AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND EDGEWOOD CENTER FOR CHILDREN AND FAMILIES

THIS AGREEMENT, entered into this _____ day of _____ , 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and Edgewood Center for Children and Families, hereinafter called "Contractor";

W I T N E S S E T H:

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

WHEREAS, it is necessary and desirable that Contractor be retained for the purpose of providing Full Service Partnership services for children, youth and transition age youth.

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
Exhibit C—Budget
Attachment C—Election of Third Party Billing Process
Attachment D—Payor Financial Form
Attachment E—Fingerprint Certification
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 NINE MILLION TWO HUNDRED FIFTY-THREE THOUSAND FOUR HUNDRED SIXTY-FOUR DOLLARS ($9,253,464).

4. Term and Termination

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2009 through June 30, 2012,

This Agreement may be terminated by Contractor, the Chief of the Health System 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 insurance and to obtain such approval. The Contractor shall furnish the County 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 County 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. Further, Contractor certifies that the Contractor and all of its subcontractors will adhere to all applicable provisions of Chapter 4.106 of the San Mateo County Ordinance Code, which regulates the use of disposable food service ware.

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. <u>Non-Discrimination and Other Requirements</u>

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.

12. <u>Compliance with Contractor Employee Jury Service Ordinance</u>

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.

13. <u>Retention of Records, Right to Monitor and Audit</u>

(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.

14. 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. In the event that any term, condition, provision, requirement or specification set forth in this body of the agreement conflicts with or is inconsistent with any term, condition, provision, requirement or specification in any exhibit and/or attachment to this agreement, the provisions of this body of the agreement shall prevail. 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.

15. Controlling Law and Venue

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. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or the United States District Court for the Northern District of California.

16. Notices

Any notice, request, demand, or other communication required or permitted hereunder shall be deemed to be properly given when both (1) transmitted via facsimile to the telephone number listed below and (2) either deposited in the United Sates mail, postage prepaid, or when deposited for overnight delivery with an established overnight courier that provides a tracking number showing confirmation of receipt for transmittal, charges prepaid, addressed to:

In the case of County, to:
San Mateo County
Behavioral Health and Recovery Services
225 37th Avenue
San Mateo, CA 94403

In the case of Contractor, to:
Edgewood Center for Children and Families
1801 Vicente Street
San Francisco, CA 94116

In the event that the facsimile transmission is not possible, notice shall be given both by United States mail and an overnight courier as outlined above.

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

COUNTY OF SAN MATEO

By:_____
Mark Church, President,
Board of Supervisors, San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES

_____
Contractor's Signature

Date:_____

Edgewood Center
Full Service Partnership Services 2009- 2012
Exhibit A

In consideration of the payments set forth in Exhibit B, Contractor shall provide the following services:

I. Description of Services to be Performed by Contractor

Contractor shall provide Full Service Partnership (FSP) mental health service programs for the highest risk children/youth (C/Y) and transition age youth (TAY) in San Mateo County. The purpose of these two programs is to assist each enrolled client ("enrollees") and families to achieve independence, stability and wellness within the context of their cultures, communities, and family/caregiver units, and to remain living in their respective communities. Contractor shall work with San Mateo County Behavioral Health and Recovery Services ("BHRS") staff ("County") to implement these services in accordance with requirements of the California Mental Health Services Act (MHSA) requirements.

A. Values and Principles

1. Wraparound

The FSP programs shall reflect the core values of Wraparound, including recognition of the family's cultural values as a strength of the family. Family shall be defined to mean relatives, caregivers, peers, friends, and significant others as determined by the individual client. The provision of Wraparound services shall be in accordance with the Best Practices Standards as developed by the California Department of Social Services. (See Attachment B – Wraparound Standards Guidelines for Planning and Implementation.)

2. The concept of self help shall be a part of every enrollee care plan.

3. Services shall be linguistically and culturally competent and provided to a substantial degree by staff from the same ethnic groups as enrollees. The program shall incorporate the following cultural competence elements:
   - Outreach and engagement strategies designed to reach identified diverse communities and to engage them in services.
   - Provide culturally competent services that are sensitive to the enrollee's cultural identity, available in the enrollee's primary language and make use of the natural supports provided by the enrollee's culture and community.

- Team members shall be trained in culturally competent practices. Services shall be delivered by bilingual, culturally competent staff.
- Goal setting and planning process shall be culturally sensitive and shall build on the enrollee's and family's cultural community resources and context. Individual, culturally focused community supports shall be identified and integrated into planning. Enrollee care plans shall reflect and respect the healing traditions and healers of each child/youth and family.

B. Populations to be Served

1. Program services will be open to all youth meeting the population criteria described below, however it is specifically targeted to Asian/Pacific Islander, Latino and African American children/youth (C/Y) and transition age youth (TAY). Medi-Cal and non-Medi-Cal eligible clients shall be offered the opportunity to participate.

   Populations to be served by the program are:
   - Severely Emotionally Disturbed (SED) and dually diagnosed C/Y (ages 6 to 18, including 16 /17 year olds when it is developmentally appropriate and/or best meets the needs of the client and family) and TAY (age 16 to 25 years old) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
   - SED and dually diagnosed C/Y, and their families, who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
   - SED and dually diagnosed homeless C/Y/TAY and C/Y/TAY exiting school based, IEP driven services.
   - Newly identified TAY who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice and/or child welfare systems.
   - Current clients in the County TDS program may be referred to FSP services when the youth is failing the TDS intensive program or at risk of out of home placement.

2. Youth enrolled in SB163 are considered as being in a placement equivalent to FSP program services.

3. Client Eligibility Criteria

   Eligibility criteria shall include:

   a. Enrollees must be San Mateo County residents.

b. At risk for placement in a level 10-14 residential facility or is "stepping down" from a level 10-14 residential facility (for SB163 enrollees).
c. For C/Y enrollees the family must be willing and able to participate in the treatment process.
d. For SB163 C/Y funded slots, enrollees must be currently involved in Chapter 26.5, HSA, or Probation.

C. Program Planning

Prior to implementation Contractor shall initiate the following planning steps:

1. Establish Youth and Caregiver Advisory Committees (Advisory Committees) to review, guide and/or modify FSP program implementation and policy development, including consultation and planning assistance for ongoing operation of the development of the TAY Drop In Center.

2. Initiate consultation/collaboration with the County co-occurring disorders provider.

3. Collaborate with County community college and vocational education programs, as needed.

D. Full Service Partnership Services

FSP services shall be delivered by two separate multidisciplinary teams, one for C/Y and one for TAY. There shall be a 1:10 staff to enrollee ratio. Except as specifically delineated below in this Paragraph D, all services described shall be provided for both C/Y and TAY enrollees. It is anticipated that enrollees will receive an average of three (3) to seven (7) hours of services per week.

1. Program capacity

a. The C/Y team shall serve forty (40) clients. This team will have thirty (30) slots operated under the SB163 program and ten (10) MHSA funded slots.
b. The TAY team shall have forty (40) slots. All services shall be funded by the MHSA.
c. The average length of stay is anticipated to be eighteen (18) months for both the C/Y and TAY programs.

2. Program services shall have four (4) phases:

a. Phase I (Discovery) – Engagement, assessment, stabilization and planning
b. Phase II (Hope) – Build skills and family connectedness
c. Phase III (Renewal) – Strengthening and expanding formal and informal community support systems; affirm and support self-reliance strategies; prevent relapse; and leadership training
d. Phase IV (Constancy) – Individualized aftercare planning to promote stability and permanence.

3. FSP teams shall operate under policies and procedures that ensure:

a. 24-hour, 7-day a week availability of program staff, including access to medication support services
b. Continuity of care during inpatient episodes including visits with local hospitals that allow program staff to have regular contact with client and with inpatient treatment staff while client is hospitalized
c. Continuity of care during criminal justice contacts
d. Coordination with client's primary care physician
e. Contact with each client as often as clinically necessary, which might be daily

4. FSP teams shall be responsible for delivery of services and service outcomes. FSP staff will provide the services identified in the individualized enrollee care plan (Care Plan). Some C/Y enrollees and family members may continue to receive other services in the MH system (e.g., County Therapeutic Day Schools, clinic medication services). The FSP team will work in collaboration with the other County staff and contract providers to assure implementation of each enrollee's Care Plan.

Enrollees may be referred to TDS if that is determined by the IEP to be their school placement

5. Initiation of Services

No later than five (5) days following authorization by County a member of the FSP team shall meet with the C/Y/TAY client and family (as applicable to TAY enrollees) to conduct an orientation and strengths assessment to enroll the client, and to set the groundwork for the first Multidisciplinary Team (MDT) meeting. The MDT shall include the FSP team, other system providers, and the C/Y enrollee and family.

