

**AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND
SUNNY HILLS SERVICES**

THIS AGREEMENT, entered into this _____ day of _____, 20____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and Sunny Hills Services 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 the professional services hereinafter described for the Health Department, Mental Health Services Division

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

1. Exhibits and Attachments

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

Exhibit A—Services

Exhibit B—Payments and rates

Attachment C – Election of Third Party Billing Process

Attachment D – Payor Financial Form

Attachment I—§504 Compliance

2. Services to be performed by Contractor

In consideration of the payments set forth herein and in Exhibit "B," Contractor shall perform services for County in accordance with the terms, conditions and specifications set forth herein and in Exhibit "A."

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B." 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 HUNDRED SEVENTY-SIX THOUSAND DOLLARS (\$176,000).

4. Term and Termination

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2006 through June 30, 2007.

This Agreement may be terminated by Contractor, the Director of Mental Health Services or his/her designee at any time without a requirement of good cause upon thirty (30) days' written notice to the other party.

In the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and materials (hereafter referred to as materials) prepared by Contractor under this Agreement shall become the property of the County and shall be promptly delivered to the County. Upon termination, the Contractor may make and retain a copy of such materials. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that portion of the full payment which is determined by comparing the work/services completed to the work/services required by the Agreement.

5. Availability of Funds

The County may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon unavailability of Federal, State, or County funds, by providing written notice to Contractor as soon as is reasonably possible after the county learns of said unavailability of outside funding.

6. Relationship of Parties

Contractor agrees and understands that the work/services performed under this Agreement are performed as an independent Contractor and not as an employee of the County and that Contractor acquires none of the rights, privileges, powers, or advantages of County employees.

7. Hold Harmless

Contractor shall indemnify and save harmless County, its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description, brought for, or on account of: (A) injuries to or death of any person, including Contractor, or (B) damage to any property of any kind whatsoever and to whomsoever belonging, (C) any sanctions, penalties, or claims of damages resulting from Contractor's failure to comply with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended, or (D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of County, its officers, agents, employees, or servants, resulting from the performance of any work required of Contractor or payments made pursuant to this Agreement, provided that this shall not apply to injuries or damage for which County has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of Contractor to indemnify and save harmless as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

8. Assignability and Subcontracting

Contractor shall not assign this Agreement or any portion thereof to a third party or subcontract with a third party to provide services required by contractor under this Agreement without the prior written consent of County. Any such assignment or subcontract without the County's prior written consent shall give County the right to automatically and immediately terminate this Agreement.

9. Insurance

The Contractor shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this paragraph has been obtained and such insurance has been approved by Risk Management, and Contractor shall use diligence to obtain such issuance and to obtain such approval. The Contractor shall furnish the Department/Division with certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending the Contractor's coverage to include the contractual liability assumed by the Contractor pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to the Department/Division of any pending change in the limits of liability or of any cancellation or modification of the policy.

- (1) **Worker's Compensation and Employer's Liability Insurance** The Contractor shall have in effect during the entire life of this Agreement Workers' Compensation and Employer's Liability Insurance providing full statutory coverage. In signing this Agreement, the Contractor certifies, as required by Section 1861 of the California Labor Code, that it is aware of the provisions of Section 3700 of the California Labor Code which requires every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions of the Code, and I will comply with such provisions before commencing the performance of the work of this Agreement.
- (2) **Liability Insurance** The Contractor shall take out and maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Liability Insurance as shall protect him/her while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from contractors operations under this Agreement, whether such operations be by himself/herself or by any sub-contractor or by anyone directly or indirectly employed by either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall be not less than the amount specified below.

Such insurance shall include:

(a) Comprehensive General Liability	\$1,000,000
(b) Motor Vehicle Liability Insurance	\$1,000,000
(c) Professional Liability	\$1,000,000

County and its officers, agents, employees and servants shall be named as additional insured on any such policies of insurance, which shall also contain a provision that the insurance afforded thereby to the County, its officers, agents, employees and servants shall be primary insurance to the full limits of liability of the policy, and that if the County or its officers and employees have other insurance against the loss covered by such a policy, such other insurance shall be excess insurance only.

In the event of the breach of any provision of this section, or in the event any notice is received which indicates any required insurance coverage will be diminished or canceled, the County of San Mateo at its option, may, notwithstanding any other provision of this Agreement to the contrary, immediately declare a material breach of this Agreement and suspend all further work pursuant to this Agreement.

10. Compliance with laws; payment of Permits/Licenses

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, including, but not limited to, Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended, and the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, as amended and attached hereto and incorporated by reference herein as Attachment "I," which prohibits discrimination on the basis of handicap in programs and activities receiving any Federal or County financial assistance. Such services shall also be performed in accordance with all applicable ordinances and regulations, including, but not limited to, appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations.

In the event of a conflict between the terms of this agreement and State, Federal, County, or municipal law or regulations, the requirements of the applicable law will take precedence over the requirements set forth in this Agreement.

Contractor will timely and accurately complete, sign, and submit all necessary documentation of compliance.

11. Non-Discrimination and Other Requirements

- A. *Section 504 applies only to Contractors who are providing services to members of the public.* Contractor shall comply with § 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

- B. *General non-discrimination.* No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this Agreement.
- C. *Equal employment opportunity.* Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County of San Mateo upon request.
- D. *Violation of Non-discrimination provisions.* Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to
 - i) termination of this Agreement;
 - ii) disqualification of the Contractor from bidding on or being awarded a County contract for a period of up to 3 years;
 - iii) liquidated damages of \$2,500 per violation;
 - iv) imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this section, the County Manager shall have the authority to examine Contractor's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to Contractor under the Contract or any other Contract between Contractor and County.

Contractor shall report to the County Manager the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. Contractor shall provide County with a copy of their response to the Complaint when filed.

- E. *Compliance with Equal Benefits Ordinance.* With respect to the provision of employee benefits, Contractor shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.
- F. The Contractor shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.
- 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.

12. Retention of Records, Right to Monitor and Audit

(a) CONTRACTOR shall maintain all required records for three (3) years after the COUNTY makes final payment and all other pending matters are closed, and shall be subject to the examination and/or audit of the County, a Federal grantor agency, and the State of California.

(b) Reporting and Record Keeping: CONTRACTOR shall comply with all program and fiscal reporting requirements set forth by appropriate Federal, State and local agencies, and as required by the COUNTY.

(c) CONTRACTOR agrees to provide to COUNTY, to any Federal or State department having monitoring or review authority, to COUNTY's authorized representatives, and/or their appropriate audit agencies upon reasonable notice, access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules and regulations, and this Agreement, and to evaluate the quality, appropriateness and timeliness of services performed.

13. Merger Clause

This Agreement, including the Exhibits attached hereto and incorporated herein by reference, constitutes the sole Agreement of the parties hereto and correctly states the rights, duties, and obligations of each party as of this document's date. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications shall be in writing and signed by the parties.

14. Controlling Law

The validity of this Agreement and of its terms or provisions, as well as the rights and duties of the parties hereunder, the interpretation, and performance of this Agreement shall be governed by the laws of the State of California.

15. Notices

Any notice, request, demand, or other communication required or permitted hereunder shall be deemed to be properly given when deposited in the United State mail, postage prepaid, or when deposited with a public telegraph company for transmittal, charges prepaid, addressed to:

In the case of County, to:
San Mateo County
Mental Health Services Division
225 37th Avenue
San Mateo, CA 94403

In the case of Contractor, to:
Sunny Hill Services
300 Sunny Hill Drive
San Anselmo, CA 94960

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

COUNTY OF SAN MATEO

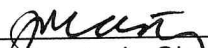
By: _____
Jerry Hill, President
Board of Supervisors, San Mateo County

Date: _____

ATTEST:

By: _____
Clerk of Said Board

SUNNY HILLS SERVICES


Contractor's Signature

Date: 6/26/06

Long Form Agreement/Non Business Associate v 1/09/06

Exhibit "A"

I. Description of Services to be Performed by the Contractor

In full consideration of the payments herein provided for, Contractor shall provide Day Treatment (Intensive and Rehabilitative) Services, Medication Support Services, Mental Health Services, and Therapeutic Behavioral Services authorized by the San Mateo County Division of Mental Health, and as meet medical necessity. These services shall be provided in manner prescribed by the laws of California and in accord with the applicable laws, titles, rules, and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. The San Mateo County Mental Services Documentation Manual ("County Documentation Manual") is included herein by reference. To the extent that there is inconsistency between a provision in the County Documentation Manual and this Agreement, the provisions in the County Documentation Manual shall prevail. All payments under this Agreement must directly support services specified in this Agreement. These services are provided to a distinct group of seriously emotionally disturbed children and adolescents and occur in a therapeutic, organized and structured setting.

