AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND REBEKAH CHILDREN'S SERVICES

THIS AGREEMENT, entered into this _____ day of _____ ,

20_____, by and between the COUNTY OF SAN MATEO, hereinafter called

"County," and REBEKAH CHILDREN'S SERVICES, hereinafter called "Contractor";

W I T N E S S E T H:

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

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

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

1. Exhibits and Attachments

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

Exhibit A—Services
Exhibit B—Payments and rates
Attachment C—Election of Third Party Billing Process
Attachment D—Payor Financial Form
Attachment E—Fingerprinting Certification
Attachment I—§504 Compliance

2. Services to be performed by Contractor

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

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed ONE HUNDRED SIXTEEN THOUSAND EIGHT HUNDRED FIFTY-EIGHT DOLLARS ($116,858).

4. Term and Termination

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2010 through June 30, 2011.

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

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

5. Availability of Funds

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

6. Relationship of Parties

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

7. Hold Harmless

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

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

8. Assignability and Subcontracting

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

9. Insurance

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

(1) **Worker's Compensation and Employer's Liability Insurance** The Contractor shall have in effect during the entire life of this Agreement Workers' Compensation and Employer's Liability Insurance providing full statutory coverage. In signing this Agreement, the Contractor certifies, as required by Section 1861 of the California Labor Code, that it is aware of the provisions of Section 3700 of the California Labor Code which requires every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions of the Code, and I will comply with such provisions before commencing the performance of the work of this Agreement.

(2) **Liability Insurance** The Contractor shall take out and maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Liability Insurance as shall protect him/her while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from contractors operations under this Agreement, whether such operations be by himself/herself or by any sub-contractor or by anyone directly or indirectly employed by either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall be not less than the amount specified below.

Such insurance shall include:

(a) Comprehensive General Liability $1,000,000

(b) Motor Vehicle Liability Insurance $1,000,000
(c) Professional Liability $1,000,000

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

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

10. Compliance with laws; payment of Permits/Licenses

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, including, but not limited to, Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended, and the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, as amended and attached hereto and incorporated by reference herein as Attachment "I," which prohibits discrimination on the basis of handicap in programs and activities receiving any Federal or County financial assistance. Such services shall also be performed in accordance with all applicable ordinances and regulations, including, but not limited to, appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. Further, Contractor certifies that the Contractor and all of its subcontractors will adhere to all applicable provisions of Chapter 4.106 of the San Mateo County Ordinance Code, which regulates the use of disposable food service ware.

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

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

11. Non-Discrimination and Other Requirements

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

B. General non-discrimination. No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this Agreement.

C. Equal employment opportunity. Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County of San Mateo upon request.

D. Violation of Non-discrimination provisions. Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to

   i) termination of this Agreement;
   ii) disqualification of the Contractor from bidding on or being awarded a County contract for a period of up to 3 years;
   iii) liquidated damages of $2,500 per violation;
   iv) imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

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

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

E. Compliance with Equal Benefits Ordinance. With respect to the provision of employee benefits, Contractor shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits

between an employee with a domestic partner and an employee with a spouse.

F. The Contractor shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

12. Compliance with Contractor Employee Jury Service Ordinance

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

13. Retention of Records, Right to Monitor and Audit

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

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

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

14. Merger Clause

This Agreement, including the Exhibits attached hereto and incorporated herein by reference, constitutes the sole Agreement of the parties hereto and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement or specification set forth in this body of the agreement conflicts with or is inconsistent with any term, condition, provision, requirement or specification in any exhibit and/or attachment to this agreement, the provisions of this body of the agreement shall prevail. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications shall be in writing and signed by the parties.

15. Controlling Law and Venue

The validity of this Agreement and of its terms or provisions, as well as the rights and duties of the parties hereunder, the interpretation, and performance of this Agreement shall be governed by the laws of the State of California. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or the United States District Court for the Northern District of California.