Within each team, a personal services coordinator (case manager) shall be identified for each enrollee.

The MDT shall develop the individualized care plan ("Wrap Plan"), which shall identify the highest priority needs which may include but not be limited to any of the following five life domains: 1) support/self efficacy, 2) education, 3) employment, 4) wellness, and 5) safety and permanence. Action steps shall be developed and responsibility for completing those steps shall be assigned. The MDT shall meet as often as needed to address the C/Y enrollee and family's/TAY enrollee's needs. The Wrap Plan timeline shall be as follows:

Timeframe	**Action**
Intake	Preliminary Safety Plan, Consents & Release of Information
Within 30 days	Strength and Needs Assessment completed
Within 60 days	Wrap Plan and Discharge Plan are implemented
As needed	Wrap Plan is reviewed and updated
Within 90 days of discharge	After care meeting

6. Volume of Services

Contractor will provide the minimum volume of services per contract period established below. One (1) unit equals one (1) minute of service. The average level of service per enrollee shall be four and one half (4.5) hours per week.

		Minimum Number of Eligible Units
a.	July 1, 2009 – June 30, 2010	
	C/Y Program	561,600
	Units of service	
	TAY FSP Program	561,600
	Units of service	
	Total	1,123,200
b.	July 1, 2010 – June 30, 2011	
	C/Y Program	561,600
	Units of Service	
	TAY FSP Program	561,600
	Units of Service	
	Total	1,123,200

c. July 1, 2011 – June 30, 2012

C/Y Program	561,600
Units of Service	
TAY FSP Program	561,600
Units of Service	
Total	1,123,200

7. Clinical Services

The FSP teams shall provide the following clinical services. Contractor shall employ evidence-based practices to include Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Systemic Family Treatment, as clinically appropriate.

a. Mental Health Services

Contractor shall provide Mental Health Services ("Mental Health Services") to include:

1) Individual Therapy: Individual Therapy is those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual Therapy is usually delivered to an individual but may include family therapy when the individual is present.
2) Group Therapy: Group Therapy is those therapeutic interventions for more than one client that focuses primarily on symptom reduction as a means to improve functional impairments. It may include group family therapy (when families of two or more clients are present).
3) Family Therapy: Therapeutic interventions focused on the care and management of the enrollee's mental health condition within the family system when an enrollee and one or more family member/significant other are present.

4) Collateral Services: Collateral Services consists of contact with one or more significant support persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of service plan(s). Family counseling or therapy which is provided on behalf of the client is considered collateral.

5) Assessment services: This includes clinical analysis of the history and current status of the client/enrollee's mental, emotional or behavioral condition.

6) Plan Development: The development of client plans, approval of client plans, and/or monitoring of enrollee progress.

7) Rehabilitation Services: Assistance in improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, medication compliance and access to support resources. This includes psychosocial education aimed at helping to achieve enrollee's goals.

b. Medication Support Services

1) Contractor shall provide Medication Support Services by a psychiatrist.

2) Medication Support Services ("Medication Support Services") shall include:
   a) Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals, necessary to alleviate the symptoms of mental illness;
   b) Evaluation of the need for medication, prescribing and/or dispensing;
   c) Evaluation of clinical effectiveness and side effects of medication;
   d) Obtaining informed consent for medication(s); and
   e) Medication education (including discussing risks, benefits and alternatives with the consumer or significant support persons).

3) Contractor shall provide peer medication support groups

c. Case Management

Case Management Services are activities that are provided by Contractor's staff to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed services for eligible clients. Services may include the following:

1) Linkage and Coordination - the identification and pursuit of resources including, but not limited to, the following:
   a) Inter- and intra-agency communication, coordination, and referral, including reports to CPS.
   b) Monitoring service delivery to ensure an individual's access to service and the service delivery system
   c) Linkage, brokerage services focused on transportation, housing, or finances
2) Placement Services Supportive assistance to the individual in the assessment, determination of need, and securing of adequate and appropriate living arrangements including, but not limited to, the following:
   a) Locating and securing an appropriate living environment
   b) Locating and securing funding
   c) Pre-placement visit(s)
   d) Negotiation of housing or placement contracts
   e) Placement and placement follow-up
   f) Accessing services necessary to secure placement

d. Crisis Intervention

Crisis response services shall be available 24 hours per day, 7 days per week with the following three-tiered response system: 1) clinical management staff; 2) psychiatrist; 3) agency administrator.

1) Contractor shall provide Crisis Intervention ("Crisis Intervention"). Crisis Intervention is a service, lasting less than twenty-four (24) hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit.

2) Contractor shall provide Crisis Intervention as medically necessary.

e. Intensive in-home services

f. Intensive case management

g. Referrals for psychiatric inpatient services shall be made as necessary.

h. Therapeutic Behavioral Services (TBS): If TBS are identified as necessary, the case manager will work with San Mateo County staff to arrange access to those services for those eligible enrollees (full scope Medi-Cal under age 21).

i. Substance Abuse/Co-occurring disorders services
Services for clients with co-occurring disorders shall be treated in a harm reduction, Stages of Change model. Where substance abuse is determined to be life threatening, more assertive interventions may be implemented, as determined by Contractor.

8. Non-Clinical Services

a. Centralized intake

b. Outreach and Engagement

1) Client engagement and outreach
Contractor shall establish Care Teams that will utilize Family Conferencing in the care planning process. Enrollees and their families shall be included in all Care Team meetings, and shall be the final decision makers in the treatment process.

2) Community engagement and outreach
Youth transitioning out of residential facilities, jail, hospitals and long term care facilities will be engaged in pre-discharge planning to include multi-modal assessment and crisis plan development. The initial Care Team meeting shall take place prior to discharge.

c. Contractor shall make available transportation, childcare and home-based services to increase client engagement.

d. Family/caregiver support and Family Finding services

Services shall address the whole family, not only the enrollee, and shall support parents when they have their own mental health or substance abuse needs. The FSP shall facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and Other Drug Services (AOD) of BHRS Division when family members meet MHS and/or AOD criteria or providing crisis/brief intervention services to those not meeting criteria and referring them to primary care or community resources, as needed.

Family support shall include peer support and encouragement to the parents to enhance the family's community and natural supports, transportation services, and supports as identified in the individualized action plan. Services for family/caregivers shall include:

1) Parent management curriculum for dealing with behavior problems
2) Support groups
3) Educational groups focusing on mental illness, co-occurring disorders and finding resources.
4) Night and weekend activities shall be part of program services.
5) Family finding services shall be provided for enrollees.
6) Contractor shall provide two Parent Partners to operate a family/caregiver support center. Parent Partners shall be part of the FSP team and shall be assigned to a child/youth/family to provide support in identifying strengths, pinpointing areas of growth, and creating plans that will promote positive change. Parent partners shall coordinate group events to bring family members/parents/caregivers together.
7) Respite Services
8) Shadow services (1:1 mentoring)
9) Any services that is needed in order to manage the youth safely in the community.

9. Flexible Funds – FSP Programs

The FSP teams shall utilize to flexible funds (including SB163 funds and MHSA funds) to support unique needs identified in the individualized action plan of FSP enrollees, or during a crisis, to avert out of home placement or hospitalization. The Contractor shall manage the fiscal distribution of the flexible funds for enrollees. This shall include:

a. Maintaining proper documentation of fund transactions and distribution.
b. Providing all pertinent documentation required for maintenance of fiscal and pragmatic accountability.
c. Work collaboratively with other BHRS contractor to establish a small portion of housing funds to be allocated to the FSP for the management of housing crises for TAY enrollees.