A. Day Treatment (Intensive/Rehabilitative) Services (Full-day) programs, Medication Support Services, and Mental Health Services

1. General Description of Services

- a. The Day Treatment (Intensive/Rehabilitative) Services (Full-day) programs, Medication Support Services, and Mental Health Services shall collectively be referred to herein as "Services".
- b. As of the date of this Agreement Contractor provides Day Treatment (Intensive and Rehabilitative) Services (Full-day) for severely emotionally disturbed children/youth. Such Day Treatment (Intensive and Rehabilitative) Services (Full-day) shall collectively be referred to herein as "Day Treatment Services".
- c. Full-day Day Treatment Services must be available more than four (4) hours and less than twenty-four (24) hours each program day to qualify as a full day program. The client must be present each day Day Treatment Services are claimed. On an exceptional occasion when a client is unavailable for the entire program day, the client must be present a minimum of fifty percent (50%) of the program day for that day's services to be claimed.

- d. For seriously emotionally disturbed children and adolescents, Day Treatment Services provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, out-of-home placement, and/or to maintain the client in a community setting. A key component of Day Treatment Services is contact with the families of clients. This may be integrated with an education program as long as it meets all Day Treatment Services requirements.
- e. Day Treatment Rehabilitative Services may be provided for those clients for whom those services are clinically appropriate and who do not require the level of services provided through Day Treatment Intensive Services.
- f. San Mateo County clients authorized for Day Treatment Intensive Services who subsequently are authorized for Day Treatment Rehabilitative Services may continue to receive services in Contractor's Day Treatment Intensive Services program. Services provided for such clients shall be reimbursed at the Day Treatment Rehabilitative Services rates set forth in Exhibit B.
- g. Contractor shall develop and maintain a Day Treatment Services program description, and shall provide such program description to County annually and upon request.
- h. County reserves the right and authority to set additional higher or more specific standards necessary to manage the delivery of Day Treatment Services than those set by the State of California.

2. Day Treatment Intensive Services

- a. For the period July 1, 2006 through August 14, 2006 Contractor shall provide Day Treatment Intensive Services to seriously emotionally and behaviorally disturbed San Mateo County resident youth(s) pre-authorized for service by the Deputy Director of Youth Services or her designee.
- b. The Contractor's full-day Day Treatment Intensive Services hours of operation are 2:00 PM to 6:15 PM, five (5) days per week, fifty-one (51) weeks per year.

- c. The program is multi-disciplinary in its approach and provides a range of treatment services, including, but not limited to:
 - i. Psychological assessment, evaluation, and plan development;
 - ii. Recreation therapies;
 - iii. Individual and group psychotherapy;
 - iv. Psychosocial, functional skills development;
 - v. Crisis response; and
 - vi. Case management.
- d. Day Treatment Intensive Services shall occur in a therapeutic milieu. The purposes of the therapeutic milieu are as follows:
 - i. To provide the foundation for the provision of Day Treatment Intensive Services and differentiate these services from other specialty mental health services;
 - ii. To include a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff;
 - iii. To create a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction;
 - iv. To support peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
 - v. To empower clients through involvement in the overall program (such as the opportunity to lead community meetings and to provide feedback to peers) and the opportunity for risk taking in a supportive environment; and
 - vi. To support behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function with minimal or no additional therapeutic intervention.
- e. Therapeutic Milieu Service Components

The following services must be made available during the course of the therapeutic milieu for an average of at least three hours per day for a full-day Day Treatment Intensive Services program, and an average of at least two hours per day for a half-day program. One program staff member must be present and available to the group during the milieu for all scheduled hours of therapeutic milieu.

- i. Psychotherapy: the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. This service is provided by licensed, registered, or waived staff practicing within their scope of practice. This service does not include physiological interventions, including medication intervention.
- ii. Process groups: program staff will facilitate groups to help clients develop skills to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
- iii. Skill building groups: program staff will help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and increase adaptive behaviors.
- iv. Adjunctive Therapies: non-traditional therapy that utilizes self-expression (for example: art, recreation, dance, and music) as the therapeutic intervention.

f. Daily Community Meetings

A community meeting will take place at least once a day, but may occur more frequently as necessary to address issues pertinent to the continuity and effectiveness of the treatment milieu. This meeting must involve staff and clients. One participating staff member must have a scope of practice that includes psychotherapy. The content of the meeting must include, at minimum, the following:

- i. Schedule for the day;
- ii. Any current events;
- iii. Individual issues that clients or staff wish to discuss to elicit support of the group process;
- iv. Conflict resolution within the milieu;
- v. Planning for the day, the week or for special events;
- vi. Old business from previous meetings or from previous day treatment experiences; and
- vii. Debriefing or wrap-up.

g. Weekly Schedule

A detailed written weekly schedule will be made available by Day Treatment Intensive Services program staff to clients and, as appropriate, to client families, caregivers or significant support persons. The schedule will identify staffing, time, and location of program components. It will also specify the qualifications and the scope of responsibility of staff.

h. Excluded Activities

The time required for staff travel, documentation and caregiver contact is not to be included in the hours of therapeutic milieu.

i. Contact with Significant Support Persons

The Day Treatment Intensive Services program must allow for at least one contact (face-to-face, e-mail, telephone) per month with the legally responsible adult (for a client who is a minor), or with a family member, caregiver or other significant support person. Adult clients may choose whether or not this service component is done for them. These contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for Day Treatment Service.

j. Crisis Response

The Day Treatment Intensive Services program must have an established protocol for responding to clients experiencing a mental health crisis. This must assure availability of appropriately trained staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition. If clients will be referred to services outside the program, the program staff must have the capacity to handle the crisis until the client is linked to outside crisis services.

k. Authorization Requests

The Deputy Director of Youth Services or her designee will authorize payment for all admissions of San Mateo County clients to the Day Treatment Intensive Services program. Authorization will be based at a minimum on medical and service necessity criteria in State Medi-Cal guidelines and regulations. In order to be reimbursed for Day Treatment Intensive Services contractor must meet the following authorization requirements:

- i. Contractor must request prior authorization for payment from County using the Authorization Form or a similar form approved by County, and clinical documentation that establishes the need for the service.
- ii. Contractor must provide an additional prior authorization request for services that exceed five (5) days per week.
- iii. Contractor must request authorization for the continuation of services at least every three (3) months or more frequently, if requested by County.

- iv. Contractor must request prior authorization for the provision of counseling, psychotherapy, and other similar intervention services, including Mental Health Services, beyond those provided in the Intensive Day Treatment Services. These services may not be provided at the same time as Intensive Day Treatment Services even if authorized. (Excluded from this authorization are services to treat emergency and urgent conditions, and Therapeutic Behavioral Services that are provided on the same day as Day Treatment Intensive Services.) Reauthorization of these services must occur on the reauthorization schedule determined by the Deputy Director or her designee and no later than on the same cycle as reauthorization for Day Treatment Intensive Services.
- v. Authorization must specify the number of days per week as well as the length of time services will be provided.