16. Notices

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

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

In the case of Contractor, to:
Rebekah Children's Services
290 100F Avenue
Gilroy, CA 95020

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

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

COUNTY OF SAN MATEO

By:_____
Richard S. Gordon
President, Board of Supervisors

Date:_____

ATTEST:

By:_____
Clerk of Said Board

REBEKAH CHILDREN'S SERVICES

_____

Contractor's Signature

Date:_____

REBEKAH CHILDREN'S SERVICES
EXHIBIT "A"
FY 2010 – 2011

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

In full consideration of the payments herein provided for, Contractor shall provide Youth Day Treatment Services (Day Treatment Intensive and Day Rehabilitation), Medication Support services, Crisis Intervention, Mental Health services, and Therapeutic Behavioral Services authorized by the San Mateo County Behavioral Health & Recovery Services Division (BHRS), and as meet medical necessity. These services shall be provided in manner prescribed by the laws of California and in accord with the applicable laws, titles, rules, and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. All payments under this Agreement must directly support services specified in this Agreement. These services are provided to a distinct group of seriously emotionally disturbed children and adolescents and occur in a therapeutic, organized and structured setting.

A. Therapeutic Behavioral Services

1. General Description of Services

a. Therapeutic Behavioral Services ("TBS") are one-to-one therapeutic contacts between a mental health provider and a beneficiary for a specified short-term period of time that are designed to maintain the child/youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals. A contact is considered therapeutic if it is intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that are the barrier to achieving residence in the lowest appropriate level.

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

c. Two important components of delivering TBS include the following:
   i. Making collateral contacts with family members, caregivers, and others significant in the life of the beneficiary; and
   ii. Developing a plan 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 (i) and (ii).
   i. Full-scope Medi-Cal beneficiary, under twenty-one (21) years, AND
   ii. Meets State medical necessity criteria for Medi-Cal Program.
b. Member of the Certified Class – must meet criteria (i), (ii), (iii), or (iv).
   i. Child/youth is placed in a group home facility of RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs which is not an Institution for Mental Disease which disqualifies them from receiving federally reimbursed Medi-Cal services; or

ii. Child/youth is being considered by the County for placement in a facility described in 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; orChild/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

iii. 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

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

c. Need for TBS – must meet criteria (i) and (ii).

i. The child/youth is receiving other specialty mental health services, and

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

1) The child/youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in current facility; or

2) The child/youth needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS 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. However, it may be approved for less days as deemed necessary by the Deputy Director of Child and Youth Services or designated TBS Coordinator. The contractor must submit the following required elements at the time of the Initial Review:
      i. Initial TBS Assessment, which must address target symptom(s) or behavior(s), including a functional analysis; Initial TBS Assessment, which must address target symptom(s) or behavior(s), including a functional analysis;
      ii. 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; 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;
      iii. Progress notes for each TBS service provided. Documentation requirements for progress notes are set forth in Paragraph I.B.7.

   b. Ongoing Utilization Requests

i. Ongoing utilization request may not exceed ninety (90) days. However, utilization reviews may occur more frequently as deemed necessary by the Deputy Director of Child and Youth Services or designated TBS Coordinator.

ii. Continuation of services will be based upon a progress summary that includes clear documentation of:
    1) Client progress toward specific goals and timeframes of TBS Client Plan.
    2) Provision of interventions to address specific goals and target behaviors. Provision of interventions to address specific goals and target behaviors.
    3) 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. 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.
    4) 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).
    5) Significant changes, challenges, and or obstacles to client environment and progress.
    6) 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). 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).
    7) Provision of skills/strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

iii. 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. However progress summaries may be requested more frequently as deemed necessary by the Deputy Director of Child and Youth Services or designated TBS Coordinator. Progress summaries must be reviewed by the TBS coordinator to ensure that TBS continues to be effective for the beneficiary in making progress towards the specified measurable outcomes.