10. Services specific to TAY enrollees

a. TAY FSP services will be coordinated with services provided by the San Mateo Youth Transition to Adult Committee (YTAC), the Support and Advocacy for Young Adults in Transition (SAYAT) program, the Young Adults Independent Living (YAIL) program, and the HSA Adolescent Services Unit.

b. Services shall be provided in a modified Assertive Community Treatment (ACT) model as defined by the Substance Abuse and Mental Health Administration (SAMHSA).

c. The TAY FSP team will emphasize the enrollee's role in developing individual wellness and recovery plans, focusing on assisting TAY to become "interdependent." These enrollees shall be supported to build on or develop the skills to become independent through their continued education and /or employment and their own housing, and to sustain continued relationships with family (if they choose) and other adults in their lives who provide ongoing support.

d. TAY enrollees shall have access to housing subsidies to insure they have housing and linkages to resources to meet their housing needs. The majority of these FSP housing resources for all age groups will be managed by a separate contractor. Emancipated foster care enrollees who meet program guidelines shall be supported in accessing monthly housing stipends provided through the Human Services Agency.

e. The FSP team will coordinate with the County contracted supported education program to create a focus on TAY enrollees. TAY enrollees shall be supported to access this program. The supported education program will be designed to address the specific interests and goals of transition age youth. The work-study peer positions related to the drop-in center shall be available for enrollees or FSP graduates.

f. TAY enrollees who meet program guidelines will be linked as appropriate to the Independent Living Skills Program (ILSP) for educational assistance, employment, classes in life skills training, financial aid workshops, computer classes, transportation, mentoring, housing, and tutoring.

g. Housing

1) Contractor shall work collaboratively with the BHRS contractor selected to provide housing support services for TAY enrollees. Contractor shall establish an MOU with the BHRS contractor identifying roles and responsibilities of each provider in order to best support TAY enrollees to secure, retain and care for housing. Housing subsidies for TAY enrollees will be managed by a separate contractor. Access to these resources will be determined by BHRS, Contractor and the County housing contractor.
2) Contractor shall work with other community agencies to maximize the availability of housing resources for TAY enrollees.

h. Supported Education

TAY supported education services will be provided only when this service is a part of the comprehensive action plan. Referrals will not be accepted for non-enrollees. Supported education will be funded with MHSA FSP funds and managed through an agreement with another contractor. Contractor shall collaborate with the College of San Mateo to gain enrollee access for existing programs. Contractor shall also provide the following services to assist enrollees to become involved in supported education:

1) Conduct a thorough assessment of enrollee educational skills and needs
2) Assist with educational and vocational goal-setting
3) Provide daily living and social skills coaching
4) Develop classes to teach the skills necessary to be a successful student
5) Accompany students to matriculate in educational and academic programs
6) Use flex funds to provide incentives to pursue education or to pay for specific courses
7) Engage in educational advocacy, especially around re-enrolling youth who have left school

8) Collaborate with vocational rehabilitation services
9) Provide pregnancy prevention counseling
10) Help obtain assistance for parenting youth
11) Obtain tutoring services as needed for enrollees.

i. Supported Employment

Contractor shall provide the following services to assist enrollees to become involved in supported employment:

1) Conduct a thorough assessment of enrollee vocational skills and needs
2) Provide assistance with résumé writing/job applications
3) Provide onsite occupational therapy
4) Facilitate seminars on professional development and job seeking skills
5) Help with job placement and coaching
6) Assistance with securing entry level employment
7) Mentoring youth in volunteer work and providing youth with job shadowing opportunities

E. Drop In Center Services

1. The focus of the Drop In Center is to provide a safe location for TAY to meet, and to be a central point for the delivery of services. The Drop In Center and its services and supports will be organized around self-help, independence, and skill building. Drop In Center services shall be provided to TAY enrollees as well as other SED TAY who are currently receiving County mental health services or identified as needing engagement in MH services, and for C/Y who have these services included in their treatment plans.

2. The Drop In Center will serve enrollees in the TAY program and shall be used as a step down support for enrollees transitioning from FSP team services as well as for other youth not receiving FSP team services. The Center will serve individuals whether or not currently enrolled in FSP team services. Referrals may come from MHSA community outreach and school based programs. The Drop In Center is not a referral-based or authorized service.

3. The center shall include staffing by people close to the TAY age group. The center shall be open twenty-three (23) hours per week with flexible hours. It shall be strategically located to provide maximum accessibility to Center services for residents of San Mateo County.

4. Drop in center services shall include, but not be limited to:

    a. self help supports
    b. recreational and social activities
    c. Group lunches and dinners
    d. Legal clinic
    e. Health clinic
    f. assistance with domestic violence issues
    g. co-occurring disorder self-help groups
    h. living skills classes
    i. gender-based groups
    j. support for those seeking to enter the college system
    k. peer support
    l. other supports identified as needed by those using the center, in order to enhance client ability to manage independence
    m. Warm line services
    n. support groups for lesbian/gay/bisexual/transgender/ questioning (LGBTQ) SED youth

6. Services will be available to TAY enrollees on a drop-in basis, and for C/Y enrollees if part of the enrollee care plan

7. Staff from the FSP team will offer onsite services

8. The Drop In Center shall be located in a community location near bus route to the community college campus

9. The center will be staffed by 3.0 FTE peer support staff and volunteers who mirror the target population

F. Non-FSP Flexible Funds Administration

1. General Description. The Contractor shall manage the fiscal distribution of Flexible Funds for the Child and Youth System of Care (referred to as “Program”) for non-FSP enrollees. Upon receiving BHRS authorized requests for goods and services for the Program, the Contractor shall issue a check for the amount requested to the specified vendor or to reimburse a provider.

2. Administrative duties includes the following activities:

    a. Receiving and processing Program requests for payments (including postal costs). At receipt of these requests, the Contractor will provide confirmation of receipt.

b. Check requests received by Contractor from County by 5:00 PM on any given Tuesday will result in County receiving a check from Contractor by the following Monday. For emergency situations, as determined by BHRS Child/Youth Management staff, Contractor will use best efforts to process Program requests and issue checks the same day the emergency request is received. Such emergency requests may result in a "Rush Fee" pursuant to Paragraph I.L.1. of Exhibit B.

c. Receiving authorized funds, returning documentation of completed transactions and sending fiscal expenditure reports to BHRS Administration.

d. Maintaining proper documentation of checks distributed and transactions completed.

e. Providing all pertinent documentation required for maintenance of fiscal and pragmatic accountability.

f. Effectively transfer management of Flex Funds.

G. Admission and Discharge

1. The County Youth Case Management Unit will manage the overall referral and authorization process in collaboration with the review/authorization committees.

2. Services shall be provided for unserved and underserved populations.

a. Un-served populations include C/Y that have previously been known (via PES/inpatient, juvenile hall, child welfare) but are not currently engaged in community based services, as well as C/Y that are completely new to the system. The SB163 Program entry point for enrollment of children/youth will be through the Interagency Placement Review Committee (IPRC), which is comprised of representatives from the Human Services Agency (Children and Family Services), BHRS, the Probation Department (Juvenile Probation Division), Education, and Alcohol and Other Drugs. The IPRC will oversee authorization to both the 30 SB163 slots and the 10 MHSA slots. The FSP team will adhere to all current SB163 enrollment and disenrollment protocols.

b. Under-served populations include C/Y currently engaged in community based services, but at risk of out of home placement without additional intensive services. FSP enrollment to the TAY FSP program will be authorized by the Youth to Adult Transition Committee (YTAC), an interagency collaboration including Mental Health, Alcohol and Other Drug, Probation, and Education, in order to coordinate services and resources.

3. Referrals to the FSP teams will come from probation officers, child welfare social workers, and mental health professionals.

4. BHRS will review enrollee status and progress towards planned transition with the FSP supervisor and determine when the FSP program has met individual/family goals and discharge planning should be initiated, with a step down to less intensive services and natural supports.

5. Contractor may not refuse to enroll clients who have been referred to them by the County Youth Case Management and the YTAC Team. Upon authorization to the FSP team, following the team assessment and planning process, the FSP case manager will complete the full system documentation if the client is not already open to the system

6. If an enrollee requires residential placement the case manager will contact the BHRS Youth Case Management Unit for consultation on how to proceed

7. BHRS will develop disenrollment procedures for enrollees who choose to leave the program. This will include an "interim" period during which the enrollee can change his/her mind and during which the program will be responsible for continued outreach/engagement as well as linking the enrollee to alternative services. The Contractor shall notify BHRS of disenrollment within two (2) working days

H. Staffing

Program staff shall include the following:

Program Director, licensed	1.0 FTE
Crisis Response Workers	3.0 FTE
TAY Clinic Manager, licensed/eligible	1.0 FTE
C/Y Clinic Manager, licensed/eligible	1.0 FTE
TAY Case Managers	3.0 FTE
C/Y Case Managers	4.0 FTE
TAY Asset Coach	1.0 FTE
Parent Partners	3.5 FTE

Peer Partners	2.0 FTE
Associate Medical Director	.5 FTE
Clinicians	6.0 FTE
Family Specialists (Behavior Coaches)	4.5 FTE
TBS Supervisor	1.0 FTE
TBS Coaches	1.3 FTE

1. Each FSP program shall have a 1.0 FTE program manager.

2. Psychiatry services shall be provided by a .5 FTE Associate Medical Director. The psychiatrist shall assist with diagnosis and assessment, and shall participate in Care Team meetings when needed.

3. The staff to enrollee ratio shall be 1:8 or better. Each enrollee shall have a case manager and clinician, and shall be assigned an assets coach and family specialist as needed.

4. Staff shall reflect the ethnic/cultural/linguistically diverse populations that are served by these programs and shall include staff who are Spanish speaking.

