7. Assigns Path Three referral to ER Social Worker for immediate response.

II. INITIAL CONTACT WITH THE FAMILY-PATH ONE

A. - Community Partner/PHN Response:

1. Community Partner/PHN receives Path One referral via MDT:
   a) Receives referral assignments on a flow basis
   b) Reviews information
   c) Determines key issues to explore in initial meeting
   d) Checks school records if accessible
   e) Accesses referral information in CARE database

2. Community Partner/PHN calls client to set up home visit within 10 days. If unable to contact the family, community partner/PHN will make at least 3 attempts in 30 days which will include at least:
    a) One phone call to the parent
    b) One visit to the home (or other face- to- face contact)
    c) One letter to the client

3. If family is contacted but declines family meeting, Community Partner/PHN inputs info into CARE database.

4. Once contact with the client is made and appointment is set, Community Partner/PHN sees client on home visit and engages family using strength-based intervention:
    a) Introduces self and clarifies reason for the visit. Reviews the referral information with the family
    b) Includes all family members and others living in the home in the discussion whenever possible
    c) Engages family in assessment process using observation and interviewing skills to gather information
    d) Completes Family Assessment Scale Tool (FAST)
    e) Assessment will focus on parental capacity but if any safety or risk issues are identified a referral is made back to the child abuse hotline(650 595-7922)

5. If necessary, Community Partner/PHN initiates follow-up face-to-face visit with family in home or in office to complete assessment.

III CASE PLANNING AND CASE MANAGEMENT-PATH ONE (COMMUNITY RESPONSE)

A. - Community Partner/PHN:

1 Community Partner/PHN schedules case planning meeting within one week of completed assessment. Case planning meeting will include FRC Team and other service providers as needed.

2 Develops case plan with family and Case Planning Team. If appropriate, sets up FSST to assist in developing case plan.
a) Invites family members, support persons, Community Partners to participate in the case planning as appropriate
b) Reviews the initial information received in the referral
c) Reviews the information gathered in the family assessment reflecting the family's perception of their needs
d) Establishes specific, measurable, achievable, realistic, time specific goals
e) Clarifies roles and responsibilities

3 Provides case management services for a 30-90 day period.
a) Refers clients to community agencies for appropriate treatment
~~b)~~ Makes appointments and keeps records
c) Transports or escorts adults, adolescents or children receiving services to community agencies as needed
d) Confers with other agencies or departments regarding needs of individual clients
e) Develops immediate solutions to emergency problems and expedites delivery of needed services if possible

4 Has weekly contact with the family, with face- to- face contact a minimum of twice monthly.

5 Contacts collaterals about client's progress in services.

6 Inputs info in CARE database about client's progress in services.

7 Makes new referral to hotline if allegations of abuse or neglect arise.

8 Completes re-assessment at 90 days or prior to closing case.

9 Conducts case closure review or 90 day reassessment with FRC Team.

10 Provides closure summary in CARE database.

IV. INITIAL CONTACT WITH THE FAMILY -PATH TWO (JOINT RESPONSE)

A. ER Social Worker:

1. Reviews referral:
   a) Confers with CalWORKS staff if case is open to them
   b) Reviews and organizes information
   c) Determines key issues to explore in initial meeting
   d) Contacts collaterals or background screener for additional information if necessary

2. Depending on circumstances, initiates visit to school to see child alone.

3. Coordinates with community partner/PHN/Benefits Analyst and calls client to arrange home visit with community partner/PHN/Benefits Analyst; obtains permission to include community partner/PHN/Benefits Analyst.

4. Conducts face-to-face assessment in the client's home, Social Worker assessing for risk and safety issues and Community Partner/PHN assessing for parental capacity:
   a) Introduces self and clarifies reason for the visit. Reviews the referral information with the family
   b) Includes all family members and others living in the home in the discussion whenever possible
   c) Engages family in assessment process using observation and interviewing skills to gather information

5. Completes CAT.
   If there are no safety issues, risk level is low to medium, and family does not require agency supervision then the Social Worker closes the referral and the community partner takes lead in case planning.

   If there are risk issues, Social Worker can provide 30 days of ER services, open a voluntary case, file petition in court.