I. Authorization Decisions

- i. For authorization decisions other than the expedited decisions described below in Paragraph I.A.2.I.ii., County shall provide notice as expeditiously as the client's mental health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the client or Contractor requests an extension; or if County identifies a need for additional information.
- ii. In cases in which Contractor or County determines that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the County will make an expedited authorization decision and provide notice as expeditiously as the client's mental health condition requires and no later than three (3) working days after receipt of the request for authorization. The County may extend the three- (3) working day time period by up to fourteen (14) calendar days if the client requests an extension, or if the County identifies a need for additional information.
- iii. The County shall notify the Contractor of any decision to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

m. Documentation

Each youth will have an individualized client treatment plan developed by the Day Treatment Intensive Services program staff signed by a licensed, waived or registered staff member. A copy of this plan will be provided to the Deputy Director of Youth Services or designee upon admission and every three (3) months thereafter.

i. Client treatment plans will:

- 1) Be provided to the Deputy Director of Youth Services or her designee within thirty (30) days of admission to the program;
- 2) Be updated at least annually and are due to the Deputy Director of Youth Services or her designee during the calendar month prior to the anniversary date or on the anniversary date of the client's entry into the County system;
- 3) Have specific observable and/or specific quantifiable goals;
- 4) Identify the proposed type(s) of intervention;
- 5) Have a proposed duration of intervention(s); and
- 6) Be signed (or electronic equivalent) by:
 - a) The person providing the service(s), or
 - b) A person representing a team or program providing Services, or
 - c) When the client plan is used to establish that Services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category, by a:
 - i) Physician,
 - ii) Licensed/registered/waivered psychologist,
 - iii) Licensed/registered/waivered social worker,
 - iv) Licensed/registered/waivered MFT, or
 - v) Registered nurse who is either staff to the program or the person directing the Services.

ii. Client Progress Notes

- 1) Day Treatment Intensive Services require:
 - a) Daily progress notes on activities, and

- b) Weekly clinical summaries, which must be signed (or electronic equivalent) by a:
 - i) Physician,
 - ii) Licensed/registered/waivered psychologist,
 - iii) Clinical social worker,
 - iv) MFT, or
 - v) Registered nurse who is either staff to the program or the person directing the Services.
- 2) The signature for the weekly summary shall include the person's professional degree, licensure, or job title, and will include the dates Services were provided and progress towards meeting client goals. Copies of weekly summaries shall be forwarded along with the monthly invoice to the Deputy Director of Youth Services or her designee

n. Staffing

The staff must include at least one person whose scope of practice includes psychotherapy.

- i. Staff Qualifications: Commensurate with scope of practice, Day Treatment Intensive Services may be provided by any of the following staff:
 - 1) Licensed Physician,
 - 2) Licensed/Waivered Clinical Psychologist,
 - 3) Licensed/Registered Clinical Social Worker,
 - 4) Licensed/Registered Marriage, Family and Child Counselor,
 - 5) Registered Nurse,
 - 6) Licensed Vocational Nurse,
 - 7) Licensed Psychiatric Technician,
 - 8) Occupational Therapist, or

- 9) Mental Health Rehabilitation Specialist. A Mental Health Rehabilitation Specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two (2) years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two (2) years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting.
- ii. Staffing Ratio
 - 1) At a minimum there must be an average ratio of at least one (1) professional staff member (see staffing list above) to eight (8) individuals ($1 \leq 8$) in attendance during the period the program is open. In Day Treatment Intensive Services programs serving more than twelve (12) clients ($1 > 12$) there shall be at least one (1) person from two (2) of the staffing groups listed above. One staff person must be present and available to the group in the therapeutic milieu in all hours of operation.
 - 2) Other staff may be utilized according to program need, but shall not be included as part of the above ratio. A clear audit trail shall be maintained for staff members who function as both Day Treatment Intensive Services program staff and in other capacities.

3. Day Treatment Rehabilitative Services

- a. Contractor shall provide Day Treatment Rehabilitative Services to seriously emotionally and behaviorally disturbed San Mateo County resident youth(s) pre-authorized for service by the Deputy Director of Youth Services or her designee.
- b. The Contractor's full-day Day Rehabilitative Services hours of operation are 3:00 PM to 7:15 PM, five (5) days per week, fifty-two (52) weeks per year.
- c. The Day Treatment Rehabilitative Services program is multi-disciplinary in its approach and provides a range of treatment services, including, but not limited to:

- i. Psychological assessment, evaluation, and plan development;
 - ii. Recreation therapies;
 - iii. Psychosocial/functional skills development;
 - iv. Crisis response; and
 - v. Case management.
- d. Day Treatment Rehabilitative Services shall occur in a therapeutic milieu. The purposes of the therapeutic milieu are as follows:
 - i. To provide the foundation for the provision of Day Treatment Rehabilitative Services and differentiate these services from other specialty mental health services;
 - ii. To include a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff;
 - iii. To create a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction;
 - iv. To support peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
 - v. To empower clients through involvement in the overall program (such as the opportunity to lead community meetings and to provide feedback to peers) and the opportunity for risk taking in a supportive environment; and
 - vi. To support behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function with minimal or no additional therapeutic intervention.
- e. Therapeutic Milieu Service Components

The following services must be made available during the course of the therapeutic milieu for an average of at least three hours per day for a full-day Day Treatment Rehabilitative Services program, and an average of at least two hours per day for a half-day program. One program staff member must be present and available to the group during the milieu for all scheduled hours of therapeutic milieu.

- i. Process groups: program staff will facilitate groups to help clients develop skills to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
 - ii. Skill building groups: program staff will help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and increase adaptive behaviors.
 - iii. Adjunctive Therapies: non-traditional therapy that utilizes self-expression (for example: art, recreation, dance, and music) as the therapeutic intervention.
- f. Daily Community Meetings

A community meeting will take place at least once a day, but may occur more frequently as necessary to address issues pertinent to the continuity and effectiveness of the treatment milieu. This meeting must involve staff and clients. The content of the meeting must include, at minimum, the following:

 - i. Schedule for the day,
 - ii. Any current event;
 - iii. Individual issues that clients or staff wish to discuss to elicit support of the group process;
 - iv. Conflict resolution within the milieu;
 - v. Planning for the day, the week or for special events;
 - vi. Old business from previous meetings or from previous day treatment experiences; and
 - vii. Debriefing or wrap-up.
- g. Weekly Schedule

A detailed written weekly schedule will be made available by program staff to clients and, as appropriate, to client families, caregivers or significant support persons. The schedule will identify staffing, time, and location of program components. It will also specify the qualifications and the scope of responsibility of staff.
- h. Excluded Activities

The time required for staff travel, documentation and caregiver contact is not to be included in the hours of therapeutic milieu.

i. Contact With Significant Support Persons

The Day Treatment Rehabilitative Services program must allow for at least one contact (face-to-face, e-mail, telephone) per month with the legally responsible adult (for a client who is a minor), or with a family member, caregiver or other significant support person. Adult clients may choose whether or not this service component is done for them. These contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for Day Treatment Service.

j. Crisis Response

The Day Treatment Rehabilitative Services program must have an established protocol for responding to clients experiencing a mental health crisis. This must assure availability of appropriately trained staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition. If clients will be referred to services outside the program, the program staff must have the capacity to handle the crisis until the client is linked to outside crisis services.

k. Authorization Requests

The Deputy Director of Youth Services or her designee will authorize payment for all admissions of San Mateo County clients to the Day Treatment Rehabilitative Services program. Authorization will be based at a minimum on medical and service necessity criteria in State Medi-Cal guidelines and regulations. In order to be reimbursed for services Contractor must meet the following authorization requirements:

- i. Contractor must request prior authorization for payment from County using the Authorization Form or a similar form approved by County and clinical documentation that establishes the need for the service.
- ii. Contractor must provide an additional prior authorization request for services that exceed five (5) days per week.

- iii. Contractor must request authorization for the continuation of services at least every six (6) months or more frequently, if requested by County.
- iv. Contractor must request prior authorization for the provision of counseling and other similar intervention services beyond those provided in the Rehabilitative Day Treatment Services. These services may not be provided to a Rehabilitative Day Treatment Services client during the Rehabilitative Day Treatment Services program hours, even if such service is authorized. (Excluded from this authorization are services to treat emergency and urgent conditions, and Therapeutic Behavioral Services that are provided on the same day as Day Treatment Rehabilitative Services.) Reauthorization of these services must occur on the reauthorization schedule determined by the Deputy Director of Youth Services or her designee and no later than on the same cycle as reauthorization for Day Treatment Rehabilitative Services.
- v. Authorization must specify the number of days per week as well as the length of time services will be provided.

I. Authorization Decisions

- i. For authorization decisions other than the expedited decisions described below in Paragraph I.A.3.I.(ii), County shall provide notice as expeditiously as the client's mental health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the client or Contractor requests an extension; or if County identifies a need for additional information.
- ii. In cases in which Contractor or County determines that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the County will make an expedited authorization decision and provide notice as expeditiously as the client's mental health condition requires and no later than three (3) working days after receipt of the request for authorization. The County may extend the three- (3) working day time period by up to fourteen (14) calendar days if the client requests an extension, or if the County identifies a need for additional information.