5. Contractor shall provide .5 FTE staff to provide Quality Assurance, Quality Improvement, and Utilization Management duties.

6. Staff proficiencies shall include:

    a. Dialectical Behavioral Therapy (DBT)
    b. Cognitive Behavioral Therapy CBT
    c. Family therapy
    d. Motivational interviewing skills
    e. Experience working with trauma
    f. Personality disorders
    g. Co-occurring disorders
    h. Eating disorders
    i. LGBTQ youth
    j. Early onset of psychosis

8. Each team will have specific expertise in working with their target age group population. Each team will be supervised by a single Program Director to assure consistent vision across both teams and collaboration between teams.

9. Parent and Peer Partners

a. The Parent Partner must have personal knowledge and experience as a caregiver for a special needs child.
b. The Peer Partner must have personal experience as a consumer of mental health services.

10. Staff Training

a. Contractor shall provide FSP staff fifty-two (52) hours of training in the first month of employment, including cultural competency training. Staff shall receive an additional sixty (60) hours of training, to include the following topics:

1) Care Team planning
2) Harm reduction
3) Asset mapping
4) Support care management
5) Principles and practices of wraparound
6) Project Cornerstone's 41Developmental Assets
7) Family conferencing

b. Contractor shall utilize updated SB163 Wrap Around Program training sessions developed for the original pilot shall to train staff. Family members and system of care staff shall be included at every session.

c. All FSP staff shall participate in BHRS system wide trainings covering:

1) cultural competence
2) sexual orientation and gender differences
3) consumer culture
4) co-occurring disorder assessment and treatment skills
5) cognitive behavioral approaches, including Trauma Focused CBT

11. Service Locations

Services shall be provided in enrollee homes and other community sites throughout the County. In addition Contractor shall maintain service sites at the following three locations or similarly situated locations:

- 957 Industrial Road, San Carlos
- 363 El Camino Real, South San Francisco
- Drop In Center - TBD

Service sites may be changed upon the approval of the Deputy Director of Child and Youth Services for BHRS.

I. Therapeutic Behavioral Services

Contractor shall provide Therapeutic Behavioral Services ("TBS") as authorized by County to clients eligible to receive these services, as defined in Paragraph I.B.10. Services shall be provided to clients as authorized.

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 person providing TBS is available on-site to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan. A necessary component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time. The expectation is that the staff person will be with the child/youth for a designated time period which may vary in length and may be up to twenty-four (24) hours a day, depending upon the needs of the child/youth. Services shall be available up to twenty-four (24) hours a day, seven (7) days a week as approved.

c. Two important components of delivering TBS are:
   1) Making collateral contacts with family members, caregivers, and others significant in the life of the beneficiary; and
   2) 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.

d. Contractor shall provide TBS approved by the BHRS Deputy Director of Child and Youth Services or designated TBS coordinator, to clients up to age twenty-one (21). These services shall be provided to full scope Medi-Cal beneficiaries.

e. 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.

f. TBS services are not reimbursable on days when Inpatient Services in an acute hospital or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

2. Eligibility Criteria

TBS services shall be offered in a manner that is compliant with requirements for Medi-Cal reimbursement. 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 1) and 2).
   1) Full-scope Medi-Cal beneficiary, under twenty-one (21) years, And
   2) Meets State medical necessity criteria for Medi-Cal Program.

b. Member of the Certified Class – must meet criteria 1), 2), 3), or 4).
   1) 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
   2) Child/youth is being considered by the county for placement in a facility described in b.1 above as one option (not necessarily the only option). Additionally, a child/youth meets the requirements when his or her behavior could result in placement in such a facility if the facility were actually available, regardless of whether the placement is available; or
   3) Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding twenty-four (24) months; or

4) Child/youth previously received TBS while a member of the certified class.

c. Need for TBS – must meet criteria 1) and 2).

1) The child/youth is receiving other specialty mental health services, and

2) It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:

a) 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

b) 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 are 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.)

3. TBS Assessment Process

Contractor will have up to thirty (30) days to complete a TBS Assessment. A TBS Assessment is the initial assessment and plan development of a child/youth referred for TBS services. A TBS Assessment, including functional analysis, and TBS Client Plan must be completed. This period at the beginning stage of TBS includes giving immediate assistance to the child/youth and parent/caregiver to relieve stress and avoid crisis, while gathering valuable information on the function and intensity of the behavior in the environment where it occurs. Detailed requirements and formats for TBS Assessments and TBS Client Plans are described below in Paragraph I.B.5 and I.B.6.

4. TBS Discharge Process

Contractor shall discuss termination of services with the primary therapist, child/youth, and family/caregivers prior to termination of services. During the thirty (30) days prior to termination of TBS, Contractor shall discuss the termination and its impact on the child/youth and family/caregivers with the primary therapist, child/youth, and family/caregivers. Contractor shall establish a setback prevention and response plan. Contractor shall complete a discharge summary documenting the discussion process with primary therapist, child/youth, and family/caregiver, the reason(s)/rationale for termination, and a transition plan that includes a setback prevention and response plan.

5. During both the assessment process and at time of discharge, Contractor shall complete a Level of Care Utilization Score (CALOCUS) in order to assess the clinical needs of client to determine the appropriate intensity of care and to provide outcome measurement data at the time of discharge.

6. TBS Utilization Request and Review Process

Contractor shall request payment for TBS from the County. Approval is required in advance of the provision of TBS included in the utilization request form. Services will be approved by the BHRS Deputy Director of Child and Youth Services or designated TBS coordinator.

a. Initial Utilization Request may not exceed ninety (90) days. The contractor must submit the following required elements at the time of the Initial Review:
    1) Initial TBS Assessment, which must address target symptom(s) or behavior(s), including a functional analysis;
    2) TBS Client Plan, which must include at least one (1) TBS intervention. The TBS Client Plan must meet the criteria as set forth in Paragraph I.B.6;
    3) Progress notes for each TBS service provided. Documentation requirements for progress notes are set forth in Paragraph I.B.7.

b. Ongoing Utilization Requests
    1) Ongoing utilization request may not exceed ninety (90) days.
    2) Continuation of services will be based upon a progress summary that includes clear documentation of:
        a) Client progress toward specific goals and timeframes of TBS Client Plan.

b) Provision of interventions to address specific goals and target behaviors.

c) Strategy to decrease intensity of services, initiate transition plan, and/or terminate services when TBS has promoted progress toward measurable outcomes identified in the TBS Client Plan; or client has reached plateau in benefit effectiveness.

d) If applicable, lack of client progress toward specific goals and timeframes in TBS Client Plan, and changes needed to address the issue(s). If the TBS being provided has been ineffective and client is not progressing toward identified goals, possible treatment alternatives, and the reason that only additionally requested TBS will be effective, and not identified alternative(s).

e) Significant changes, challenges, and or obstacles to client environment and progress.

f) Review and update of TBS Client Plan to address new target behaviors, interventions and outcomes as necessary and appropriate; and as necessary significant changes to client environment (e.g., change of residence).

g) Provision of skills / strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

4) Contractor must initiate Utilization Request no less than ten (10) days prior to the end of the approved service period.

c. Contractor shall complete a progress summary every ninety (90) days. Progress summaries must be reviewed by the TBS coordinator to ensure that TBS continues to be effective for the beneficiary in making progress towards the specified measurable outcomes.

d. Contractor shall monitor the number of hours and days TBS are provided, and shall be responsible for requesting continuation of services according to the timelines identified in Paragraph I.B.4.b.

e. Utilization Decision

1) For utilization decisions other than the expedited decisions described below in Paragraph I.B.4e.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.

2) 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 utilization 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 utilization request. 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.

3) The County shall notify the Contractor of any decision to deny a utilization request, or to approve a service in an amount, duration, or scope that is less than requested.

7. TBS Assessment

a. TBS Assessments must be done initially and are part of a separate process to determine the need for TBS. The TBS Assessment must be completed using a format provided and approved by the County. The TBS Assessment must identify that client:
   1) Meets medical necessity criteria,
   2) Is full scope Medi-Cal under twenty-one (21) years of age,
   3) Is a member of the certified class,
   4) Needs specialty mental health services in addition to TBS, and
   5) Has specific behaviors and/or symptoms that require TBS.

b. TBS Assessments must:

1) 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;
2) Describe the critical nature of the situation, severity of the clients' behaviors and/or symptoms, other less intensive services that have been tried and/or considered, and why TBS would be appropriate;
3) Provide sufficient clinical information to support the need for TBS;
4) 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
5) 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.