6. Attends case planning meeting with family, Community Partner and collaterals.

B. COMMUNITY PARTNER (FRC CW/PHN):

Community Partner/PHN receives Path Two referral from the Liaison Worker through an MDT.

1. Reviews information
    a) Determines key issues to explore in initial meeting with Social Worker
    b) Checks school records if accessible
    c) Accesses referral information in CARE database
    d) Contacts Social Worker to schedule home visit

2. With Social Worker, conducts face-to-face assessment in the family's home, Social Worker assessing for risk and safety issues and Community Partner/PHN assessing for parental capacity.

    a) Introduces self and clarifies reason for the visit. Reviews the referral information with the family
    b) Includes all family members and others living in the home in the discussion whenever possible
    c) Engages family in assessment process using observation and interviewing skills to gather information

3. Initiates follow-up face-to-face visit with family in home or in office if necessary.

4. Completes FAST

V. CASE PLANNING AND CASE MANAGEMENT-PATH TWO (JOINT RESPONSE)

Community Partner/PHN:

1 Schedules case planning meeting to follow FSST within one week of completed assessment. Case planning meeting will include identified service providers as needed.

2. Develops case plan with family and FSST Team if appropriate.
    a) Invites family members, support persons, Community Partners to participate in the case planning as appropriate
    b) Reviews the initial information received in the referral
    c) Reviews the information gathered in the family assessment reflecting the family's perception of their needs
    d) Establishes specific, measurable, achievable, realistic, time specific goals
    e) Clarifies roles and responsibilities. Case manager duties may be reassigned if needed

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3. Provides case management services for a 30-90 day period.
    a) Refers clients to community agencies for appropriate treatment
    b) Makes appointments and keeps records
    c) Transports or escorts adults, adolescents or children receiving services to community agencies as needed
    d) Confers with other agencies or departments regarding needs of individual clients
    e) Develops immediate solutions to emergency problems and expedites delivery of needed services if possible

4. Has weekly contact with the family, with face- to- face contact a minimum of twice monthly.

5. Contacts collaterals about client's progress in services.

6. Inputs info in CARE database about client's progress in services.

7. Makes new referral to hotline if allegations of abuse or neglect arise.

8. Completes assessment at 90 days or prior to closing case.

9. Conducts case closure review or 90 day reassessment with FRC Team.

10. Completes FAST

11. Provides closure summary in CARE database

VI. PATH THREE:

ER WORKER:

1) Receives Path Three referral and cross-reports to police.

2) Conducts in-person investigation of child and family with police. If there are risk issues that are substantiated and continue to exist, the Social Worker can provide 30 days of ER services, open a voluntary case, file petition in court.

3) If risk issues cannot be substantiated discusses Differential Response options with client and obtains permission to set a meeting with a community partner. Referral continues as a Path Two (see process above).

EXHIBIT A1(03/06)
Program/Project Description

CITY OF REDWOOD CITY AS FISCAL AGENT FOR REDWOOD CITY 2020
Differential Response
JANUARY 1, 2006 THROUGH JUNE 30, 2008

Contractor will provide, to the satisfaction of the Director of Human Services Agency (HSA) or his designee, services in connection with the specified Differential Response (DR) services, as described in Attachment I1, to Path One and Path Two families in Redwood City as follows:

I. Training and Standardized Assessments

Determine the appropriate staff to attend the training, including but not limited to, Case Managers, Program Director, Mental Health Clinician, supervisors, managers and multi-disciplinary team members.

II. Initial Assessments and Contact

1. Path One - Contractor's Program Manager or designee will meet with County Community Worker (CCW) through a Multi-Disciplinary Team (MDT) process, to jointly identify families to be served. Program Manager or designee will determine the assignment of referrals to Case Managers.

2. Path Two – Contractor's Program Manager or designee will meet with County Community Worker through an MDT process to jointly identify families to be served. Program Manager or designee will determine the assignment of referrals to Case Managers. Case Manager will contact Social Worker to arrange joint response. Case Manager and SW will conduct joint response. The SW will assess for risk using Comprehensive Assessment Tool (CAT). Case Manager will assess for service needs using FAST.

III. Case Management

1. Path One Referrals,

- Develop service plan and assume all case management duties.
- Assess families' services needs using Family Assessment Screening Tool (FAST).
- Track and monitor case activities through the life of a case and case closure using the web-based Community Approach to Relating and Engaging with Families (CARE) tracking system.
- Follow DR process as described in Attachment I1.
- Re-refer cases to Children and Family Services (CFS) Hotline, as appropriate.