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

e. Utilization Decision
   i. 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.
   ii. In cases in which Contractor or County determines that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the County will make an expedited 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.
   iii. 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:
      i. Meets medical necessity criteria;
      ii. Is full scope Medi-Cal under twenty-one (21) years of age;
      iii. Is a member of the certified class;
      iv. Needs specialty mental health services in addition to TBS; and
      v. Has specific behaviors and/or symptoms that require TBS.

b. TBS Assessments must:
    i. Identify the client's specific behaviors and/or symptoms that jeopardize current placement and/or symptoms that are expected to interfere with transitioning to a lower level of placement;
    ii. Describe the critical nature of the situation, severity of the clients' behaviors and/or symptoms, other less intensive services that have been tried and/or considered, and why TBS would be appropriate;
    iii. Provide sufficient clinical information to support the need for TBS;
    iv. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated; and
    v. Identify skills and adaptive behaviors that the client is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

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:
        i. 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).
        ii. Specific interventions to resolve targeted behaviors or symptoms, such as anger management techniques.
        iii. Specific description of changes in behaviors and/or symptoms that interventions are intended to produce, including a time frame for those changes.
        iv. Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced with adaptive behaviors.
        v. 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 behaviors, interventions and outcomes as necessary and appropriate; and reviewed and updated as necessary whenever there is a change in the child/youth's residence.

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

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

e. For clients between the 18 and 21 years of age notes regarding any special considerations should be taken into account, e.g. the identification of an adult case manager.

f. If the TBS are intensive and last for several months without observable improvement towards the treatment goals, the client shall be re-evaluated for a more appropriate placement.

g. TBS Client Plan Addendum

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

i. Significant changes in the client's environment since the initial development of the TBS Client Plan.
ii. 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.

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:
   i. Licensed Physician;
   ii. Licensed/Registered/Waivered Clinical Psychologist;
   iii. Licensed/Registered/Waivered Clinical Social Worker;
   iv. Licensed/Registered/Waivered Marriage, Family, and Child Therapist;
   v. Registered Nurse;
   vi. Licensed Vocational Nurse;
   vii Licensed Psychiatric Technician;
   viii. Occupational Therapist; or
   ix. 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.

B. Youth Day Treatment Services (Day Treatment Intensive/Day Rehabilitation), (Full/Half-day) programs, Medication Support Services, Mental Health Services, and Crisis Intervention

1. General Description of Services

a. Youth Day Treatment Services (Day Treatment Intensive/Day Rehabilitation), (Full/Half-day) programs, Medication Support Services, Mental Health Services and Crisis Intervention shall collectively be referred to herein as “Services.”

b. Youth Day Treatment Services (Day Treatment Intensive / Day Rehabilitation) (Full and Half-day) shall collectively be referred to herein as “Day Treatment Services.”

c. Day Treatment Intensive Services provide a structured multi-disciplinary treatment program for seriously emotionally disturbed children and adolescents. Day Treatment Intensive Services provide a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, out-of-home placement, and/or to maintain the client in a community setting.

d. Day Rehabilitation is a structured program of rehabilitation and therapy – to improve, maintain or restore personal independence and functioning. For seriously emotionally disturbed children and adolescents. Day Rehabilitation Services focus on maintaining individuals in their community and school settings, consistent with their requirements for learning and development and enhanced self-sufficiency.

These services emphasize delayed personal growth and development. Day Rehabilitation Services may be provided for those clients for whom those services are clinically appropriate and who do not require the level of services provided through Day Treatment Intensive Services.

e. San Mateo County clients authorized for Day Treatment Intensive Services who subsequently are authorized for Day Rehabilitation Services may continue to receive services in Contractor's Day Treatment Intensive Services program. Services provided for such clients shall be reimbursed at the Day Rehabilitation Services rates set forth in Exhibit B.

f. Day Treatment Services may be integrated with an education program as long as it meets all Day Treatment Services requirements. A key component of these services is contact with the families of clients.