8. TBS Client Plan

a. TBS Services provided shall be specified in a written treatment plan using a format provided or approved by County (herein referred to as "TBS Client Plan"). TBS must be identified as an intervention on the overall Client Treatment and Recovery Plan. TBS is not a stand-alone service The TBS Client Plan shall include the following criteria:
1) Specific target behaviors or symptoms that jeopardize the current placement or present a barrier to transition to a lower level of care (e.g., tantrums, property destruction, assaultive behavior in school).
2) Specific interventions to resolve targeted behaviors or symptoms, such as anger management techniques.
3) Specific description of changes in behaviors and/or symptoms that interventions are intended to produce, including a time frame for those changes.
4) Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced with adaptive behaviors.
5) The TBS Client Plan shall be developed, signed and dated by the TBS staff member, and co-signed by the supervising mental health clinician.

b. The TBS Client Plan should be adjusted to identify new target behaviors, interventions and outcomes as necessary and appropriate; and reviewed and updated as necessary whenever there is a change in the child/youth's residence.

c. As TBS is a short-term service, each TBS Client Plan must include a transition plan from the inception of this service to decrease and/or discontinue TBS when no longer needed, or appear to have reached a plateau in benefit effectiveness.

d. When applicable, the TBS Client Plan must include a plan for transition to adult services when the beneficiary turns twenty-one (21) years old and is no longer eligible for TBS. The plan shall address assisting parents and/or caregivers with skills and strategies to provide continuity of care when this service is discontinued.

e. 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.

f. 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.

g. TBS Client Plan Addendum

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

1) Significant changes in the client's environment since the initial development of the TBS Client Plan.
2) When TBS has not been effective and the client is not making progress as expected there must be documented evidence in the chart and any additional information indicating the consideration of alternatives.

9. 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. Significant interventions identified in the Client Treatment Plan;

10. Strategies to Address Quality Improvement Including Increase Utilization
    a. Contractor shall participate with the County in the development and convening of two (2) annual meetings lasting a minimum of two (2) hours each to review the core minimum TBS data elements on access, utilization, and behavioral and institutional risk reduction. One (1) meeting will be a general forum open to the public and the other meeting will include designees of local authorities.
    b. Contractor shall summarize the meeting findings in a brief TBS report within thirty (30) days of each meeting.
    c. Contractor shall participate in outreach efforts to County mental health providers and local authorities/departments.
    d. Contractor shall participate in outreach efforts to County mental health providers and local authorities/departments.

11. Service Delivery and Staffing Requirements

    a. TBS must be provided by a licensed practitioner of the healing arts or by trained staff members who are under the direction of a licensed practitioner of the healing arts. The qualifications of organizational provider staff delivering this service will be determined by the MHP and may include non-licensed staff. The individuals providing this service must be available on-site to intervene with the child/youth as needed.

    b. Commensurate with scope of practice, TBS 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 and Family Therapist,
        5) Registered Nurse,
        6) Licensed Vocational Nurse,
        7) Licensed Psychiatric Technician,
        8) Occupational Therapist, or

9) Staff with other education/experience qualifications. The San Mateo County staffing guideline shall be for TBS staff to have a minimum of a Bachelor's Degree in a mental health related field. TBS workers 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.

c. TBS is not to supplant other mental health services provided by other mental health staff.

d. Direct TBS providers delivering services in group homes may not be counted in the group home staffing ratio.

e. Direct TBS providers delivering services 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.

f. Contractor must have contact with the parents or caregivers of the client. Contact must be with individuals identified as significant in the clients' life, and must be directly related to the needs, goals and interventions of the TBS client plan. These 'collateral TBS' must meet the requirements of Title 9, CCR, Sections 1810.206 and 1840.314.

J. Quality and Outcomes

Contractor shall provide quality assurance, quality improvement and utilization management services to ensure compliance with all federal, State and County requirements, including compliance with documentation requirements for Medi-Cal reimbursable services. Contractor shall monitor all FSP services provided to satisfaction of County.

II. Administrative Requirements

A. Paragraph 13 of the Agreement and Paragraph I.T.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 (18^{th}) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

B. Administering Satisfaction Surveys

Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

C. Cultural Competency

1. 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.

2. Contractor shall use good faith efforts to translate health-related materials in a culturally and linguistically appropriate manner, as needed. 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.

3. Contractor shall use good faith efforts to hire clinical staff members who can communicate with clients in a culturally and linguistically appropriate manner, and who reflect the cultural and ethnic diversity of the population served. 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 have translation services available for any language for which staff capacity is not available.

D. Contractor shall submit a copy of any licensing report issued by a licensing agency to County Mental Health Children and Youth Services Deputy Director within 5 business days of Contractor's receipt of any such licensing report.

E. Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement. Documentation shall be completed in compliance with the San Mateo County Mental Health Plan (BHRS) Documentation Manual, which is incorporated into this Agreement by reference herein.

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

G. 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.

H. Advance Directives

Contractors providing state funded health services may not employ any persons deemed an Ineligible Person by the California Department of Health Services (CDHS) 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 has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking: http://www.medi-cal.ca.gov/references.asp - Suspended & Ineligible Provider List.

I. Advance Directives

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

J. Beneficiary Rights

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

K. 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.

L. 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.

M. 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.

N. 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.

O. All enrollees/families will be assessed for insurance status and potential eligibility for third party coverage, and that assistance in obtaining coverage will be provided by the FSP team.

P. Developmental Assets

Contractor shall incorporate the Forty-One (41) Developmental Assets into program treatment goals, individual goals and family goals.

Q. Fingerprint Certification

At County's sole discretion, Contractor certifies that its employees and/or its subcontractors, assignees, and volunteers who, during the course of performing services under this Agreement, have contact with children, will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of children with whom Contractor's employees and/or its subcontractors, assignees, or volunteers have contact. If said employees and/or subcontractors, assignees, and volunteers have such a criminal history, they shall not have contact with children who receive services through this agreement. A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

III. GOALS AND OBJECTIVES / REPORTING

A. Program Objectives

1. C/Y FSP Services

a. Dropout rates will not exceed twenty percent (20%) of the total number of enrollees each year.

Data to be collected by Contractor.

b. Ninety percent (90%) of residents will verbalize that they are satisfied with the services and support received.

Data to be collected by Contractor.

2. TAY FSP Services

a. Dropout rates will not exceed twenty percent (20%) of the total number of enrollees each year.

Data to be collected by Contractor.

b. Ninety percent (90%) of enrollees will verbalize that they are satisfied with the services provided.

Data to be collected by County.

3. Hospitalization

Enrolled program clients shall reduce total days of psychiatric hospitalization by 70% in comparison to total days for 12 months prior to enrollment.

Data to be collected by Contractor.

4. Incarceration

Enrolled program clients shall reduce total days of incarceration by 70% in comparison to total days for 12 months prior to enrollment.

Data to be collected by Contractor.

5. Homelessness

Enrolled program clients shall reduce total days of homelessness by 70% in comparison to total days for 12 months prior to enrollment.

Data to be collected by Contractor.

6. Therapeutic Behavioral Services

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

Objective 1: At least 90% 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.

B. Reporting

1. MHSA

Contractor shall comply with all State Department of Mental Health ('DMH") reporting requirements for Mental Health Services Act Full Service Partnerships including collections using State instruments, maintenance according to State guidelines, and reporting using State processes. Data collected will include but are not to be limited to:

- Client satisfaction
- Residential status
- Medical/psychiatric hospitalization
- Incarceration
- Justice System Involvement / legal events
- Emergency Intervention
- Education
- Employment

- Benefits
- Conservatorship / Payee Status

Some of domains will be measured at intervals (e.g., at 3 months, 6 months, annually, or at other relevant time intervals). These indicators, methods and means of data capture shall be reported as determined by the DMH. Data shall be reported to the DMH per reporting requirements, and copied to County.

2. SB163

Contractor shall comply with all reporting requirements for SB163 including compliance with all State guidelines and reporting processes.

Edgewood Center
Full Service Partnership Services 2009-2012
Exhibit B

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

I. Payments

In full consideration of the services provided by Contractor and subject to the provisions of Paragraph 3. ("Payments") of this Agreement, County shall pay Contractor in the manner described below, except that any and all payments shall be subject to the conditions contained in this Agreement.

A. Notwithstanding the method of payment set forth herein, in no event shall County pay or be obligated to pay Contractor more than the sum of NINE MILLION TWO HUNDRED FIFTY-THREE THOUSAND FOUR HUNDRED SIXTY-FOUR DOLLARS ($9,253,464) for Full Service Partnership (FSP) services and Therapeutic Behavioral Services (TBS) provided under this Agreement for the period of July 1, 2009 through June 30, 2012.