2. Path Two Referrals,

- Visit the client in a joint response with SW. SW will assess risk using CAT.
- Assess families' service needs and develop service plan using FAST.
- Track and monitor case activities through the life of a case and case closure using the web-based CARE tracking system.
- Follow DR process as described in Attachment I1.
- If determined to be a Path Three, Case Manager will close the case and SW will develop the case plan and assume case management duties.

IV. Case Manager

Case Manager - the primary service coordinator for families assessed to receive non-County services. The Contractor will supervise and train the Case Managers to work with children and families. Case Managers will perform the following activities, including but not limited to:

- Complete all County-provided training related to DR, as determined by the County, such as the Community Worker curriculum, DR process, FAST, CARE, MDT and Mandated Reporter Training (MRT).
- Participate in on-going training activities, as required by the County.
- Conduct standardized Path One family assessments using pre-FAST. As indicated, develop service plans through the use of strength-based assessment tools that identify family strengths and needs.
- Work jointly with SWs to conduct standardized Path Two family assessments using pre-FAST. SW will conduct assessment including safety, risk and protective capacity using CAT, and develop service plans as indicated and described above.
- Provide services to a caseload of no more than 20 cases per Case Manager.
- Engage families in services through a strength-based working relationship by meeting with families in their homes whenever possible.
- Identify, establish, and link families to services and resources including on-site services as well as neighborhood-based services.
- Provide family support through home visitation and informational services (i.e., home-teaching, motivational support, parent education, coaching, supportive problem solving, when appropriate, linkages to drug and alcohol treatment programs and domestic violence services, etc.).
- Conduct periodic reassessments and service plan updates as indicated.
- Consult with other Family Resource Center (FRC) staff when clinical expertise is needed in development of service plans.
- Close cases as appropriate, conducting post-FAST at time of closure.
- Assist in coordinating transportation to appointments, meetings, and classes.
- Participate in regular MDTs, Family Self Sufficiency Team (FSST) meetings, individual supervision sessions and other meetings as appropriate.
- Identify and invite additional parties to FSSTs.
- Participate in community outreach activities.
- Maintain up-to-date case records in CARE system.
- Develop and maintain case files in CARE system containing assessment information, case plan, and record of contacts with clients.
- Perform other duties as assigned.

V. Mental Health Clinician

A. Mental Health Clinician's duties may include, but are not limited to, the following:

• Complete all County-provided training related to DR, such as the Community Worker curriculum, DR process, FAST, CARE, MDT and MRT.
• Participate in on-going training activities.
• Work with the DR Team and provide clinical expertise, as needed, in the development of service plans.
• Provide mental health services to DR Paths One and Two families and provide input to the Case Manager concerning families' progress.
• Participate in regular MDT, FSST meetings, individual supervision sessions and other meetings as appropriate.
• Conduct home visits as necessary.
• Provide thorough mental health assessment for individuals and families.
• Prepare and maintain case histories for use in evaluation of patient progress.
• Provide referrals and linkages to County Mental Health for families with severe mental health issues.

- Participate in developing individual and group treatment plans utilizing a variety of psychotherapeutic, psychosocial and psycho- educational modalities.
- Conduct individual, group and family counseling/therapy sessions and provide case management services as appropriate.
- Provide crisis intervention services to children and families as needed.
- Assess progress of clients and make modifications to treatment plans as necessary in order to meet goals agreed upon by the clients/patients.
- Supervise graduate interns if appropriate.
- Provide consultation services to other providers and school personnel as necessary.
- Perform related duties as assigned.

VI. Administration of Case Manager and Mental Health Clinician

Be responsible for administrative services related to recruiting and training four (4) Case Managers and one (1) Mental Health Clinician to meet DR demands. Administrative services will include:

- Approving and signing timecards, leave, sick, etc.
- Conducting performance evaluations.
- Providing coaching and mentoring.
- Identifying other appropriate training.

VII. Multi-Disciplinary Teams (MDT)

Assemble an FSST jointly with County, as appropriate, to review and provide input to the case manager concerning family service plans. The FSST may be comprised of Mental Health Clinician and professionals with individual expertise in public health nursing, family counseling, alcohol and drug abuse, CalWORKS, child welfare, and child development.