g. Full-day Day Treatment Services must be available more than four (4) hours and less than twenty-four (24) hours each program day to qualify as a full-day program. Half-day Day Treatment Services must be available at least three (3) hours each day the program is open to qualify as a half-day program. The client must be present each day (half day or full day as appropriate) Day Treatment Services are claimed. On an exceptional occasion when a client is unavailable for the entire program day, the client must be present a minimum of fifty percent (50%) of the program day for that day's services to be claimed.

h. Contractor shall develop and maintain a Day Treatment Services program description of services and groups, along with a detailed weekly schedule, and shall provide such written materials to County annually and upon request.

i. County reserves the right and authority to set additional higher or more specific standards necessary to manage the delivery of Day Treatment Services than those set by the State of California.

j. Day Treatment 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. Day Treatment Intensive Services

a. Contractor shall provide Day Treatment Intensive Services to seriously emotionally and behaviorally disturbed San Mateo County resident youth(s) who are pre-approved for service by the BHRS Deputy Director of Child and Youth Services or designee.

b. The Contractor's full-day Day Treatment Intensive Services hours of operation are 3:30 PM to 7:45 PM, five (5) days per week, fifty-two weeks per year. The half-day Day Treatment Intensive Services hours of operation are 2:00 PM to 5:15 PM, five (5) days per week, fifty-two weeks per year.

c. The program is multi-disciplinary in its approach and provides a range of treatment services, including, but not limited to:
   i. Psychological assessment, evaluation, and plan development;
   ii. Education/special education programming;
   iii. Occupational, speech/language, and recreation therapies;
   iv. Individual, group, and family psychotherapy;
   v. Medication assessment and mediation management;
   vi. Psychosocial and functional skills development;
   vii. Crisis intervention; and
   viii. Outreach social services.

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

e. Therapeutic Milieu Service Components

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

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

f. Daily Community Meetings

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

i. Schedule for the day;
ii. Any current events;
iii. Individual issues that clients or staff wish to discuss to elicit support of the group process;
iv. Conflict resolution within the milieu;
v. Planning for the day, the week or for special events;

vi. Old business from previous meetings or from previous day treatment experiences; and
vii. Debriefing or wrap-up.

g. Weekly Schedule

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

h. Excluded Activities

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

i. Contact with Significant Support Persons

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

j. Crisis Response

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

k. Authorization Requests

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

i. Contractor must request authorization for payment from County using the Authorization Form or a similar form approved by County, and clinical documentation that establishes the need for the service. For initial authorizations, contractor must complete the Initial Authorization Request form within two weeks following the client's entry to the Day Treatment Program. Thereafter, requests for reauthorization of services must be submitted at least two weeks prior to end date of the previous authorization.
ii. Contractor must provide an additional prior authorization for services that exceed five (5) days per week.
iii. Contractor must request authorization for the continuation of services at least every three (3) months, or more frequently if requested by County.
iv. Contractor must request authorization for the provision of counseling, psychotherapy, and other similar intervention services, including Mental Health Services, beyond those provided in the Day Treatment Intensive Services. These services may not be provided at the same time as Day Treatment Intensive Services even if authorized. (Excluded from this restriction are services to treat emergency and urgent conditions, medication support services, and Therapeutic Behavioral Services that are provided on the same day as Day Treatment Intensive Services.) Authorization of these services must occur on the authorization schedule determined by the BHRS Deputy Director or designee and no later than on the same cycle as authorization for Day Treatment Intensive Services.
v. The authorization must specify the number of days per week as well as the length of time services will be provided.

l. Authorization Decisions
   i. For authorization decisions other than the expedited decisions described below in Paragraph I.A.2.l.ii., County shall provide notice as expeditiously as the client's mental health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the client or Contractor requests an extension; or if County identifies a need for additional information.

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

iii. The County shall notify the Contractor of any decision to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

m. Documentation

Each youth will have an individualized client treatment plan developed by the Day Treatment Intensive Services program staff signed by a licensed, waivered or registered staff member. A copy of this plan will be provided to the BHRS Deputy Director of Child and Youth Services or designee upon admission and annually thereafter.