B. In consideration of the services to be provided by Contractor, payment by County to Contractor shall be subject to the Cost Settlement process defined in Paragraph I.Q. of this Exhibit B.

C. Payment for the period of July 1, 2009 – June 30, 2010

Maximum payment for FSP services, Non-FSP Flexible Fund Administration services, and Therapeutic Behavioral Services for the period July 1, 2009 through June 30, 2010 shall not exceed THREE MILLION EIGHTY-FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($3,084,488).

1. Full Service Partnership Services

Total payment for Full Service Partnership Services, including Flexible Fund Payments for FSP enrollees and Drop In Center Services, for the period of July 1, 2009 through June 30, 2010, shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488). The total obligation of the County for payment for Contractor's actual costs for these services shall be determined through the cost settlement process, as defined in Paragraph I.Q. of this Exhibit B.

a. Maximum Payment Amount (“MPA”)

1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488) ("Maximum Payment Amount" or "MPA") for these services for the period of July 1, 2009 – June 30, 2010. The MPA is the sum of the MHSA funding allotted to this Agreement for this period, including operating costs, of TWO MILLION TWENTY-FOUR THOUSAND EIGHT HUNDRED FIFTEEN DOLLARS ($2,024,815) and the revenues expected to be generated by third-party billings for Contractor's services under this Agreement of SEVEN HUNDRED SEVENTY-NINE THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($779,673) ("Revenue Component"). County and Contractor agree that the Revenue Component of the MPA for the Third Year may be reduced if the revenues actually collected for Contractor's services under this Agreement during this period are less than the Revenue Component. These services shall be reported to County through the Monthly Reporting process as described in Paragraph I.I. of this Exhibit B. Revenue Component reduction, as described in the following Paragraph I.C.1.a.2) of this Exhibit B, shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.D.6. of Exhibit A.

2) In the event that the revenues collected for Contractor's services for the period of July 1, 2009 – June 30, 2010 are less than $779,673 (Revenue Component) and that difference is shown to have been generated by County's failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); or 3) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the MPA may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement for the period of July 1, 2009 – June 30, 2010. County shall notify Contractor of any MPA reduction for this period no later than January 31, 2010, using the best Revenue Component estimate available at that time.

b. Monthly Payments

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.F.2.b. of this Exhibit B, the monthly payments by County to Contractor for this period for these services shall be according to the following schedule:

Period	**Amount**
July	$ 233,707
August	233,707
September	233,707
October	233,707
November	233,707
December	233,707
January	233,707
February	233,707
March	233,708
April	233,708
May	233,708
June	233,708
Total	$2,804,488

2. Non-FSP Flexible Fund Administration

Contractor shall administer Flexible Funds for County clients who are not enrollees in the Full Service Partnership Program. Contractor shall receive THIRTY THOUSAND DOLLARS ($30,000) as an advance for Expenditures and Administrative Fees. At the end of the term of this Agreement any unexpended funds remaining with Contractor shall be returned to County except as provided below in Paragraph I.U. of this Exhibit B. Contractor shall be paid an administrative fee equivalent to fifteen percent (15%) of the total amount of funds administered. The maximum amount of funds administered and the maximum fee for those services for this period of the agreement are:

Flexible Fund expenditures		$26,087
Administration fee (15%)		3,913
	Total	$30,000

3. Therapeutic Behavioral Services (TBS)

For TBS services as described in Paragraph I.I. of Exhibit A Contractor shall be paid at a rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.H. of this Exhibit B.

a. Contractor shall be paid at the rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute up to a maximum of six (6) hours for the completion of the initial TBS Assessment as described in Paragraph I.I. of Exhibit A and development of the initial TBS Client Treatment Plan as described in Paragraph I.I.3. of Exhibit A. Such payment shall be exclusive of and separate from payment for all other TBS services as described in Paragraph I.I. of Exhibit A. County shall pay such rate less any third-party payments as set forth in Paragraph I.K. of this Exhibit B.

b. For the period of July 1, 2009 through June 30 2010, the maximum payment for Therapeutic Behavioral Services shall not exceed TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000).

c. 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 for TBS.

d. The billing unit for TBS is staff time, based on minutes.

e. 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.

f. County shall pay Contractor for TBS provided by Contractor during FY 2009-10 in the amount of the FY 2008-09 Short-Doyle Medi-Cal Maximum Reimbursement Rate (the "SMA") until the SMA rates for Fiscal Year 2009-10 are published. Once the SMA rates for FY 2009-10 are in effect, and upon both parties finalizing an amendment to this Agreement, Contractor will be paid at the FY 2009-10 SMA rate retroactively to the effective date of that rate. In no case shall the Contractor be paid at a rate in excess of the SMA rate.

D. Payment for the period of July 1, 2010 – June 30, 2011

Maximum payment for FSP services, Non-FSP Flexible Fund Administration services, and Therapeutic Behavioral Services for the period July 1, 2010 through June 30, 2011 shall not exceed THREE MILLION EIGHTY-FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($3,084,488).

1. Full Service Partnership Services

Total payment for Full Service Partnership Services, including Flexible Fund Payments for FSP enrollees and Drop In Center Services, for the period of July 1, 2010 through June 30, 2011, shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488). The total obligation of the County for payment for Contractor's actual costs for these services shall be determined through the cost settlement process, as defined in Paragraph I.Q. of this Exhibit B.

a. Maximum Payment Amount (“MPA”)

1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488) ("Maximum Payment Amount" or "MPA") for these services for the period of July 1, 2010 – June 30, 2011. The MPA is the sum of the MHSA funding allotted to this Agreement for this period, including operating costs, of TWO MILLION TWENTY-FOUR THOUSAND EIGHT HUNDRED FIFTEEN DOLLARS ($2,024,815) and the revenues expected to be generated by third-party billings for Contractor's services under this Agreement of SEVEN HUNDRED SEVENTY-NINE THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($779,673) ("Revenue Component"). County and Contractor agree that the Revenue Component of the MPA for the Third Year may be reduced if the revenues actually collected for Contractor's services under this Agreement during this period are less than the Revenue Component. These services shall be reported to County through the Monthly Reporting process as described in paragraph I.I. of this Exhibit B. Revenue Component reduction, as described in the following Paragraph I.D.1.a.2) of this Exhibit B, shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.D.6. of Exhibit A.

2) In the event that the revenues collected for Contractor's services for the period of July 1, 2010 – June 30, 2011 are less than $779,673 (Revenue Component) and that difference is shown to have been generated by County's failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); or 3) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the MPA may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement for the period of July 1, 2010 – June 30, 2011. County shall notify Contractor of any MPA reduction for this period no later than January 31, 2011, using the best Revenue Component estimate available at that time.

b. Monthly Payments

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.F.2.b. of this Exhibit B, the monthly payments by County to Contractor for this period for these services shall be according to the following schedule:

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June	233,708
Total	$2,804,488

2. Non-FSP Flexible Fund Administration

Contractor shall administer Flexible Funds for County clients who are not enrollees in the Full Service Partnership Program. Contractor shall receive THIRTY THOUSAND DOLLARS ($30,000) as an advance for Expenditures and Administrative Fees. At the end of the term of this Agreement any unexpended funds remaining with Contractor shall be returned to County except as provided below in Paragraph I.U. of this Exhibit B. Contractor shall be paid an administrative fee equivalent to fifteen percent (15%) of the total amount of funds administered. The maximum amount of funds administered and the maximum fee for those services for this period of the agreement are:

Flexible Fund expenditures		$26,087
Administration fee (15%)		3,913
	Total	$30,000

3. Therapeutic Behavioral Services (TBS)

a. For TBS services as described in Paragraph I.I. of Exhibit A Contractor shall be paid at a rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.H. of this Exhibit B.

b. Contractor shall be paid at the rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute up to a maximum of six (6) hours for the completion of the initial TBS Assessment as described in Paragraph I.I. of Exhibit A and development of the initial TBS Client Treatment Plan as described in Paragraph I.I.3. of Exhibit A. Such payment shall be exclusive of and separate from payment for all other TBS services as described in Paragraph I.I. of Exhibit A. County shall pay such rate less any third-party payments as set forth in Paragraph I.K. of this Exhibit B.

c. For the period of July 1, 2010 through June 30 2011, the maximum payment for Therapeutic Behavioral Services shall not exceed TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000).

d. 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 for TBS.

e. The billing unit for TBS is staff time, based on minutes.

f. 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.

g. County shall pay Contractor for TBS provided by Contractor during FY 2010-11 in the amount of the FY 2009-10 Short-Doyle Medi-Cal Maximum Reimbursement Rate (the "SMA") until the SMA rates for Fiscal Year 2010-11 are published. Once the SMA rates for FY 2010-11 are in effect, and upon both parties finalizing an amendment to this Agreement, Contractor will be paid at the FY 2010-11 SMA rate retroactively to the effective date of that rate. In no case shall the Contractor be paid at a rate in excess of the SMA rate.

