

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

THIS AMENDMENT TO THE 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, the parties entered into an Agreement for comprehensive Full Service Partnership services on September 29, 2009; and

WHEREAS, the parties wish to amend the Agreement to add the provision of integrated FSP services.

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

1. Paragraph 3 Payments of the Agreement is amended to read as follows:

In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "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 TWELVE MILLION THREE HUNDRED NINETY-SIX THOUSAND ONE HUNDRED FORTY-EIGHT DOLLARS (\$12,396,148).

2. The original Exhibit A is replaced with Revised Exhibit A attached hereto.
3. The original Exhibit B is replaced with Revised Exhibit B attached hereto.
4. Exhibit C1 - Contractors Budget - (Integrated FSP Svc. – FY 2009-12) supplements original Exhibit C and is attached hereto.

5. All other terms and conditions of the agreement dated September 29, 2009, between the County and Contractor shall remain in full force and effect.

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

COUNTY OF SAN MATEO

By: _____
President, Board of Supervisors

Date: _____

ATTEST:

By: _____
Clerk of the Board of Supervisors

Date: _____

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES.

Contractor's Signature

Date: _____

Edgewood Center For Children and Families
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 comprehensive and integrated 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:

a. Outreach and engagement strategies designed to reach identified diverse communities and to engage them in services.

- b. 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.
- c. Team members shall be trained in culturally competent practices. Services shall be delivered by bilingual, culturally competent staff.
- d. 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:

- a. 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.
 - b. 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.
 - c. SED and dually diagnosed homeless C/Y/TAY and C/Y/TAY exiting school based, IEP driven services.
 - d. 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.
 - e. 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. Comprehensive 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 serve forty (40) clients. 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. Twenty-four (24) hour, seven (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 (clinical 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 / TAY enrollee and family of the enrollee’s needs. The Wrap Plan timeline shall be as follows:

Timeframe	Action
Intake	Preliminary Safety Plan, Consents & Release of Information
Within thirty (30) days	Strength and Needs Assessment completed
Within sixty (60) days	Wrap Plan and Discharge Plan are implemented
As needed	Wrap Plan is reviewed and updated
Within ninety (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	
	<u>C/Y Program</u>	561,600
	Units of service	
	<u>TAY FSP Program</u>	561,600
	Units of service	
	Total	1,123,200

b.	July 1, 2010 – June 30, 2011	
	<u>C/Y Program</u>	561,600
	Units of Service	
	<u>TAY FSP Program</u>	561,600
	Units of Service	
	Total	1,123,200
c.	July 1, 2011 – June 30, 2012	
	<u>C/Y Program</u>	561,600
	Units of Service	
	<u>TAY FSP Program</u>	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 twenty-four (24) hours per day, seven (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 clinical 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. 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

j. Staffing – Comprehensive FSP Services

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	0.5 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 0.5 FTE Associate Medical Director. The psychiatrist shall assist with diagnosis and assessment, and shall participate in Care Team meeting 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 0.5 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

- 7) 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.

- 8) 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.

- 9) Staff Training - comprehensive FSP employees
 - 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:
 - i) Care Team planning
 - ii) Harm reduction
 - iii) Asset mapping
 - iv) Support case management
 - v) Principles and practices of wraparound
 - vi) Project Cornerstone's 41 Developmental Assets
 - vii) Family conferencing

- b) Contractor shall utilize updated SB163 Wrap Around Program training sessions developed for the original pilot to train staff. Family members and system of care staff shall be included at every session.
- c) All comprehensive FSP staff shall participate in BHRS system wide trainings covering:
 - i) Cultural competence
 - ii) Sexual orientation and gender differences
 - iii) Consumer culture
 - iv) Co-occurring disorder assessment and treatment skills
 - v) Cognitive behavioral approaches, including Trauma Focused CBT

10. 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:

- a. 957 Industrial Road, San Carlos
- b. 363 El Camino Real, South San Francisco
- c. Drop in Center(s) – San Bruno and denovo location in San Carlos

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

11. Drop In Center Services – Comprehensive FSP Services – primarily San Bruno

- a. 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 include in their treatment plans.