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

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

ii. Client Progress Notes
1) Day Treatment Intensive Services require:
a) Daily progress notes on activities, and
b) Weekly clinical summaries, which must be signed (or electronic equivalent) by a:
i) Physician,
ii) Licensed/registered/waivered psychologist,
iii) Clinical social worker,
iv) MFT, or
v) Registered nurse who is either staff to the program or the person directing the Services. v) Registered nurse who is either staff to the program or the person directing the Services.

2) The signature for the weekly summary shall include the person's professional degree, licensure, or job title, and will include the dates Services were provided and progress towards meeting client goals. Copies of weekly summaries shall be forwarded along with the monthly invoice to the BHRS Deputy Director of Child and Youth Services or designee.

n. Staffing

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

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

9) Mental Health Rehabilitation Specialist. A Mental Health Rehabilitation Specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two (2) years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two (2) years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting.

ii. Staffing Ratio: At a minimum there must be an average ratio of at least one (1) professional staff member (see staffing list above) to eight (8) individuals (1:≤8) in attendance during the period the program is open. In Day Treatment Intensive Services programs serving more than twelve (12) clients (1:>12) there shall be at least one (1) person from two (2) of the staffing groups listed above. One staff person must be present and available to the group in the therapeutic milieu in all hours of operation.

Other staff may be utilized according to program need, but shall not be included as part of the above ratio. A clear audit trail shall be maintained for staff members who function as both Day Treatment Intensive Services program staff and in other capacities.

3. Day Rehabilitation Services

a. Contractor shall provide Day Rehabilitation Services to seriously emotionally and behaviorally disturbed San Mateo County resident youth(s) pre-approved for service by the BHRS Deputy Director of Child and Youth Services or designee.

b. The Contractor's full-day Day Rehabilitation Services hours of operation are 3:00 PM to 7:15 PM, five (5) days per week, fifty-two (52) weeks per year. The half-day Day Rehabilitation Services hours of operation are 2:00 PM to 5:15 PM, five (5) days per week, fifty-two (52) weeks per year.

c. The Day Rehabilitation Services program is multi-disciplinary in its approach and provides a range of treatment services, including, but not limited to:
   i. Psychological assessment, evaluation, and plan development;
   ii. Education/special education programming;
   iii. Occupational, speech/language, and recreation therapies;
   iv. Medication assessment and medication management;

v. Psychosocial/functional skills development;
vi. Crisis intervention; and
vii. Outreach social services.

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

e. Therapeutic Milieu Service Components

   The following services must be made available during the course of the therapeutic milieu for an average of at least three hours per day for a full-day Day Rehabilitation Services program, and an average of at least two hours per day for a half-day program. One program staff member must be present and available to the group during the milieu for all scheduled hours of therapeutic milieu.
   i. Process groups: program staff will facilitate groups to help clients develop skills to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
   ii. Skill building groups: program staff will help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and increase adaptive behaviors.

iii. Adjunctive Therapies: non-traditional therapy that utilizes self-expression (for example: art, recreation, dance, and music) as the therapeutic intervention.

f. Daily Community Meetings

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

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

g. Weekly Schedule

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

h. Excluded Activities

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

i. Contact With Significant Support Persons

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

j. Crisis Response

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

k. Authorization Requests

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

i. Contractor must request authorization for payment from County using the Authorization Form or a similar form approved by County, and clinical documentation that establishes the need for the service. For initial authorizations, contractor must complete the Initial Authorization Request form within two weeks following the client's entry to the Day Treatment Program. Thereafter, requests for reauthorization of services must be submitted at least two weeks prior to end date of the previous authorization.
ii. Contractor must provide an additional prior authorization for services that exceed five (5) days per week.
iii. Contractor must request authorization for the continuation of services at least every six (6) months, or more frequently if requested by County.