VIII. Supervision

1. Be responsible for developing, implementing, and maintaining program operations at the FRC in accordance with the requirements of this Agreement.
2. Be responsible for ensuring compliance with all policies and guidelines, staying current with any changes and updates.
3. Prepare, administer and monitor the program budget to ensure the accomplishment of program and service objectives within budget restrictions.
4. Hire, train and supervise the Program Director, four (4) Case Managers and one (1) Mental Health Clinician.
5. Program Director will:

    - Supervise the four (4) Case Managers and one (1) Mental Health Clinician and be responsible for reviewing Path One and Path Two referrals and service plans.
    - Assign referrals to Case Managers.
    - Coordinate and participate in the implementation of differential response, its goals, objectives, policies, and procedures.
    - Ensure cases are up-to-date and case information is current to ensure validity and accuracy of reports.
    - Participate in the evaluation of the effectiveness of DR.
    - Conduct regular meetings with DR staff to ensure all appropriate policies and guidelines are followed.
    - Coordinate all community efforts around DR to ensure seamless process for families.
    - Act as liaison and maintain an effective working relationship with HSA, FRCs, Redwood City 2020, public and private organizations, and the community.
    - Act as advocate and spokesperson in the community in support of DR programs and services.

IX. Suspected Child Abuse and Neglect/Mandated Reporter Responsibilities

Ensure that all staff working with families are trained regarding mandated reporting requirements and report suspected child abuse and neglect as required by law. This includes but is not limited to: Case Managers, Mental Health Clinician, Volunteers, Supervisors, Clerical staff, Home Visitors, Team Leaders, and Program Managers

X. Community and Facility Capacity

Coordinate the delivery of services to the families assessed for DR within the family's neighborhood or community.

The following are services and linkages required under this project, including but not limited to:

- Alcohol and Drug Treatment and Counseling
- Mental Health Services
- Domestic Violence Services
- CalWORKs, Food Stamps, and other public assistance programs
- Health Services (Public Health Nurse)
- Probation/Juvenile Justice
- Parenting and Child Development
- Employment, Education and Skills Development
- Ancillary services designed to assist children, families and foster youth to participate in activities to fulfill their service plan goals (i.e., on-site child care, transportation assistance, etc.)
- Informal supports and activities designed to enhance family well being (i.e., Support groups, community events, enrichment activities, etc.)

XI. Service Integration

1. Coordinate case plan with existing CalWORKS, food stamps and employment service plans.
2. Assist in filling out the forms and completing the application process for cases where the family has applied for aid programs.
3. Provide web and e-mail access, maintenance and technical support.
4. Collaborate with other agencies involved in the DR implementation to ensure seamless process for clients.

XII. Policies and Procedures

Submit the following policies and procedures to County:

- Incident Reporting Guidelines
- Confidentiality

XIII. Data and Evaluation

1. Ensure data in CARE System is current and accurate.
2. Develop, jointly with the County, data and evaluation procedures.
3. Participate in Quarterly Customer Service Survey as determined by the County.

XIV. Additional Service Deliverables

1. Participate in the DR Workgroup, Breakthrough Series Collaborative, and additional subcommittees as determined jointly by both County and Contractor.
2. Participate in the preparation and presentation of information and education forums for Redwood City area about DR, through DR Workgroup, System Improvement Plan (SIP) Oversight meetings, community forums or other avenues, in collaboration with the County. Forums shall be held at mutually agreed upon locations and dates and times, when possible.

3. Support County foster parent recruitment in the Redwood City area through activities identified and agreed upon jointly between the Contractor and County.
4. Respond to all referrals. If referrals exceed capacity, Contractor will notify County to discuss.
5. Service plans will be determined on a case-by-case basis and will provide appropriate services as itemized in Attachment I1.

County will:

I. Training and Standardized Assessments

1. Provide initial and on-going DR training for appropriate County and Contractor staff.
2. Train appropriate County and Contractor staff on DR process, FAST, CARE and MDT.

II. Initial Assessments and Contact

1. Assess Child Abuse Hotline referrals for Path One, Path Two, and Path Three response using standardized assessment tools.
2. For Path One and Path Two, CCW receives referral from CFS intake unit and convenes an MDT with Contractor's Project Manager and other staff as determined by Contractor.