- iii. The County shall notify the Contractor of any decision to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. County's notice to Contractor need not be in writing.

m. Documentation

Each youth will have an individualized client treatment plan developed by the program staff signed by a licensed, waived or registered staff member. A copy of this plan will be provided to the Deputy Director of Youth Services or designee upon admission and every six (6) months thereafter.

i. Client treatment plans will:

- 1) Be provided to the Deputy Director of Youth Services or her designee within thirty (30) days of admission to the program;
- 2) Be updated at least annually and are due to the Deputy Director of Youth Services or her designee during the calendar month prior to the anniversary date or on the anniversary date of the client's entry into the County system;
- 3) Have specific observable and/or specific quantifiable goals;
- 4) Identify the proposed type(s) of intervention;
- 5) Have a proposed duration of intervention(s); and
- 6) Be signed (or electronic equivalent) by:
 - a) The person providing the service(s),
 - b) A person representing a team or program providing services, or
 - c) When the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category, by a:
 - i) Physician,
 - ii) Licensed/registered/waivered psychologist,
 - iii) Licensed/registered/waivered social worker,
 - iv) Licensed/registered/waivered MFT, or

- v) Registered nurse who is either staff to the program or the person directing the service.

ii. Client Progress Notes

Day Treatment Rehabilitative Services require weekly summaries, written or co-signed (or the electronic equivalent) by a person providing the service. The signature shall include the person's professional degree, licensure, or job title. The weekly summary shall include the dates that services were provided. There is no requirement for daily progress notes.

n. Staffing

i. Staff Qualifications: Commensurate with scope of practice, Day Treatment Rehabilitative Services may be provided by any of the following staff:

- 1) Licensed Physician,
- 2) Licensed/Waivered Clinical Psychologist,
- 3) Licensed/Registered Clinical Social Worker,
- 4) Licensed/Registered Marriage, Family and Child Counselor,
- 5) Registered Nurse,
- 6) Licensed Vocational Nurse,
- 7) Licensed Psychiatric Technician, or
- 8) Mental Health Rehabilitation Specialist. A Mental Health Rehabilitation Specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two (2) years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two (2) years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting.

- ii. At a minimum there must be an average ratio of at least one professional staff member (see staffing list above) to ten individuals ($1:\leq 10$) in attendance during the period the program is open. In Day Treatment Rehabilitative Services programs serving more than 12 clients ($1:<12$) there shall be at least one person from two of the staffing groups listed in Paragraph I.A.3.n.i. of this Exhibit A. One staff person must be present and available to the group in the therapeutic milieu in all hours of operation.
- iii. Other staff may be utilized according to program need, but shall not be included as part of the above ratio. A clear audit trail shall be maintained for staff members who function as both Day Treatment Rehabilitative Services staff and in other capacities.

4. Medication Support Services

- a. Contractor shall provide Medication Support Services by a licensed psychiatrist up to twice per month for each client pre-authorized for Medication Support Services by the County Deputy Director of Youth Services or her designee and to the extent medically necessary. Additional Medication Support Services shall be provided, if medically necessary, when pre-authorized by the Deputy Director of Mental Health Services or her designee.
- b. Reauthorization shall be on the same cycle required for continuation of the concurrent Day Treatment Services.
- c. Medication Support Services include:
 - i. Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals, necessary to alleviate the symptoms of mental illness;
 - ii. Evaluation of the need for medication, prescribing and/or dispensing;
 - iii. Evaluation of clinical effectiveness and side effects of medication;
 - iv. Obtaining informed consent for medication(s); and
 - v. Medication education (including discussing risks, benefits and alternatives with the client or significant support persons).

- d. The monthly invoice for Medication Support Services must be supported by clinical documentation to be considered for payment. Medication Support Services are reimbursed by minutes of service.
- e. Medication Support Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

5. Mental Health Services

- a. Contractor shall provide Mental Health Services for each client pre-authorized for Mental Health Services by the County Deputy Director of Youth Services or her designee and to the extent medically necessary.
- b. Reauthorization shall be on the same cycle required for continuation of the concurrent Day Treatment Services.
- c. Mental Health Services include:
 - i. Therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments; and
 - ii. Therapeutic interventions consistent with the client's goals of learning, development, independent living and enhanced self-sufficiency that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning.
- d. Therapy services provided in conjunction with Day Treatment Services (Rehabilitative and Intensive) shall generally focus on family therapy.
- e. The monthly invoice for Mental Health Services must be supported by clinical documentation to be considered for payment. Mental Health Services are reimbursed by minutes of service.

B. Therapeutic Behavioral Services

1. General Description

- a. Therapeutic Behavioral Services ("TBS") are one-to-one therapeutic contacts between a mental health provider and a beneficiary for a specified short-term period of time that are designed to maintain the child/youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals. A contact is considered therapeutic if it is intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that are the barrier to achieving residence in the lowest appropriate level.
- b. The TBS Provider (as defined in Paragraph I.B.9.a. is available on-site to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written TBS Client Treatment Plan (as defined in Paragraph I.B.3.a.).
- c. TBS may not be authorized until the TBS Assessment (as defined in Paragraph I.B.2.a.) is completed and provided to the San Mateo County Mental Health Division Deputy Director of Youth Services or designated TBS authorizer.
- d. Two important components of delivering TBS are:
 - i. Making collateral contacts with family members, caregivers, and others significant in the life of the beneficiary; and
 - ii. Developing a TBS Client Treatment Plan (as defined in Paragraph I.B.3.a.) clearly identifying specific target behaviors to be addressed and the interventions that will be used to address the target behaviors.
- e. Contractor shall provide TBS to clients who meet the TBS Reimbursement Criteria (defined in Paragraph I.B.10.).
- f. County reserves the right and authority to set additional higher or more specific standards necessary to manage the delivery of TBS than those set by the State of California.

2. TBS Assessments

- a. The TBS Assessment must identify that client meet TBS Reimbursement Criteria for Medi-Cal reimbursement established in Paragraph I.B.10 ("TBS Assessment"). TBS Assessments must be done initially and periodically, and must be a separate process from TBS Authorization (as defined in Paragraph I.B.4.a.) to determine the need for TBS and must conform to the criteria included herein.
- b. TBS shall not be authorized until the appropriate TBS Assessment is completed. The assessment must be submitted to the Deputy Director of Youth Services or designated TBS authorizer within one (1) week of the receipt of the referral.
- c. The TBS Assessment must be completed using a format provided and approved by the County.
- d. TBS Assessments must:
 - i. Identify the client's specific behaviors and/or symptoms that jeopardize current placement and/or symptoms that are expected to interfere with transitioning to a lower level of placement;
 - ii. Describe the critical nature of the situation, severity of the client behaviors and/or symptoms, other less intensive services that have been tried and/or considered, and why these other services would or would not be appropriate;
 - iii. Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement, and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care;
 - iv. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated; and
 - v. Identify skills and adaptive behaviors that the client is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

- e. Prior to conducting a TBS Assessment for a particular client, Contractor shall have a reasonable expectation that such client will meet the TBS Reimbursement Criteria for Medi-Cal reimbursement established in Paragraph I.B.10.

3. Client Treatment Plan and Addendum

a. TBS Client Treatment Plan

Services provided shall be specified in a written TBS Client Treatment Plan using a format provided or approved by County ("TBS Client Treatment Plan"). The TBS Client Treatment Plan must meet the criteria in sections i. through xi. below:

- i. The TBS Client Treatment Plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS Client Treatment Plan is intended to provide clinical direction for one or a series of short-term interventions(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the TBS Assessment process.
- ii. Clearly specify target behaviors or symptoms that jeopardize the current residential placement or present a barrier to transition to a lower level of care (e.g., tantrums, property destruction, assaultive behavior in school).
- iii. Include specific interventions to resolve targeted behaviors or symptoms (such as anger management techniques) identified in the TBS Assessment and TBS Client Treatment Plan.
- iv. Include specific description of changes in behaviors and/or symptoms that interventions are intended to produce, including a time frame for those changes.
- v. Include specific outcome measures that can be used at regular intervals to demonstrate that the frequency of targeted behaviors has declined and has been replaced with adaptive behaviors and documentation of changes in planned interventions when the original plans are not achieving expected results.