- b. 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 the 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.
- c. 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.
- d. Drop In Center services shall include, but not be limited to:
 - 1) Self help supports
 - 2) Recreational and social activities
 - 3) Group lunches and dinners
 - 4) Legal clinic
 - 5) Health clinic
 - 6) Assistance with domestic violence issues
 - 7) Co-occurring disorder self-help groups
 - 8) Living skills classes
 - 9) Gender-based groups
 - 10) Support for those seeking to enter the college system
 - 11) Peer support
 - 12) Other supports identified as needed by those using the Center, in order to enhance client ability to manage independence
 - 13) Warm line services
 - 14) Support groups for lesbian / gay/ bisexual / transgender / questioning (LGBTQ) SED youth
- e. Services will be available to TAY enrollees on a drop-in basis, and for C/Y enrollees if part of the enrollee care plan
- f. Staff from the FSP team will offer onsite services
- g. The Drop In Center shall be located in a community location near bus routes
- h. The San Bruno Drop In Center will be staffed by 3.0 FTE peer support staff and volunteers who mirror the target population

12. Admission and Discharge – Comprehensive FSP Services
 - a. The County Youth Case Management Unit will manage the overall referral and authorization process in collaboration with the review / authorization committees.
 - b. Services shall be provided for unserved and underserved populations.
 - 1) Unserved 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 thirty (30) SB163 slots and the ten (10) MHSA slots. The FSP team will adhere to all current SB163 enrollment and disenrollment protocols.
 - 2) 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.
 - c. Referrals to the FSP teams will come from probation officers, child welfare social workers, and mental health professionals.
 - d. 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.

- e. Contractor may not refuse to enroll clients who have 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.
- f. If an enrollee requires residential placement, the case manager will contact the BHRS Youth case Management Unit for consultation on how to proceed.
- g. BHRS will develop disenrollment procedures for enrollees who chose 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 with two (2) working days.

E. Integrated Full Service Partnership Services

Integrated FSP services is a family-focused, strengths-based wraparound and crisis response service tailored to meet the specific mental health, educational, social and cultural needs of youth as well as their parents/caregivers and siblings. The Integrated FSP Program: shall support, augment and extend the clinical work and existing treatment plan within: 1) the outpatient and TDS programs, and 2) clients who are currently being served by BHRS in a Regional county clinic requiring an array of services to remain in their communities. This program is designed to serve these youth and will provide the foundation for a step-down system as well as preventing other youth from needing higher level mental health services. A second Drop-In Center modeled on the Drop-In Center for TAY in San Bruno will be opened for C/Y at the San Carlos space.

1. Program Capacity

- a. The Integrated FSP program will meet the needs of twenty (20) SED C/Y and TAY who are enrolled in, or at-risk of placement in an intensive school-based program. These services will begin on March 1, 2010.
- b. The Integrated FSP program shall also meet the needs of twenty (20) SED C/Y and TAY who are currently being served in Regional County clinics and are at-risk of out-of-home placement. These services will begin on March 1, 2010.

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 system; affirm and support self-reliance strategies; prevent relapse; and leadership training
 - d. Phase IV (Constancy) – Individualized aftercare planning to promote stability and permanence.

3. Integrated FSP teams shall operate under policies and procedures that ensure:
 - a. Twenty-four (24) hour, seven (7) day a week availability of program staff, including access to medication support services
 - 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. Integrated FSP teams shall be responsible for delivery of services and service outcomes. Integrated FSP staff shall provide the services identified in the individualized enrollee care plan (Care Plan). Some integrated C/Y enrollees and family members will continue to receive other services in the MH system (E.g. County/TDS, clinic medication services). The Integrated FSP team will work in collaboration with the other County staff and contract providers to assure implementation of each enrollee's Care Plan.

5. Initiation of Services

No later than five (5) days following authorization by County a member of the Integrated FSP team shall meet with the C/Y SED 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 Integrated FSP team, other system providers and the C/Y / SED / TAY enrollee and family.

Within each team, a personal services coordinator (Clinical 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 five (5) life domains: 1) support/self efficiency, 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 / SED / TAY enrollee and family’s needs. The Wrap timeline shall be as follows:

Timeframe	Action
Intake	Initial Safety Plan is developed
Within thirty (30) days	Strength and Needs Assessment completed. First Family Conference held to develop strategies to meet the needs
At least quarterly, but often as needed	Wrap Plan will be reviewed and as updated.
Within sixty (60) days	Wrap Plan is reviewed to see if there are unmet needs.