III. Case Management

1. Perform all case management duties for Path Three referrals.
2. A SW will conduct a joint response with Contractor for Path Two referrals. SW will determine risk and Contractor's staff will complete the service needs assessment using FAST tool.

IV. County Community Worker

Be responsible for hiring, training and supervising CCWs. The CCWs will perform the following activities, including but not limited to:

- Coordinate and facilitate MDT meetings.
- Participate in community outreach activities.
- Assist and participate in FRC activities such as parenting workshops, as time allows.
- Perform short-term case management; identify, establish and utilize a variety of community resources.
- Work with community agencies as required to assist clients in their case plan.
- Attend FSST meetings, staff conferences and related meetings.
- Complete initial and on-going DR training including DR process, FAST, CARE, MDT and MRT.
- Perform other duties as assigned.

V. Administration of County Community Worker

Be responsible for providing administrative services to the CCWs including:

- Approving and signing timecards, leave, sick, etc.
- Conducting performance evaluations.
- Providing coaching and mentoring.
- Identifying other appropriate training.

VI. Multi-Disciplinary Teams (MDTs)

Provide Contractor with policies and procedures related to MDTs.

VII. Service Integration

1. Provide the following resources to serve and support families that are referred for DR services

    - CCWs
    - Psychiatric Social Workers

2. Provide financial resources for the purchase of two computers for the purpose of implementing Differential Response.

VIII. Policies and Procedures

Provide the following polices and procedures:

- DR
- MDTs
- FSSTs

IX. Data and Evaluation

1. Gather data and reports using the CARE system.
2. Provide Quarterly Customer Service Survey forms to Contractor.

EXHIBIT B1 (03/06)

PAYMENT SCHEDULE

CITY OF REDWOOD CITY AS FISCAL AGENT FOR REDWOOD CITY 2020
Differential Response
JANUARY 1, 2006 THROUGH JUNE 30, 2008

I. County shall pay Contractor quarterly according to the following payment schedule listed below in consideration for Differential Response Case Management services as described in Exhibit A1, and other services provided by Contractor pursuant to the Agreement.

Payments will be made as follows:

a. **Operational Costs**: County shall pay Contractor for operational costs not to exceed **ONE HUNDRED TWO THOUSAND EIGHT HUNDRED FORTY FOUR DOLLARS, ($102,844) FOR FY 2005-08.**

FY 2005-06	
March 2006	$11,284.50
June 2006	$11,284.50
SUBTOTAL	**$22,569.00**
FY 2006-07	
September 2006	$9,897.00
December 2006	$9,897.00
March 2007	$9,897.00
June 2007	$9,899.00
SUBTOTAL	**$39,590.00**
FY 2007-08	
September 2007	$10,170.00
December 2007	$10,170.00
March 2008	$10,170.00
June 2008	$10,175.00
SUBTOTAL	**$40,685.00**

b. **Facilities:** County shall pay Contractor for actual facilities/office space costs not to exceed **FIFTY TWO THOUSAND DOLLARS ($52,000) FOR FY 2005-08.**

FY 2005-06 - $24,000
FY 2006-07 - $14,000
FY 2006-08 - $14,000

SUBTOTAL -$52,000

c. **Computers:** County will pay Contractor a one-time operational cost for the purchase of two computers amount not to exceed **THREE THOUSAND FIVE HUNDRED THIRTY FOUR DOLLARS ($3,534), which will be expended prior to June 30, 2006.** Contractor will submit invoices for reimbursement of actual costs.

d. **Salaries & Benefits**: County shall pay Contractor for actual salaries and benefits associated with required Differential Response Program Staffing as described in Exhibit AI. **Costs will not exceed SEVEN HUNDERED FIFITY TWO THOUSAND SIX HUNDRED NINETY THREE ($752,693).** Contractor must provide detailed invoice with actual salaries and benefits for each staff.

FY 2005-06 - $144,136
FY 2006-07 - $298,802
FY 2007-08 - $309,755

SUBTOTAL- $752,693

e. **Salary and Benefits for Mental Health Clinician:** County shall pay Contractor for actual salaries and benefits associated with the Mental Health Clinician as described in Exhibit A1. Costs for the Mental Health Clinician will not exceed **NINETY SIX THOUSAND FOUR HUNDRED SIXTY SIX DOLLARS ($96,466) for FYs 2005-08.** Contractor must provide detailed invoice with actual salaries and benefits for each staff.