E. Payment for the period of July 1, 2011 – June 30, 2012

Maximum payment for FSP services, Non-FSP Flexible Fund Administration services, and Therapeutic Behavioral Services for the period July 1, 2011 through June 30, 2012 shall not exceed THREE MILLION EIGHTY-FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($3,084,488).

1. Full Service Partnership Services

Total payment for Full Service Partnership Services, including Flexible Fund Payments for FSP enrollees and Drop In Center Services, for the period of July 1, 2011 through June 30, 2012, shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488). The total obligation of the County for payment for Contractor's actual costs for these services shall be determined through the cost settlement process, as defined in Paragraph I.Q. of this Exhibit B.

a. Maximum Payment Amount (“MPA”)

1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed TWO MILLION EIGHT HUNDRED FOUR THOUSAND FOUR HUNDRED EIGHTY-EIGHT DOLLARS ($2,804,488) ("Maximum Payment Amount" or "MPA") for these services for the period of July 1, 2011 – June 30, 2012. The MPA is the sum of the MHSA funding allotted to this Agreement for this period, including operating costs, of TWO MILLION TWENTY-FOUR THOUSAND EIGHT HUNDRED FIFTEEN DOLLARS ($2,024,815) and the revenues expected to be generated by third-party billings for Contractor's services under this Agreement of SEVEN HUNDRED SEVENTY-NINE THOUSAND SIX HUNDRED SEVENTY-THREE DOLLARS ($779,673) ("Revenue Component"). County and Contractor agree that the Revenue Component of the MPA for the Third Year may be reduced if the revenues actually collected for Contractor's services under this Agreement during this period are less than the Revenue Component. These services shall be reported to County through the Monthly Reporting process as described in paragraph I.I. of this Exhibit B. Revenue Component reduction, as described in the following Paragraph I.E.1.a.2) of this Exhibit B, shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph I.D.6. of Exhibit A.

2) In the event that the revenues collected for Contractor's services for the period of July 1, 2011 – June 30, 2012 are less than $779,673 (Revenue Component) and that difference is shown to have been generated by County's failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); or 3) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third Party Disallowances"), the MPA may be reduced by the amount of that difference. In determining the amount of such reduction, the Third Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement for the period of July 1, 2011 – June 30, 2012. County shall notify Contractor of any MPA reduction for this period no later than January 31, 2012, using the best Revenue Component estimate available at that time.

b. Monthly Payments

Unless otherwise authorized by the Chief of the Health System or designee, and/or as adjusted subject to Paragraph I.F.2.b. of this Exhibit B, the monthly payments by County to Contractor for this period for these services shall be according to the following schedule:

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Total	$2,804,488

2. Non-FSP Flexible Fund Administration

Contractor shall administer Flexible Funds for County clients who are not enrollees in the Full Service Partnership Program. Contractor shall receive THIRTY THOUSAND DOLLARS ($30,000) as an advance for Expenditures and Administrative Fees. At the end of the term of this Agreement any unexpended funds remaining with Contractor shall be returned to County except as provided below in Paragraph I.U. of this Exhibit B. Contractor shall be paid an administrative fee equivalent to fifteen percent (15%) of the total amount of funds administered. The maximum amount of funds administered and the maximum fee for those services for this period of the agreement are:

Flexible Fund expenditures		$26,087
Administration fee (15%)		3,913
	Total	$30,000

3. Therapeutic Behavioral Services (TBS)

a. For TBS services as described in Paragraph I.I. of Exhibit A Contractor shall be paid at a rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.H. of this Exhibit B.

b. Contractor shall be paid at the rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute up to a maximum of six (6) hours for the completion of the initial TBS Assessment as described in Paragraph I.I. of Exhibit A and development of the initial TBS Client Treatment Plan as described in Paragraph I.I.3. of Exhibit A. Such payment shall be exclusive of and separate from payment for all other TBS services as described in Paragraph I.I. of Exhibit A. County shall pay such rate less any third-party payments as set forth in Paragraph I.K. of this Exhibit B.

c. For the period of July 1, 2011 through June 30 2012, the maximum payment for Therapeutic Behavioral Services shall not exceed TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000).

d. 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 for TBS.

e. The billing unit for TBS is staff time, based on minutes.

f. 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.

g. County shall pay Contractor for TBS provided by Contractor during FY 2011-12 in the amount of the FY 2010-11 Short-Doyle Medi-Cal Maximum Reimbursement Rate (the "SMA") until the SMA rates for Fiscal Year 2011-12 are published. Once the SMA rates for FY 2011-12 are in effect, and upon both parties finalizing an amendment to this Agreement, Contractor will be paid at the FY 2011-12 SMA rate retroactively to the effective date for that rate. In no case shall the Contractor be paid at a rate in excess of the SMA rate.

F. Contractor's Budget

1. Contractor's annual Budget for these services for is incorporated into this agreement as Exhibit C. The allocation of funding for the C/Y and TAY FSPs shall be provided according to the Contractor's Budget.

2. Contractor shall be responsible for all expenses incurred during the performance of services rendered under this Agreement that are not included in Exhibit C.

G. Budget modifications may be approved by the Chief of the Health System or designee, subject to the maximum amount set forth in Paragraph 3.

H. The Chief of the Health System or designee is authorized to execute subsequent amendments and minor modifications not to exceed an aggregate of $25,000 and to make minor changes in the types of services and activities provided under the agreement.

I. Monthly Reporting and Invoices

Payment by County to Contractor shall be monthly. Contractor shall bill County monthly, no later than ten (10) days following close of each service month. The invoice shall include:

A summary of services and charges for the particular month of service. In addition contractor shall provide back-up to the invoice. Such back-up shall be in the form of:

1. County provided service reporting form(s) ("Service Reporting Form(s)") completed by Contractor according to the instructions accompanying the Service Reporting Form(s), or

2. 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 (hour/minute format).

3. County reserves the right to change the reporting forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary.

J. 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. Within ten (10) days of the end of each month, 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 services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph M. of this Exhibit B. 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, through the Cost Report reconciliation.

b. Contractor shall provide a copy of each 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 within ten (10) days of the end of the first month of the Agreement.

2. Option Two

a. Contractor shall provide information to County so that County may bill applicable/eligible other third-parties for services provided by Contractor through this Agreement. County shall retain these revenues and shall not offset these revenues against payments to Contractor.

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 within ten (10) days of the end of the first month of the Agreement.

K. Flexible Fund Reporting

Contractor shall provide reports specific to flexible fund expenditures as described below.

1. Non-FSP Program Flexible Funds

Contractor shall report flexible funds expenditures for clients who are not FSP enrollees using the following categories: after-school services, shadow services, respite care, family support, and recreation, and other categories added by Contractor, as appropriate. Reporting shall be quarterly.

In the event Contractor is specifically requested by BHRS Child/Youth Management staff to process a check on a "rush" basis, Contractor may charge County an additional FIFTEEN DOLLARS ($15.00) administrative fee per request. Such rush fee reimbursement shall not be included in the Expenditure figure upon which the Administrative Fee is calculated.

2. FSP Program Flexible Funds

Contractor shall report flexible funds expenditures for the purchase goods and services by using the following categories: after-school services, shadow services, respite care, family support, and recreation, and other categories added by Contractor, as appropriate. Reporting shall be provided quarterly. Reporting shall identify expenditures per individual enrollee and shall include separate reporting for enrollees who receive SB163 flexible funds and for enrollees who receive MHSA flexible funds.

3. County reserves the right to change the reporting forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary.

L. 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.

M. Contractor shall maintain all program fiscal records to maintain current and future requirements for MHSA funded FSP services as determined by the State DMH, and as requested by the County.

N. In the event this Agreement is terminated prior to June 30, 2009, the Contractor shall be paid for services already provided pursuant to this Agreement.

O. 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.

Funding for services provided to by County to Contractor through this agreement shall be subject to receipt of anticipated State funding by County. Should actual funding be less than the anticipated amount for any period of this Agreement, funding provided to Contractor may be reduced accordingly.

P. Contractor shall submit to County year-end Cost Reports no later than ninety (90) days after the end of each applicable fiscal year (June 30th). These reports shall be in accordance with the principles and format outlined in the Cost Reporting/Data Collection (CR/DC) Manual. These Cost Reports shall include accountings for all services provided through the agreement for the applicable period, and separate accountings for: 1) Full Service Partnership services; 2) Drop In Center services; 3) One-time Expenditures; 4) flexible funds, and; 5) non-FSP enrollee flexible funds administration. Contractor shall have its books of accounts audited annually by a Certified Public Accountant and a copy of said audit reports shall be submitted along with the Cost Reports.