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. March 1, 2010—June 30, 2010	
Integrated FSP Program	
Units of Service	
Integrated FSP Program	187,200
Total	187,200
b. July 1, 2010—June 30, 2011	
Integrated FSP Program	
Units of Service	
Integrated FSP Program	561,600
Total	561,600

c.	July 1, 2011—June 30, 2012	
	Integrated FSP Program	
	Units of Service	
	Integrated FSP Program	<u>561,600</u>
	Total	561,600

7. Clinical Services for Integrated FSP's

The Clinical Services noted in Section D.7 of this Exhibit A will be available to enrollees of the Integrated FSP Programs as needed. Clinical services for these enrollees will be primarily provided by the County. In situations where enrollees receiving service at clinic-based FSP's in the Region require therapy services, these services will be secured on an as needed basis.

8. Non-Clinical Services for Integrated FSP's

a. Centralized intake

b. Outreach and Engagement

1) Client engagement and outreach

Contractor shall actively participate 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 and 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 - all FSP Programs

The FSP teams shall utilize to flexible 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 and for C/Y enrollees.
10. Services specific to Integrated TAY FSP enrollees.

The range of services noted in D.9 a. - i. of this Exhibit A. are also provided to Integrated TAY FSP enrollees effective March 1, 2010 through June 30, 2012. Housing services as described in D.9.d. and D.9.g. for specific TAY enrollees shall be provided subject to mutual approval of BHRS Deputy Director of Child and Youth Services and Contractor.

F. Drop In Center Services – Integrated FSP enrollees – San Carlos.

1. The focus of the Drop In Center is to provide safe locations for C/Y 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 primarily aimed at C/Y FSP enrollees.

C/Y who are currently receiving County mental health services or identified as needing engagement in MH services included in their treatment plans are also eligible.

2. The Drop In Center will serve enrollees in the integrated FSP C/Y programs 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 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
5. Services will be available to all FSP enrollees on a drop-in basis but particularly for integrated C/Y FSP enrollees if part of the enrollee care plan.
 6. Staff from the FSP team will offer onsite services.
 7. The Drop In Center shall be located in a community location near bus routes.
 8. The San Carlos Drop In Center will be staffed by two (2.0) FTE peer support staff and volunteers who mirror the target population.
- G. Admission and Discharge – Integrated FSP program.
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 the thirty (30) SB163 slots and ten (10) MHSA slots. Of those, twenty (20) slots shall be for SED C/Y and TAY who are enrolled in, or at-risk of placement in an intensive school-based program, and twenty (20) slots shall be for SED C/Y and TAY who are currently being served in a Regional County clinic and at-risk of out-of-home placement. The comprehensive and integrated FSP teams will adhere to all current SB163 enrollment and disenrollment protocols.
 - b. Under-served populations include integrated FSP C/Y currently engaged in community based services, but at risk of out of home placement without additional intensive services. Integrated 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 Integrated 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 appropriate FSP Clinical Case Manager 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 appropriate FSP team, following the team assessment and planning process, the appropriate FSP Clinical 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 for Integrated FSP programs

Program staff for the Integrated TDS and Integrated clinic-based FSP programs shall include the following:

Manager/Supervisor	1.0 FTE
Clinical/Case Managers (2/2)	4.0 FTE
Family Specialists	4.0 FTE
Family Partners	3.0 FTE
Asset Coach/Peer Ptnrs (1/1)	2.0 FTE
TBS Coach	2.0 FTE
Transportation	1.0 FTE
Administrative Support	0.5 FTE

The total FTE staff count for both the integrated TDS and Integrated clinic-based FSP programs will amount to seventeen and one-half (17.5).

All Upper management and Family Conferencing facilitation will be provided under the Comprehensive contract.