- vi. As TBS is a short-term service, there must be a transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving TBS Client Treatment Plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. The TBS Client Treatment Plan shall address assisting parent/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.
- vii. When applicable, the TBS Client Treatment Plan must include a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. The TBS Client Treatment Plan shall address assisting parents and/or caregivers with skills and strategies to provide continuity of care when this service is discontinued.
- viii. For clients between the 18 and 21 years of age notes regarding any special considerations should be taken into account, e.g. the identification of an adult case manager.
- ix. If the TBS are intensive and last for several months without observable improvement towards the treatment goals, the client shall be re-evaluated for a more appropriate placement.
- x. The TBS Client Treatment Plan shall be developed, signed and dated by the TBS Provider staff member, and co-signed by the TBS Provider supervising mental health clinician.
- xi. The TBS Client Treatment Plan shall be reviewed monthly by the Deputy Director of Youth Services or designee to ensure that TBS continue to be effective for the beneficiary in making progress towards the specified measurable outcomes. The TBS Client Treatment Plan should be:
 - a) Adjusted to identify new target behaviors, interventions and outcomes as necessary and appropriate; and
 - b) Reviewed and updated as necessary whenever there is a change in the child/youth's residence.

b. TBS Client Treatment Plan Addendum

A TBS Client Treatment Plan addendum shall be used to document the following:

- i. Significant changes in the client's environment since the initial development of the TBS Client Treatment Plan; and/or
- ii. When TBS has not been effective and the client is not making progress as expected toward individual goals. There must be documented evidence in the chart indicating the consideration of alternatives. Requested additional hours/days for TBS shall be based on the documented expectation that the additional time will be effective.

4. General Authorization Requirements

- a. TBS will be authorized by the Deputy Director of Youth Services or her designated TBS authorizer ("TBS Authorization"). Contractor shall request TBS Authorization from the County in advance of the provision of TBS included in the TBS Authorization request. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities, but does not include the TBS Assessment, as defined in Paragraph I.B.2. that determines whether or not TBS Reimbursement Criteria are met, nor to the initial development of the TBS Client Treatment Plan.
- b. The County shall make decisions on TBS Authorization requests in advance of the delivery of TBS for the first TBS Authorization and subsequent TBS reauthorizations ("TBS Reauthorizations").
- c. The County shall issue decisions on TBS Authorization requests for TBS in accordance with the timeliness required by DMH Regulations Exhibit A, Attachment 2, Section B, and by Title 9, CCR, Section 1810.405 (c) except that when the County extends the timeline for an expedited TBS Authorization request to obtain additional information from contractor, the County shall issue a decision on the TBS Authorization request within three (3) working days of the receipt of additional information from the Contractor or within 14 calendar days of the extension, whichever ever is earlier.

5. Initial Authorization

Initial TBS Authorization will cover initial delivery of direct one-to-one TBS ("Initial TBS Authorization"). Initial TBS Authorization may not exceed 30 (thirty) days. In order for Initial TBS Authorization to be approved Contractor must submit a TBS Client Treatment Plan as defined in Paragraph I.B.3.a.

6. TBS Reauthorization

- a. TBS Reauthorization may not exceed thirty (30) days if the Contractor is requesting TBS Authorization of direct one-to-one TBS that exceeds twelve (12) hours per day, or exceed sixty (60) days if the provider is requesting TBS Authorization of direct one-to-one TBS that is less than or equal to twelve (12) hours per day.
- b. TBS Reauthorization decisions will be based upon clear documentation of:
 - i. Client progress toward specific goals and timeframes of TBS Client Treatment Plan.
 - ii. Strategy to decrease intensity of TBS, initiate transition plan, and/or terminate TBS when TBS has been effective in making progress toward specified measurable outcomes identified in the TBS Client Treatment Plan or client has reached plateau in benefit effectiveness. A strategy to terminate TBS shall consider the intensity and duration of TBS necessary to stabilize client behavior and reduce risk of regression.
 - iii. If applicable, lack of client progress toward specific goals and timeframes in TBS Client Treatment Plan, and changes needed to address the issue(s). If the TBS being provided has been ineffective and client is not making expected progress toward identified goals, documentation shall include the alternatives considered, and the reason that only the approval of the additionally requested hours/days of TBS, instead of or in addition to the alternatives, will be effective.
 - iv. Review and update of TBS Client Treatment Plan as necessary to address significant changes to client environment (e.g., change of residence).
 - v. Provision of skills/strategies to parents/caregivers to provide continuity of care when TBS is discontinued.
 - vi. Contractor must initiate TBS Reauthorization no less than ten (10) days prior to the end of the authorized TBS period.

- c. Contractor shall monitor the number of hours and days TBS are provided, and shall be responsible for requesting TBS Reauthorization according to the timelines identified in Paragraph I.B.6.b.vi.

7. TBS Authorization Decisions

- a. For TBS Authorization decisions other than the expedited decisions described in Paragraph I.B.7.b., County shall provide notice of such decisions as expeditiously as the client's mental health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the client/client's guardian or Contractor requests an extension; or if County identifies a need for additional information.
- b. In cases in which Contractor or County determines that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the County will make an expedited TBS Authorization decision and provide notice of such decision as expeditiously as the client's mental health condition requires and no later than three (3) working days after receipt of the request for TBS Authorization. The County may extend the three (3) working days time period by up to fourteen (14) calendar days, consistent with the client's/client's guardian request, if the client requests an extension. If the County identifies a need for additional information and documents the need and how the extension is in the client's interest, the County may extend the three (3) working day time period to three (3) working days from the date the additional information is received, or fourteen (14) calendar days, whichever is less.
- c. The County shall notify the Contractor of any decision to deny a TBS Authorization request, or to authorize TBS in an amount, duration, or scope that is less than requested. County's notice to Contractor need not be in writing.

8. Progress Notes

Progress notes are required each day TBS is delivered and must include a comprehensive summary covering the time that services were provided. In the progress note, the time of the service may be noted by contact/shift. As with other MHP progress notes, staff travel and documentation time are included with direct service time; on call time may not be claimed. The following must be clearly documented:

- a. Occurrences of specific behaviors and/or symptoms that jeopardize the residential placement or prevent transitions to a lower level of placement;
- b. The delivery of significant interventions identified in the TBS Client Treatment Plan;
- c. Progress in stabilizing behaviors and/or symptoms by changing or eliminating maladaptive behaviors and replacing them with adaptive behaviors.

9. Service Delivery and Staffing Requirements

- a. TBS must be provided by a licensed practitioner of the healing arts or by trained Contractor staff members who are under the direction of a licensed practitioner of the healing arts ("TBS Provider"). The qualifications of Contractor's TBS Providers will be determined by the County and may include non-licensed staff.
- b. A necessary component of TBS is having the TBS Provider on-site and immediately available to intervene for a specified period of time as needed. The expectation is that the TBS Provider will be with the child/youth for a designated time period which may vary in length and may be up to 24 hours a day, depending upon the needs of the child/youth. TBS shall be available up to 24 hours a day, seven days a week as authorized.
- c. Commensurate with scope of practice, TBS Providers may be any of the following staff:
 - i. Licensed Physician,
 - ii. Licensed/Waivered Clinical Psychologist,
 - iii. Licensed/Registered Clinical Social Worker,
 - iv. Licensed/Registered Marriage and Family Therapist,
 - v. Registered Nurse,
 - vi. Licensed Vocational Nurse,
 - vii. Licensed Psychiatric Technician,
 - viii. Occupational Therapist, or

- ix. Staff with other education/experience qualifications. The County staffing guideline requires Contractor TBS Providers to have a minimum of a Bachelor's Degree in a mental health related field. TBS Providers shall be licensed practitioners of the healing arts or trained staff members who are under the direction of a licensed practitioner of the healing arts.
- d. TBS is not to supplant other mental health services provided by other mental health staff.
- e. TBS Providers delivering TBS in group homes may not be counted in the group home staffing ratio.
- f. TBS Providers delivering TBS in day treatment intensive or day treatment rehabilitation sites may not be counted in the day treatment staffing ratio, and the TBS Providers function must be clearly differentiated.
- g. Contractor must have contact with the parents or caregivers of the client. Contact must be with individuals identified as significant in the client's life, and must be directly related to the needs, goals and interventions of the TBS Client Treatment Plan. These 'collateral TBS' must meet the requirements of Title 9, CCR, Sections 1810.206 and 1840.314.

10. TBS Reimbursement Criteria

TBS shall be offered in a manner that is compliant with requirements for Medi-Cal reimbursement ("TBS Reimbursement Criteria"). To qualify for Medi-Cal reimbursement for TBS, a child/youth must meet the criteria in Paragraphs a, b, and c below.

- a. Eligibility for TBS – must meet criteria (i) and (ii).
 - i. Full-scope Medi-Cal, under 21 years, and
 - ii. Meets State medical necessity criteria for the Medi-Cal Program.
- b. Member of the Certified Class – must meet criteria (i), (ii), (iii), or (iv).
 - i. Child/youth is placed in a group home facility of RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs which is not an Institution for Mental Disease which disqualifies them from receiving federally reimbursed Medi-Cal services; or

- ii. Child/youth is being considered by the county for placement in a facility described in c.i. above; or
 - iii. Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months; or
 - iv. Child/youth previously received TBS while a member of the certified class.
- c. Need for TBS – must meet criteria (i) and (ii).
- i. The child/youth is receiving other specialty mental health services, and
 - ii. It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:
 - 1) The child/youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in current facility; or
 - 2) The child/youth needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child in the new environment. (The MHP or its provider must document the basis for the expectation that the behavior or symptoms will change.)