FY 2005-08 - $96,466

f. **In no event shall the total amount exceed ONE MILLION SEVEN THOUSAND FIVE HUNDRED THIRTY SEVEN DOLLARS ($1,007,537) for the contract term.**

II. Invoices shall be sent to: Judy Knowlton, County of San Mateo, Human Services Agency, 400 Harbor Blvd., Bldg. B, Belmont, CA 94002. Payments shall be made within two weeks upon receipt of Contractor's invoice.

III. All payments under this Agreement must directly support services specified in this Agreement.

IV. County may withhold all or part of Contractor's total payment if the Director of Human Services or his designee reasonably determines that Contractor has not satisfactorily performed the services described in Exhibit A1.

V. County will give thirty (30) days prior written notice to Contractor of County's intent to withhold payment.

VI. If County reasonably determines that circumstances warrant immediate action, County may withhold payment immediately, without the thirty (30) day waiting period, upon County's written notice with justification to Contractor.

EXHIBIT C1 (03/06)
PROGRAM MONITORING

CITY OF REDWOOD CITY AS FISCAL AGENT FOR REDWOOD CITY 2020
Differential Response
January 1, 2006 through June 30, 2008

A. PROGRAM MONITORING

1. Contractor will be responsible for submitting 6-month and year-end narrative reports and year-end financial reports.

   6-Month reports are to be submitted as follows:
   January 31, 2007
   January 31, 2008

   Year-end reports and year-end financial reports are to be submitted as follows:
   July 31, 2006
   July 31, 2007
   July 31, 2008

   Reports will be submitted to: Marissa Saludes, Contract Monitor, Human Services Agency, 400 Harbor Blvd., Bldg. B, Belmont, CA 94002.

2. Contractor will submit to the Children and Family Services Contract Monitor at 400 Harbor Blvd. Bldg. B., Belmont, CA 94002, a roster of RWC 2020's Board of Directors and meeting dates with the year-end report.

3. Contractor will submit to the Children and Family Services Contract Monitor at 400 Harbor Blvd. Bldg. B., Belmont, CA 94002, a financial audit, as soon as it becomes available.

4. County will conduct site visit during the term of the Agreement to review all aspects of program operations and review Contractor's documentation related to case management. This site visit will be arranged in advance with the Director of RWC2020.

5. Contractor will be responsible in meeting the following Differential Response:
Outcomes for Case Management.

OUTCOME	Source of Data	Projected 2005-2006
Number of contacts with engaged (completed pre-FAST) families per month.	CARE System	4
% of referrals engaged in case management (completed service plan) and/or referral services.	CARE System	50%
Of those with a case plan, % of service needs that were met.	CARE System	50%
% of families engaged for whom a pre-FAST has been completed.	CARE System	100%
% of families with pre-FAST for whom a post-FAST has been completed.	CARE System	50%
Of those for whom a pre and post-FAST has been completed, % of families who demonstrated an increase in family functioning as indicated by an increase in FAST scores.	CARE System	70%

Of those who completed a customer service survey form, % of families who rated their overall customer service satisfaction good or excellent.	QUARTERLY CUSTOMER SERVICE SURVEY FORM	75%

6. The Lucile Packard Foundation for Children's Health grant will provide enhanced prevention and early intervention services through the addition of one Mental Health clinician. The following outcomes meet Lucille Packard Foundation for Children's Health focus on preventing child abuse and neglect in children 0-5 years. The Contractor will be responsible in meeting the following Outcomes:

OUTCOME	Source of Data	Projected November 2005- November 2006
By December 2007, number of families with children, ages 0-5, will be offered early intervention services through community response (Path 1) by the City of Redwood City through Redwood City 2020.	CARE System	28
By December 2007, number of families with children, ages 0-5, will be offered early intervention services through joint response (Path 2) by the City of Redwood City through Redwood City 2020 and the San Mateo County Human Services Agency.	CARE System	196
By December 2007, of those families with children, ages 0-5, who have mental health service needs, percent of families who will receive needed services.	CARE System	60%