iv. Contractor must request authorization for the provision of counseling and other similar intervention services beyond those provided in the Day Treatment Services. These services may not be provided to a Day Rehabilitation Services client during the Day Rehabilitation Services program hours, even if such service is authorized. (Excluded from this restriction are services to treat emergency and urgent conditions, medication support services, and Therapeutic Behavioral Services that are provided on the same day as Day Treatment Rehabilitation Services.) Authorization of these services must occur on the authorization schedule determined by the BHRS Deputy Director of Child and Youth Services or designee and no later than on the same cycle as authorization for Day Rehabilitation Services.
v. Authorization must specify the number of days per week as well as the length of time services will be provided.

l. Authorization Decisions

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

m. Documentation

Each youth will have an individualized client treatment plan developed by the program staff signed by a licensed, waivered or registered staff member. A copy of this plan will be provided to the BHRS Deputy Director of Child and Youth Services or designee upon admission and annually thereafter.

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

ii. Client Progress Notes

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

n. Staffing

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

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

ii. At a minimum there must be an average ratio of at least one professional staff member (see staffing list above) to ten individuals (1:≤10) in attendance during the period the program is open. In Day Rehabilitation Services programs serving more than 12 clients (1:<12) there shall be at least one person from two of the staffing groups listed in Paragraph I.A.3.m. of this Exhibit A. One staff person must be present and available to the group in the therapeutic milieu in all hours of operation.

iii. Other staff may be utilized according to program need, but shall not be included as part of the above ratio. A clear audit trail shall be maintained for staff members who function as both Day Rehabilitation Services staff and in other capacities.

4. Medication Support Services

a. Contractor shall provide Medication Support Services by a licensed psychiatrist up to twice per month for each client pre-approved for Medication Support Services by the BHRS Deputy Director of Child and Youth Services or designee and to the extent medically necessary. Additional Medication Support Services shall be provided, if medically necessary, when pre-approved by the BHRS Assistant Director or designee.

b. Authorization shall be on the same cycle required for continuation of the concurrent Day Treatment Services.

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

d. The monthly invoice for Medication Support Services must be supported by clinical documentation to be considered for payment. Medication Support Services are reimbursed by minutes of service.

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

5. Mental Health Services

a. Contractor shall provide Mental Health Services for each client pre-approved for Mental Health Services by the BHRS Deputy Director of Child and Youth Services or designee and to the extent medically necessary.

b. Authorization shall be on the same cycle required for continuation of the concurrent Day Treatment Services.

c. Mental Health Services include:

   i. Therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments; and

   ii. Therapeutic interventions consistent with the client's goals of learning, development, independent living and enhanced self-sufficiency that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning.

d. Therapy services provided in conjunction with Day Treatment Services shall generally focus on family therapy. These services provided during Day Treatment Services program hours may not be billed as a separate service.

e. The monthly invoice for Mental Health Services must be supported by clinical documentation to be considered for payment. Mental Health Services are reimbursed by minutes of service.

f. Mental Health 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.

6. Crisis Intervention

a. Contractor shall provide Crisis Intervention if medically necessary.

b. 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. Crisis Intervention as described in this Paragraph I.A.6. is a separate service from crisis intervention service which is an expected part of Day Treatment Services as set forth in Paragraphs I.A.2.j. and I.A.3.j.

c. To be considered for payment Crisis Intervention must be:
   i. Retroactively authorized by the BHRS Assistant Director or designee, and
   ii. Provided during non-Day Treatment (Day Rehabilitation and/or Day Treatment Intensive) hours only.

d. The monthly invoice for Crisis Intervention must be supported by clinical documentation to be considered for payment. Crisis Intervention is reimbursed by minutes of service.

e. Crisis Intervention 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.

II. Administrative Requirements (for all service components)

A. Paragraph 13 of the Agreement and Paragraph I.Q.4. of Exhibit B notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18^{th}) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

B. Administering Satisfaction Surveys

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

C. Cultural Competency

1. All program staff shall receive at least one (1) in-service training per year on some aspect of providing culturally and linguistically appropriate services. At least once per year and upon request, Contractor shall provide County with a schedule of in-service training(s) and a list of participants at each such training.