C. Administrative Requirements (for all service components)

1. Paragraph 12 of the Agreement and Paragraph I.M.4. of Exhibit B notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18th) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.
2. Administering Satisfaction Surveys

Contractor agrees to administer/utilize any and all survey instruments as directed by the County Mental Health Services Division, including outcomes and satisfaction measurement instruments.

3. Cultural Competency

- a. All program staff shall receive at least one (1) in-service training per year on some aspect of providing culturally and linguistically appropriate services. At least once per year and upon request, Contractor shall provide County with a schedule of in-service training(s) and a list of participants at each such training;
- b. Contractor shall use good faith efforts to translate health-related materials in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall provide to County copies of Contractor's health-related materials in English and as translated; and
- c. Contractor shall use good faith efforts to hire clinical staff members who can communicate with clients in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall submit to County the cultural composition and linguistic fluencies of Contractor's staff.

4. Contractor shall submit a copy of any licensing report issued by a licensing agency to County Mental Health Division Children and Youth Services Deputy Director within 10 business days of Contractor's receipt of any such licensing report.

5. Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). Documentation shall be completed in compliance with the County Documentation Manual (as defined in Paragraph I of Exhibit A).

6. Contractor shall maintain certification through San Mateo County to provide Short-Doyle Medi-Cal reimbursable services.

7. Contractor may not employ any persons deemed an Ineligible Person by the Office of the Inspector General in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. Ineligibility may be verified by checking: www.Exclusions.OIG.HHS.Gov.

8. Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

9. Beneficiary Rights

Contractor will comply with County policies and procedures relating to beneficiary's rights and responsibilities.

10. Physician Incentive Plans

Contractor shall obtain approval from County prior to implementing a Physician Incentive Plan as described by Title 42, CFR, Section 438.6(h). The County will submit the Physician Incentive Plan to the State for approval. The State shall approve the Contractor's request for a Physician Incentive Plan only if the proposed Physician Plan complies with all applicable federal and state regulations.

11. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

12. Compliance Plan and Code of Conduct

Contractor shall read and be knowledgeable of the compliance principles contained in the Mental Health Compliance Plan and Code of Conduct. In addition, Contractor shall assure that Contractor's workforce is aware of compliance mandates, and are informed of the existence and how to use the Compliance Improvement Hotline Telephone Number (650) 573-2695.

13. Beneficiary Brochure and Provider Lists

Contractor agrees to provide Medi-Cal clients who are new to the Mental Health System with a brochure (an original of which shall be provided by County) when a client first receives a specialty mental health service from the Contractor. Such brochure shall contain a description of County services available; a description of the process for obtaining County services, including the County's state-wide toll-free telephone number; a list of the County's providers; a description of the County's beneficiary problem resolution process, including the complaint resolution and grievance processes; and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process.

D. Goals and Objectives

1. Day Treatment Services

Goal 1: To maintain clients at the current or reduced level of placement.

Objective 1: At least 95% of children served will be maintained in their current or reduced level of placement during their course of treatment.

Objective 2: There will be no more than one (1) psychiatric hospitalization during the course of Day Treatment Intensive Services per enrolled youth.

Data to be collected by Contractor.

2. Therapeutic Behavioral Services

Goal 1: To maintain clients at the current or reduced level of placement.

Objective 1: At least 95% of children served will be maintained in their current or reduced level of placement during their course of treatment.

Data to be collected by Contractor.

3. Satisfaction

Goal 1: To enhance clients' and parents' or other caregivers' satisfaction with the services provided.

Objective 1: At least ninety percent (90%) of respondents will agree or strongly agree that they are satisfied with services received.

Objective 2: At least seventy-five percent (75%) of respondents will agree or strongly agree that the client is better at handling daily life.

Data to be collected by County in cooperation with Contractor.

Exhibit "B"

In consideration of the services provided by Contractor in Exhibit "A", County shall pay Contractor based on the following fee schedule:

I. Amount and Method of Payment

A. Day Treatment (Intensive and Rehabilitative) Services (Full-day) programs

1. For full-day Day Treatment Intensive Services described in Paragraphs I.A.1. and I.A.2. of Exhibit A Contractor shall be paid at the rate of ONE HUNDRED NINETY-FIVE DOLLARS AND FIFTY-EIGHT CENTS (\$195.58) per day. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.
2. For full-day Day Treatment Rehabilitative Services described in Paragraph I.A.1. and I.A.3. of Exhibit A Contractor shall be paid at the rate of ONE HUNDRED TWENTY-SIX DOLLARS AND EIGHTY CENTS (\$126.80) per day. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.
3. For Day Treatment (Intensive/Rehabilitative) Services payment shall be made on a monthly basis upon County's receipt of the following:
 - a. All required documentation adhering to Medi-Cal guidelines, and the terms of this Agreement,
 - b. Documentation for each day of service, and
 - c. Documentation relating to each appropriate authorization.
4. Day Treatment Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

B. Medication Support Services and Mental Health Services

1. For Medication Support Services described in Paragraph I.A.1. and I.A.4. of Exhibit A, County shall pay Contractor at the rate of FOUR DOLLARS AND SIXTY-SIX CENTS (\$4.66) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.

2. For Mental Health Services described in Paragraph I.A.1. and I.A.5. of Exhibit A, County shall pay Contractor at the rate of TWO DOLLARS AND FIFTY-TWO CENTS (\$2.52) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.
3. For Medication Support Services and Mental Health Services payment shall be made on a monthly basis upon County's receipt of the following:
 - a. All required documentation adhering to Medi-Cal guidelines,
 - b. Documentation for each minute of service, and
 - c. Documentation relating to each appropriate authorization.
4. Medication Support Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

C. Therapeutic Behavioral Services (TBS)

1. For the Therapeutic Behavioral Services described in Paragraph I.B. of Exhibit A County shall pay Contractor at the rate of TWO DOLLARS AND FIFTY-TWO CENTS (\$2.52) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.
2. Contractor shall only be reimbursed for minutes worked by direct services staff. The cost of providing supervisory and administrative support is included in the per minute rates above.
3. The billing unit for TBS is staff time, based on minutes.
4. TBS are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services are reimbursed, except on the day of admission to those services. TBS are reimbursable during Day Treatment Services when the provider is not a staff member during the same time period of the Day Treatment Services program.

- D. County shall pay Contractor for services provided by Contractor during FY 2006-07 in the amount of the FY 2005-2006 Short-Doyle Medi-Cal Maximum Reimbursement Rate (the "SMA") until the SMA rates for Fiscal Year 2006-07 are published; at which time the SMA rates for FY 2006-07 will be in effect, and upon both parties finalizing an amendment to the Agreement, Contractor will be paid retroactively to the beginning of the FY 2006-07 fiscal year.
- E. In any event, the maximum amount County shall be obligated to pay for services rendered under this Agreement shall not exceed ONE HUNDRED SEVENTY-SIX THOUSAND DOLLARS (\$176,000).
- F. Monthly Reporting
1. Payment by County to Contractor shall be monthly. Contractor shall bill County on or before the tenth (10th) working day of each month for the prior month. The invoice shall include a summary of services and charges for the month of service. In addition contractor shall provide back-up to the invoice. Such back-up shall be in the form of:
 - a. County provided service reporting form(s) ("Service Reporting Form(s)") completed by Contractor according to the instructions accompanying the Service Reporting Form(s), or
 - b. County approved form(s) which provide detailed description of services provided including but not limited to: client name, mental health ID#, service date, type of service provided (Ex: TBS, Intensive Day Treatment, etc.), and duration of service (day/hour/minute format).
 2. County reserves the right to change the Service Report Forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary.
- G. If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, and this Agreement may either be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.
- H. In the event this Agreement is terminated prior to June 30, 2007, the Contractor shall be paid for services already provided pursuant to this Agreement.

I. In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other agreement.

J. Cost Report

1. Contractor shall submit to County a year-end cost report no later than ninety (90) days after the expiration date of this Agreement. This report shall be in accordance with the principles and format outlined in the Cost Reporting/Data Collection (CR/DC) Manual. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the Cost Report.
2. If the annual Cost Report provided to County reveals that total payments to Contractor exceed the total allowable costs for all of the services rendered by Contractor to eligible clients during the reporting period, a single payment in the amount of the contract savings shall be made to County by Contractor, unless otherwise authorized by the Director of Health or her designee.