Q. Cost Settlement

1. If the Contractor does not generate Medi-Cal reimbursable services to meet the annual targets established in Paragraphs I.C.1.a, I.D.1.a. and I.E.1.a. of this Exhibit B, then Contractor shall reimburse the difference between the target and the amount so generated in a single payment. Any such payment(s) shall incorporate any prior adjustment to the MPA made through the adjustment process described in those same paragraphs.

2. If the annual Cost Reports provided to County show that total payments to Contractor exceeds the total actual costs for services rendered by Contractor during the reporting period, following any payment made subject to Paragraph I.Q.1. of this Exhibit B above, a single payment in the amount of the contract savings shall be made to County by Contractor, unless otherwise authorized by the Chief of the Health System or designee.

3. Cost settlement for this purpose shall be conducted for each fiscal year, and shall take place no later 180 days past the end of the fiscal year.

4. Should Contractor provide fewer annual units than what are identified in Paragraph I.D.6. of Exhibit A, payment rates by County to Contractor may not exceed the State Maximum Allowance ("SMA"). In such case, the amount of the difference between the actual costs for services provided that exceed the SMA and the costs of those same number of units provided at the SMA shall be reimbursed by Contractor to the County in a single payment.

5. In any case, the total payments shall not exceed the total amounts for each area of service and each reporting period as established in this Exhibit B.

R. 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 BHRS.

S. 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. 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.

T. 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 _____, 20__

   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 EPSDT supplemental specialty mental health services included in the claim, all requirements for Contractor payment authorization for EPSDT supplemental specialty mental health services 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.

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 II.A. 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.

U. One-Time and Flex Funds Rollover

Contractor may rollover unspent one-time and flex funding only according to the following procedures. In the event this Agreement is renewed beyond the term of this Agreement, the Contractor may also rollover unspent funding to a subsequent agreement according to the following procedures. By mutual agreement of County and Contractor, contractual savings or "rollover" of Flexible Funds and One-Time Expenditures, as defined respectively in paragraphs I.C., I.D. and I.E. of this Exhibit B. may be retained by Contractor and expended the following year, provided that these funds are expended for mental health services and/or FSP Program-related services approved by County and are retained in accordance with the terms of this Paragraph I.U. No other funds provided through this agreement may be rolled over.

1. Contractor shall submit a summary calculation of any savings 90 days after end of the fiscal year. The summary calculation will be a separate report from the year-end cost report. With the summary calculation Contractor shall return the amount of the savings.

2. At the time of the submission of the summary calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the Director of BHRS or designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget. Savings shall not be spent until Contractor receives a written approval of the request. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved.

3. Contractor shall submit an accounting report of the rollover savings. This report shall include copies of the detailed expenses. The report is due 90 days after the specific purpose has been completed, or 90 days after the end of the fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

4. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, Contractor may request to rollover the unspent funds to the succeeding fiscal year by submitting a written request with the accounting report. The unspent rollover funds shall not be spent until the request is approved by the Director of BHRS or designee.

5. A final accounting of the rollover funds shall be submitted 90 days after the specific purpose has been completed, or 90 days after the end of the succeeding fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

V. County anticipates the receipt of revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, funding provided to the Contractor may be reduced accordingly.

	TP	TBS	TP	TBS	TP	TBS		
	Year 1	Year 1	Year 2	Year 2	Year 3	Year 3		
San Mateo County Behavioral Health and Recovery Services Budget Worksheet Yr. 1 Yr 2 Yr 3	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months		
	2009-2010	2009-2010	2010-2011	2010-2011	2011-2012	2011-2012	Total	
A. Expenditures								
1. Client, Family Member and Caregiver Support Expenditures								
a. Clothing, Food and Hygiene								
b. Travel and Transportation								
c. Housing (provide description in budget narrative)								
d. Employment and Education Supports (provide description in budget narrative)								
e. Other Support Expenditures (provide description in budget narrative)	76,781		76,781		76,781		230,343	
f. Total Support Expenditures	**76,781**		**76,781**		**76,781**		**230,343**	
2. Personnel Expenditures								
a. Current Existing Personnel Expenditures (if building on current programming)	1,418,373	130,434	1,418,373	130,434	1,418,373	130,434	4,646,422	
b. New Additional Personnel Expenditures								
c. Employee Benefits	354,593	32,609	354,593	32,609	354,593	32,609	1,161,606	
d. Total Personnel Expenditures	**1,772,966**	**163,043**	**1,772,966**	**163,043**	**1,772,966**	**163,043**	**5,808,028**	
3. Operating Expenditures								
a. Professional Services	2,010		2,010		2,010		6,030	
b. Translation and Interpreter Services								
c. Travel and Transportation	66,951	10,024	66,951	10,024	66,951	10,024	230,925	
d. General Office Expenditures	11,635	4,500	11,635	4,500	11,635	4,500	48,405	
e. Rent, Utilities and Equipment	257,462	25,476	257,462	25,476	257,462	25,476	848,814	
f. Medication and Medical Supports								
g. Other Operating Expenses (provide description in budget narrative)	37,671	14,348	37,671	14,348	37,671	14,348	156,058	
h. Total Operating Expenditures	**375,729**	**54,348**	**375,729**	**54,348**	**375,729**	**54,348**	**1,290,232**	
4. Indirect								
a. HR, Finance, Support, IT, Executive, Advocacy, Contracts	**365,803**	**32,609**	**365,803**	**32,609**	**365,803**	**32,609**	**1,195,235**	
5. Program Management								
a. Existing Program Management	170,567		170,567		170,567			
b. Employee Benefits	42,642		42,642		42,642			
c. Total Program Management	**213,209**		**213,209**		**213,209**		**639,626**	
6. Total Proposed Program Budget	**2,804,488**	**250,000**	**2,804,488**	**250,000**	**2,804,488**	**250,000**	**9,163,464**	
B. Revenues								
a. MHSA/CCS	2,024,815		2,024,815		2,024,815		6,074,445	
b. Medi-Cal (FFP only)	779,673	250,000	779,673	250,000	779,673	250,000	3,089,019	
c. Medicare/Patient Fees/Patient Insurance							9,163,464	
d. Realignment								
e. State General Funds								
f. County Funds								
g. Grants								
h. Other Revenue								
Total Revenues	**2,804,488**	**250,000**	**2,804,488**	**250,000**	**2,804,488**	**250,000**	**18,326,928**	

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 _____(agency name) elect option one.

_____ _____
Signature of authorized agent Name of authorized agent

_____
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?** □ Yes □ No **If no, Social Security Number (Required)**	**26.5 (AB3632)** □ Yes □ No IEP (SELPA) start date_____

Does Client have Medi-Cal? □ Yes □ No **Share of Cost?** □ Yes □ 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? □ Yes □ No **Client Referred to Medi-Cal?** □ Yes, give date: _____ □ No
Is this a Court-ordered Placement? □ Yes □ No
Does Client have Medicare? □ Yes □ 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 _____ □ Self

Address _____ City _____ State _____ Zip Code_____

□ **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 _____

Asset Amount (List all liquid assets)
A. Savings……..…….$_____
B. Checking…….…….$_____
C. Stocks……..$_____

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) $_____

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? □ Yes □ No
If Yes, complete San Mateo County Mental Health SED form.

Does this Client have Healthy Kids Insurance? □ Yes □ No
Does this Client have HealthWorx Insurance.? □ Yes □ 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

San Mateo County Mental Health Services Use Only

ENTERED BY	**CLIENT ACCOUNT #**	**DATA ENTRY DATE**

Rev 06/05

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

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 E

FINGERPRINTING CERTIFICATION

Contractor hereby certifies that Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement and who has/will have supervisory or disciplinary power over a child (Penal Code Section 11105.3) (the "Applicant") shall be fingerprinted in order to determine whether each such Applicant has a criminal history which would compromise the safety of children with whom each such Applicant has/will have contact.

Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement: (check a or b)

____ a. do NOT exercise supervisory or disciplinary power over children (Penal 11105.3).

____ b. do exercise supervisory or disciplinary power over a children (Penal 11105.3).

_____
Name of Contractor

_____
Signature of Authorized Official

_____
Name (please print)

_____
Title (please print)

_____
Date

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.

_____
Name of 504 Person - Type or Print

_____
Name of Contractor(s) - Type or Print

_____
Street Address or P.O. Box

_____
City, State, Zip Code

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

_____
Signature

_____
Title of Authorized Official

_____
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."