1. Psychiatry services for Integrated TDS enrollees may be provided by a one-half (.5) FTE Associate Medical Director of the Comprehensive FSP Program. As provided, such services will include assistance with diagnosis and assessment, and participation in Care Team meetings when needed.
2. Therapy Services for enrollees of the Integrated clinic-based FSP program will be provided as needed.
3. The staff to enrollee ratio shall be 1:8 or better. Each enrollee shall have a Clinical Case Manager 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 one-half (.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
7. Each team will have specific expertise in working with their target age group population. Each team will be supervised by a Program Manager to assure consistent vision across both teams and collaboration between teams.
8. 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.
9. Staff Training – Integrated FSP employees
 - a. Contractor shall provide integrated 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 integrated 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

10. 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:

- a. 957 Industrial Road, San Carlos
- b. 363 El Camino Real, South San Francisco
- c. Drop In Center(s) San Bruno and denovo location in San Carlos

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

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 Behavior Services (“TBS”) are one to one therapeutic contracts 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. of this Exhibit A.
- 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 eighteen (18) and twenty-one (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.

K. 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.

L. 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.

II. Administrative Requirements

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

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 BHRS Deputy Director of Child and Youth Services within five (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. 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 ninety (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 seventy percent (70%) in comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

4. Incarceration

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

Data to be collected by Contractor.

5. Homelessness

Enrolled program clients shall reduce total days of homelessness by seventy percent (70%) in comparison to total days for twelve (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 ninety (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:

- a. Client satisfaction
- b. Residential status
- c. Medical/psychiatric hospitalization
- d. Incarceration
- e. Justice System Involvement / legal events
- f. Emergency Intervention
- g. Education
- h. Employment
- i. Benefits
- j. Conservatorship / Payee Status

Some of domains will be measured at intervals {e.g., at three (3) months, six (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 For Children and Families
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 TWELVE MILLION THREE HUNDRED NINETY-SIX THOUSAND ONE HUNDRED FORTY-EIGHT DOLLARS (\$12,396,148) for Full Service Partnership (FSP) services including an Integrated Full Service Partnership Services and Therapeutic Behavioral Services (TBS) provided under this Agreement for the period of July 1, 2009 through June 30, 2012.

The maximum obligation identified in I.A of this Exhibit B includes a separate one time payment for start up funds for the Integrated FSP Services Program. These start up funds are to be utilized for various expenses that include but are not limited to the purchase of computers, network and client database upgrades, hiring staff and Drop-In Center equipment and furnishings, and other costs incurred for HR, Finance, Support, IT, Executive, Advocacy, and contracts.

The separate one time payment of start up funds for Integrated FSP Services Program will be ONE HUNDRED TWENTY ONE THOUSAND EIGHT HUNDRED EIGHTY-EIGHT DOLLARS (\$121,888). These funds shall be paid during the first week of February, 2009 month of this Agreement.

- 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.S. of this Exhibit B.
- C. Payment for the period of July 1, 2009 – June 30, 2010

Maximum payment for comprehensive and integrated FSP services including an Integrated Services Individual Support Program, 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 SIX HUNDRED THIRTY FOUR THOUSAND TWO HUNDRED THIRTY-TWO DOLLARS (\$3,634,232).

1. Comprehensive Full Service Partnership Services

Total payment for comprehensive 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.S. of this Exhibit B.

a. Maximum Payment Amount ("MPA") for comprehensive FSP Services

- 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 for the second (2nd) 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 BHRIS 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.V. 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.J. 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.J. 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.
4. Integrated Full Service Partnership (FSP) Services
- a. Maximum Payment Amount ("MPA") for Integrated FSP Services

- 1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed FOUR HUNDRED TWENTY-SEVEN THOUSAND EIGHT HUNDRED FIFTY-SIX DOLLARS (\$427,856) ("Maximum Payment Amount" or "MPA") for these services for the period of February 1, 2009 – June 30, 2010. The MPA is the sum of the MHSA (\$86,006) and other funding (\$252,000) allotted to this Agreement for this period, including operating costs, of THREE HUNDRED THIRTY-EIGHT THOUSAND SIX DOLLARS (\$338,006) and the revenues expected to be generated by third-party billings for Contractor's services for this period of the Agreement amounting to EIGHTY-NINE THOUSAND EIGHT HUNDRED FIFTY DOLLARS (\$89,850). County and Contractor agree that the Revenue Component for the second (2nd) 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.4.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 February 1, 2010 – June 30, 2010 are less than \$89,850 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 February 1, 2010 – June 30, 2010. County shall notify Contractor of any MPA reduction for this period no later than April 30, 2010, using the best Revenue Component estimate available at that time.