K. Beneficiary Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

L. County May Withhold Payment

Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the Quality Improvement Manager of the San Mateo County Mental Health Services Division of the Health Department.

M. Claims Certification and Program Integrity

1. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.
2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

"Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Executed at _____ California, on _____, 200__

Signed _____ Title _____

Agency _____"

3. The certification shall attest to the following for each beneficiary with services included in the claim:
 - a. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement;
 - b. The beneficiary was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the beneficiary;

- c. The services included in the claim were actually provided to the beneficiary;
 - d. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided;
 - e. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement;
 - f. For each beneficiary with Day Treatment Services, Medication Support Services, Mental Health Services, and/or TBS included in the claim, all requirements for Contractor payment authorization for Day Treatment Services, Medication Support Services, Mental Health Services, and/or TBS were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement; and
 - g. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.
4. Except as provided in Paragraph I.C.1. of Exhibit A relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

N. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

1. Option One

- a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. With every invoice submitted by Contractor to County, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for each such invoice. The County may withhold payment to Contractor for any and all services for which this required proof of third-party payments and/or denials of such payments is not provided. County may deduct from its payments to Contractor the amount of any such third-party payment. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement.
- b. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and in subsequent annual updates for all clients who receive services through this Agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due with the first invoice of the Agreement for services provided to said clients.

2. Option Two

- a. Contractor shall provide information to County so that County may bill applicable other third-parties before billing Medi-Cal for services provided by Contractor through this Agreement. The County may withhold payment to Contractor for any and all services pending notification or receipt of such third-party payments or denials of such payments. County may deduct from its payments to Contractor the amount of any such third-party payment. To the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement.

- b. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due with the first invoice of the Agreement for services provided to said clients.

Attachment C
Election of Third Party Billing Process

Effective July 1, 2005, San Mateo County Mental Health Services will be required to bill all other insurance (including Medicare) before billing Medi-Cal for beneficiaries who have other coverage in addition to Medi-Cal. This is called "serial billing." All claims sent to Medi-Cal without evidence of other insurance having been billed first will be denied.

In order to comply with the serial billing requirement you must elect which of the two following options to use in our contract with you. In either case, you will need to establish the eligibility of your clients through the completion of the standard form (Payor Financial Form) used to collect this information. Please select and complete one of the two options below:

Option One

Our agency will bill other insurance, and provide San Mateo County Mental Health Services (SMCMHS) with a copy of the Explanation of Benefits provided by that insurance plan before billing SMCMHS for the remainder.

We _____ (agency name) elect option one.

Signature of authorized agent

Name of authorized agent

Telephone number

Option Two

Our agency will provide information to San Mateo County Mental Health Services (SMCMHS) so that SMCMHS may bill other insurance before billing Medi-Cal on our agency's behalf. This will include completing the attached client Payor Financial Form and providing it to the SMCMHS Billing Office with the completed "assignment" that indicates the client's permission for SMCMHS to bill their insurance.

We Sunny Hills Services (agency name) elect option two.

[Signature]
Signature of authorized agent

Joseph M. Costa
Name of authorized agent

415-457-3200
Telephone number

Please note if your agency already bills private insurance including Medicare for services you provide, then you must elect Option One. This is to prevent double billing. Please return this completed form to:

Doreen Avery, Business Systems Manager
Mental Health Services
225 37th Avenue
San Mateo, CA 94403
(650) 573-2284

Attachment D - Payor Financial Form

AGENCY NAME:		
Client's Last Name/MH ID # (if known)	First Name M.I.	Alias or other names Used
Client Date of Birth	Undocumented? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Social Security Number (Required)	26.5 (AB3632) <input type="checkbox"/> Yes <input type="checkbox"/> No IEP (SELPA) start date _____
Does Client have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No Share of Cost? <input type="checkbox"/> Yes <input type="checkbox"/> No Client's Medi-Cal Number (BIC Number)? _____ Please attach copy of MEDS Screen If client is Full scope Mcal, skip the remaining sections of this form and fax to MIS/Billing Unit – 573-2110 Is Client Potentially Eligible for Medi-Cal Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Client Referred to Medi-Cal? <input type="checkbox"/> Yes, give date: _____ <input type="checkbox"/> No Is this a Court-ordered Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No Does Client have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check all that apply ____ Part A ____ Part B ____ Part D (effective 1/1/06) What is the Client's Medicare Number? _____		
Responsible Party's Information (Guarantor): Name _____ Phone _____ Relationship to Client _____ <input type="checkbox"/> Self Address _____ City _____ State _____ Zip Code _____ <input type="checkbox"/> Refused to provide Financial Information and will be charged full cost of service.		

FINANCIAL ASSESSMENT – Annual UMDAP (Uniform Method of Determining Ability to Pay)

Gross Monthly Income (include all in the Household) A. Self\$ _____ B. Parents/Spouse/Domestic Partner\$ _____ C. Other\$ _____ Number of Persons Dependent on Income _____	Allowable Expenses A. Court Ordered Monthly Obligation \$ _____ B. Monthly Child Care Payments (Only if Necessary for Employment) \$ _____ C. Monthly Dependent Support Payments \$ _____ D. Monthly Medical Expense Payments \$ _____ E. Monthly Mandated Deductions for Retirement Plan (Do not include Social Security).....\$ _____ F. Housing Cost (Mortgage/Rent) \$ _____
Asset Amount (List all liquid assets) A. Savings.....\$ _____ B. Checking.....\$ _____ C. Stocks.....\$ _____	

3rd Party HEALTH INSURANCE INFORMATION

Health Plan or Insurance Company (Not employer) Name of Company _____ Street Address _____ City _____ State _____ Zip _____ Insurance Co. phone number _____	Policy Number _____ Group Number _____ Name of Insured Person _____ Relationship to Client _____ Social Security Number of Insured Person _____ (if other than client)
Does this Client have Healthy Families Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete San Mateo County Mental Health SED form.	Does this Client have Healthy Kids Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Does this Client have HealthWorx Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

CLIENT AUTHORIZATION – This section is not required for Full scope Medi-Cal Clients

I affirm that the statements made herein are true and correct. I understand that I am responsible for paying the UMDAP liability amount or cost of treatment received by myself or by members of my household during each 1-year period. If the cost of service is more than the UMDAP liability amount, I pay the lesser amount. It is my responsibility and I agree to provide verification of income, assets and expenses. If I do not, I will be billed in full for services received. I authorize San Mateo County Mental Health to bill all applicable mental health services to Medi-Care and/or my insurance plan, including any services provided under 26.5. I authorize payment of healthcare benefits to San Mateo County Mental Health.

Signature of Client or Authorized Person

Date

Reason if client is unable to sign

Client Refused to Sign Authorization: ☐ (Please check if applicable) Date _____ Reason _____

Name of Interviewer

Phone Number

Best Time to Contact

FAX COMPLETED COPY TO: MIS/BILLING UNIT (650)-573-2110

ENTERED BY

San Mateo County Mental Health Services Use Only

CLIENT ACCOUNT #

DATA ENTRY DATE

MEDI-CAL AND HEALTHY FAMILIES/HEALTHY KIDS/HEALTH WORKS ELIGIBILITY

Below are instructions for accessing the State's MEDS (Medi-Cal Eligibility Determination System) to determine eligibility and clearing share of cost through the internet. If you do not have access to the internet, please call Bernadette Ortiz (phone: 650-573-2712) or Analiza Salise (phone: 650-573-2442) to verify eligibility.

Instructions for Obtaining Medi-Cal Eligibility Using Internet

- Double click on Internet Explorer
- Type in the address box: <https://www.medi-cal.ca.gov/eligibility>
- From the Login Center Transaction Services screen, enter
Userid: **usually 5 zeros followed by your provider number**
- Enter state assigned password – call Medi-Cal Provider Relations Phone Support @
1-800-541-5555
- Click on Submit or press enter
- From the Transaction Services screen, double click on Determine Patient's Eligibility
- From Perform Eligibility screen fill in the following fields:
 - Recipient ID – enter the client's Social Security # (without dashes)
 - Date of Birth – enter the client's DOB (mm/dd/yyyy)
 - Date of Card Issue – if unknown, enter today's date (mm/dd/yyyy)
 - Date of Service – enter the date on which the service is to be performed (mm/dd/yyyy)
 - Click on Submit or press enter

Note:

Click on Back - to return to Transaction Services screen

Clear – press this button to clear the fields in the form

Patient Recall – once any transaction has been performed on a client, pressing this button will fill in the common fields with all of the information from the last transaction. This is useful for using the same client on different transaction (such as an eligibility verification, then a Share of Cost) or for correcting data when a transaction has gone through with incorrect data.

Instructions for Clearing Medi-Cal Share of Cost Using Internet

- Double click on Internet Explorer
- Type in the address box: <https://www.medi-cal.ca.gov/eligibility>
- From the Login Center Transaction Services screen, enter
Userid: **your provider number preceded by 5 zeros**
- Enter state assigned password - call Medi-Cal Provider Relations Phone Support @
1-800-541-5555
- Click on Submit or press enter
- From the Transaction Services screen, double click on Determine
Share of Cost
- From Perform SOC screen fill in the following fields:
 - Recipient ID – enter the client’s Social Security # (without dashes)
 - Date of Birth – enter the client’s DOB (mm/dd/yyyy)
 - Date of Card Issue – if unknown, and clearing service for the current month, enter today’s date. If you are clearing a retroactive service, you must have the BIC issue date. (mm/dd/yyyy)
 - Date of Service – enter service date for the “SOC Clearance.” (mm/dd/yyyy)
 - Procedure Code – enter the procedure code for which the SOC is being cleared. The procedure code is required. (90862, 90841, 90882, etc.)
 - Billed Amount – enter the amount in dollars and cents of the total bill for the procedure code. (ex: 100 dollars would be entered as 100.00): If you do not specify a decimal point, a decimal followed by two zeros will be added to the end of the amount entered.
 - Share of Cost Case Number – optional unless applying towards family member’s SOC case
 - Amount of Share of Cost – optional unless a SOC case number was entered
 - Click on Submit or press enter

Note:

Click on Back - to return to Transaction Services screen

Clear – press this button to clear the fields in the form

Patient Recall – once any transaction has been performed on a client, pressing this button will fill in the common fields with all of the information from the last transaction. This is useful for using the same client on different transaction (such as an eligibility verification, then a Share of Cost) or for correcting data when a transaction has gone through with incorrect data.

Select SOC Case – this item affects how the Patient Recall button (described above) functions. Simply select the circle above the SOC case number that you want the Patient Recall button to use when it fills out the form. Note that the SOC case numbers are only available if the previous transaction was an Eligibility transaction.

The “Last Used” choice contains the SOC Case number that was used if the previous transaction was a SOC transaction. This is also a default choice if none are selected.

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called the "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a or b)

☐ a. Employs fewer than 15 persons.

☒ b. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Tiffany Chelsvig
Name of 504 Person - Type or Print

Sunny Hills Services
Name of Contractor(s) - Type or Print

300 Sunny Hills Drive
Street Address or P.O. Box

San Anselmo, CA 94960
City, State, Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

[Signature]
Signature

CEO
Title of Authorized Official

6/26/06
Date

*Exception: DHHS regulations state that:

"If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

CONTRACT INSURANCE APPROVAL

DATE: June 13, 2006

TO: Steve Rossi

FAX: 363-4864 PONY: EPS 163

FROM: Liz Kauk

PHONE: 573-2242

FAX: 573-2841

PONY: MLH 322

The following is to be completed by the department before submission to Risk Management:

CONTRACTOR NAME: Sunny Hills Services

DOES THE CONTRACTOR TRAVEL AS A PART OF THE CONTRACT SERVICES? yes

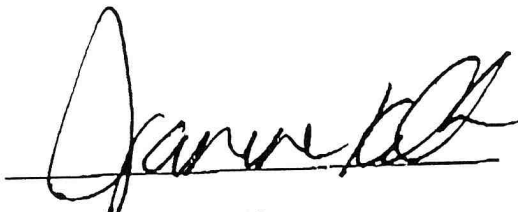
NUMBER OF EMPLOYEES WORKING FOR CONTRACTOR:

DUTIES TO BE PERFORMED BY CONTRACTOR FOR COUNTY: see attached

The following will be completed by Risk Management:

INSURANCE COVERAGE:	Amount	Approve	Waive	Modify
Comprehensive General Liability	\$1,000,000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle Liability	\$1,000,000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Liability	\$1,000,000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workers' Compensation	statutory	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS/COMMENTS:


Risk Management Signature6/13/04
Date

ACORD CERTIFICATE OF LIABILITY INSURANCEOP ID H3
SUNNY-7DATE (MM/DD/YYYY)
07/07/06

PRODUCER

(WC) Heffernan Insurance Brkrs
1350 Carlback Ave, Suite 200
Walnut Creek CA 94596
Phone: 925-934-8500 Fax: 925-934-8278

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION
ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE
HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR
ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

NAIC #

INSURED

Sunny Hills Services
Attn: Tiffany Chelsvig
300 Sunny Hills Drive
San Anselmo CA 94960-1995

INSURER A: Riverport Insurance Company

INSURER B: EVEREST NATIONAL INS. CO.

INSURER C:

INSURER D:

INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A X	GENERAL LIABILITY				EACH OCCURRENCE \$ 1000000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY	RIC0007340	07/01/06	07/01/07	DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100000
	<input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR				MED EXP (Any one person) \$ 10000
	<input checked="" type="checkbox"/> Liquor Legal Liab	RIC0007340	07/01/06	07/01/07	PERSONAL & ADV INJURY \$ 1000000
	<input checked="" type="checkbox"/> Soc Svcs Prof	RIC0007340	07/01/06	07/01/07	GENERAL AGGREGATE \$ 2000000
	GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG \$ 2000000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC				Liquor Li 1000000
A	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident) \$ 1000000
	<input checked="" type="checkbox"/> ANY AUTO	RIC0007340	07/01/06	07/01/07	BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS				BODILY INJURY (Per accident) \$
	<input type="checkbox"/> SCHEDULED AUTOS				PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS				
	<input type="checkbox"/> NON-OWNED AUTOS				
A	<input checked="" type="checkbox"/> Comprehensive	RIC0007340	07/01/06	07/01/07	
A	<input checked="" type="checkbox"/> Collision	RIC0007340	07/01/06	07/01/07	
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT \$
	<input type="checkbox"/> ANY AUTO				OTHER THAN EA ACC \$
					AUTO ONLY: AGG \$
A	EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE \$ 5000000
	<input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE	REL0007341	07/01/06	07/01/07	AGGREGATE \$ 5000000
	<input type="checkbox"/> DEDUCTIBLE				\$
	<input checked="" type="checkbox"/> RETENTION \$10000				\$
					\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	66000000569061	07/01/06	07/01/07	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT \$ 1000000
	If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE \$ 1000000
					E.L. DISEASE - POLICY LIMIT \$ 1000000
A	OTHER				
A	Property, Special	RIC0007340	07/01/06	07/01/07	Building 8673210
					Contents 715000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Re: Per contract on file.

San Mateo County Mental Health Services is named additional insured on the
General Liability policy per the attached endorsement.

*Except 10 days notice for non-payment of premium.

CERTIFICATE HOLDER

SANM-02

San Mateo County Mental Health
Services
225 37th Ave., 3rd Fl.
San Mateo CA 94403

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION
DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30* DAYS WRITTEN
NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL
IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR
REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

COUNTY OF SAN MATEO

Equal Benefits Compliance Declaration Form

I Vendor Identification

Name of Contractor: Sunny Hills Services
Contact Person: Barry Feinberg, Chief Operating Officer
Address: 300 Sunny Hills Drive
San Anselmo, CA 94960-1995
Phone Number: 415-457-3200 Fax Number: 415-456-4679

II Employees

Does the Contractor have any employees? X Yes ___ No

Does the Contractor provide benefits to spouses of employees? X Yes ___ No

If the answer to one or both of the above is no, please skip to Section IV.

III Equal Benefits Compliance (Check one)

- ☒ Yes, the Contractor complies by offering equal benefits, as defined by Chapter 2.93, to its employees with spouses and its employees with domestic partners.
- ☐ Yes, the Contractor complies by offering a cash equivalent payment to eligible employees in lieu of equal benefits.
- ☐ No, the Contractor does not comply.
- ☐ The Contractor is under a collective bargaining agreement which began on _____ (date) and expires on _____ (date).

IV Declaration

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

Executed this 26th day of June, 2006 at San Anselmo, CA.
(City) (State)

gman
Signature

Joseph M. Costa
Name (Please Print)

CEO
Title