b. A separate one time payment of start up funds for the Integrated FSP Services Program will be ONE HUNDRED TWENTY-ONE THOUSAND EIGHT HUNDRED EIGHT-EIGHT DOLLARS (\$121,888). These funds shall be paid during the first week of February, 2010, upon receipt of invoice.

c. Monthly Payments

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

Period	Amount
March	\$ 106,964
April	\$ 106,964
May	\$ 106,964
June	\$ 106,964
Total	\$ 427,856

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

Maximum payment for comprehensive and integrated 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 FOUR MILLION THREE HUNDRED EIGHTY THOUSAND NINE HUNDRED FIFTY-EIGHT DOLLARS (\$4,380,958).

1. Comprehensive 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.S. 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" 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.4.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.G. 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.V. 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.J. 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.J. 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.
4. Integrated Full Service Partnership Services
- a. Maximum Payment Amount ("MPA") for Integrated FSP Services
 - 1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed ONE MILLION TWO HUNDRED NINETY-SIX THOUSAND FOUR HUNDRED SEVENTY DOLLARS (\$1,296,470) ("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 (\$268,211) and other funding (\$756,000) allotted to this Agreement for this period, including operating costs, of ONE MILLION TWENTY-FOUR THOUSAND TWO HUNDRED ELEVEN DOLLARS (\$1,024,211) and the revenues expected to be generated by third-party billings for Contractor's services under this Agreement of TWO HUNDRED SEVENTY-TWO THOUSAND TWO HUNDRED FIFTY-NINE DOLLARS (\$272,259). County and Contractor agree that the Revenue Component for the third (3rd) 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.4.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 \$272,259 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.G. 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	\$ 108,039
August	\$ 108,039
September	\$ 108,039
October	\$ 108,039
November	\$ 108,039

December	\$ 108,039
January	\$ 108,039
February	\$ 108,039
March	\$ 108,039
April	\$ 108,039
May	\$ 108,039
June	\$ 108,041
Total	\$1,296,470

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

Maximum payment for comprehensive and integrated 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 FOUR MILLION THREE HUNDRED EIGHTY THOUSAND NINE HUNDRED FIFTY-EIGHT DOLLARS (\$4,380,958)

1. Comprehensive Full Service Partnership Services

Total payment for comprehensive 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.S. 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.4.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.G 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.V. 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.J. 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.J. 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.
4. Integrated Full Service Partnership Services
- a. Maximum Payment Amount ("MPA" for Integrated FSP Services

- 1) The total obligation of the County for payment for Contractor's actual costs for these services shall not exceed ONE MILLION TWO HUNDRED NINETY-SIX THOUSAND FOUR HUNDRED SEVENTY DOLLARS (\$1,296,470) ("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 (\$268,211) and other funding (\$756,000) allotted to this Agreement for this period, including operating costs, of ONE MILLION TWENTY-FOUR THOUSAND TWO HUNDRED ELEVEN DOLLARS (\$1,024,211) and the revenues expected to be generated by third-party billings for Contractor's services under this Agreement of TWO HUNDRED SEVENTY TWO THOUSAND TWO HUNDRED FIFTY-NINE DOLLARS (\$272,259). 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.4.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 \$272,259 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.G 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	\$108,039
August	\$108,039
September	\$108,039
October	\$108,039
November	\$108,039
December	\$108,039
January	\$108,039
February	\$108,039
March	\$108,039
April	\$108,039
May	\$108,039
June	\$108,041
Total	\$1,296,470

F. Contractor's Budget

1. Contractor's annual Budget for these services is incorporated into this agreement as Exhibits C and C1. The allocation of funding for the comprehensive and integrated 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

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 (1st) 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 (1st) 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. 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.

M. 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.

N. 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.

- 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.
- P. 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.
- Q. In the event this Agreement is terminated prior to June 30, 2012, the Contractor shall be paid for services already provided pursuant to this Agreement.
- R. 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.
- S. 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.S.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 one hundred eighty (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.

T. 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.

U. 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 (3) 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.

V. 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.V. No other funds provided through this agreement may be rolled over.

- 1. Contractor shall submit a summary calculation of any savings ninety (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 ninety (90) days after the specific purpose has been completed, or ninety (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 ninety (90) days after the specific purpose has been completed, or ninety (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.

Exhibit C1 - Contractor's Budget Amendment
 Integrated Full Service Partnership Services Program
 FY 2009-12

Integrated Full Service Partnership Services

	Year 1 Feb Start-Up 2009-2010	Year 1 Mar-Jun 2009-2010	Year 2 12 Months 2010-2011	Year 3 12 Months 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)	-	13,336	40,008	40,008	93,352
f. Total Support Expenditures	-	13,336	40,008	40,008	93,352
2. Personnel Expenditures					
a. Current Existing Personnel Expenditures (if building on current programming)	-	-	-	-	-
b. New Additional Personnel Expenditures	30,726	235,082	717,725	717,725	1,701,258
c. Employee Benefits	7,682	58,771	179,431	179,431	425,315
d. Total Personnel Expenditures	38,408	293,853	897,156	897,156	2,126,573
3. Operating Expenditures					
a. Professional Services	-	800	1,600	1,600	4,000
b. Translation and Interpreter Services	-	667	2,000	2,000	4,667
c. Travel and Transportation	-	11,200	33,600	33,600	78,400
d. General Office Expenditures	300	1,200	3,600	3,600	8,700
e. Rent, Utilities and Equipment	10,378	41,511	124,532	124,532	300,952
f. Medication and Medical Supports	-	-	-	-	-
g. Other Operating Expenses (provide description in budget narrative)	55,990	6,275	15,150	15,150	92,565
h. Total Operating Expenditures	66,668	61,652	180,482	180,482	489,284
4. Indirect					
a. HR, Finance, Support, IT, Executive, Advocacy, Contracts	16,812	59,015	178,824	178,824	433,475
5. Program Management					
a. Existing Program Management	-	-	-	-	-
b. New Program Management	-	-	-	-	-
c. Total Program Management	-	-	-	-	-
6. Total Proposed Program Budget					
	121,888	427,856	1,296,470	1,296,470	3,142,684

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

Edgewood Center For Children and Families

Name of Contractor(s) - Type or Print
1801 Vincente Street

Street Address or P.O. Box
San Francisco, California 94116

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."

**County of San Mateo
Contractor's Declaration Form**

I. CONTRACTOR INFORMATION

Contractor Name:	Edgewood Center for Children & Families	Phone:	1-(415)-681-3211
Contact Person:	Nancy Rubin / Ken Epstein	Fax:	1-(415)-681-1065
Address:	1801 Vicente Street San Francisco, CA 94116		

II. EQUAL BENEFITS (check one or more boxes)

Contractors with contracts in excess of \$5,000 must treat spouses and domestic partners equally as to employee benefits.

- Contractor complies with the County's Equal Benefits Ordinance by:
 - offering equal benefits to employees with spouses and employees with domestic partners.
 - offering a cash equivalent payment to eligible employees in lieu of equal benefits.
- Contractor does not comply with the County's Equal Benefits Ordinance.
- Contractor is exempt from this requirement because:
 - Contractor has no employees, does not provide benefits to employees' spouses, or the contract is for \$5,000 or less.
 - Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to offer equal benefits when said agreement expires.

III. NON-DISCRIMINATION (check appropriate box)

- Finding(s) of discrimination have been issued against Contractor within the past year by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. Please see attached sheet of paper explaining the outcome(s) or remedy for the discrimination.
- No finding of discrimination has been issued in the past year against the Contractor by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other entity.

IV. EMPLOYEE JURY SERVICE (check one or more boxes)

Contractors with original or amended contracts in excess of \$100,000 must have and adhere to a written policy that provides its employees living in San Mateo County up to five days regular pay for actual jury service in the County.

- Contractor complies with the County's Employee Jury Service Ordinance.
- Contractor does not comply with the County's Employee Jury Service Ordinance.
- Contractor is exempt from this requirement because:
 - the contract is for \$100,000 or less.
 - Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to comply when the collective bargaining agreement expires.

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

Signature

Name

Date

Title