2. Contractor shall use good faith efforts to translate health-related materials in a culturally and linguistically appropriate manner. 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. At least once per year and upon request, Contractor shall submit to County the cultural composition and linguistic fluencies of Contractor's staff.

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 ten (10) 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 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: www.medi-cal.ca.gov. Click the "References" tab, then the "Suspended & Ineligible Provider List" link.

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. 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.

P. Developmental Assets

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

III. GOALS AND OBJECTIVES / REPORTING

A. Therapeutic Behavioral Services

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

Objective 1: At least ninety percent (90%) of children served will be maintained at the current or a reduced level of placement during the receipt of TBS and for thirty (30) days following the receipt of direct TBS.

Data shall be collected by Contractor

Goal 2: Child/youth shall be offered an opportunity to respond to a satisfaction survey concerning TBS.

Data shall be collected by Contractor in collaboration with County

B. Day Treatment Services (Intensive and Rehabilitation)

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

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

Data shall be collected by County

Day Treatment Intensive only

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

Data shall be collected by County

C. All Programs

Goal 2: Contractor shall enhance the program's family-professional partnerships.

Objective 1: Contractor shall involve each child's family in the treatment process. This shall be measured by a rating of "satisfied" in ninety percent (90%) of all questions related to involvement in the therapeutic process in the Youth Satisfaction Survey – Family (YSSF).

Data shall be collected by Contractor in collaboration with County

D. Reporting

SB163

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

REBEKAH CHILDREN'S SERVICES
EXHIBIT "B"
FY 2010 – 2011

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

I. PAYMENT

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. Therapeutic Behavioral Services (TBS)

1. For TBS described in Paragraph I.B. of Exhibit A, except as provided in Paragraphs I.B.2. and I.B.3. of this Exhibit B, and for the term of this Agreement County shall pay Contractor on a fee for service basis at a minute 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.G. of this Exhibit B.

2. 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.B.2. of Exhibit A and development of the initial TBS Client Treatment Plan as described in Paragraph I.B.3. of Exhibit A. Such payment shall be exclusive of and separate from payment for all other services as described in Paragraph I.B.1. of this Exhibit B. County shall pay such rate less any third-party payments as set forth in Paragraph I G. of this Exhibit B.

3. Contractor shall be paid at the rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute for Collateral services as described in Exhibit A I.B.6.b.vi. County shall pay such rate less any third-party payments as set forth in Paragraph I.G. of this Exhibit B.

4. 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 in Paragraphs I.B.1., I.B.2. and I.B.3. of this Exhibit B.

5. The billing unit for TBS and Collateral Services is staff time, based on minutes.

6. 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 TBS provider is not a Day Treatment staff member during the same time period of the Day Treatment Services program.

B. Day Treatment Services (Intensive and Rehabilitative), Medication Support Services, Mental Health Services, and Crisis Intervention

1. For full-day Day Treatment Intensive Services described in Paragraphs I.C.2. of Exhibit A Contractor shall be paid at the rate of TWO HUNDRED TWO DOLLARS AND FORTY-THREE CENTS ($202.43) per day.

2. For half-day Day Treatment Intensive Services Contractor shall be paid at the rate of ONE HUNDRED FORTY-FOUR DOLLARS AND THIRTEEN CENTS ($144.13) per day.

3. For full-day Day Treatment Rehabilitation Services described in Paragraph I.C.3. of Exhibit A Contractor shall be paid at the rate of ONE HUNDRED THIRTY-ONE DOLLARS AND TWENTY-FOUR CENTS ($131.24) per day.

4. For half-day Day Treatment Rehabilitation Services Contractor shall be paid at the rate of EIGHTY-FOUR DOLLARS AND EIGHT CENTS ($84.08) per day.

5. For clients authorized for Day Treatment Intensive Services who receive full-day services in the Day Treatment Rehabilitation Services as described in Paragraph I.C.4. of Exhibit A Program Contractor shall be paid at the rate of ONE HUNDRED THIRTY-ONE DOLLARS AND TWENTY-FOUR CENTS ($131.24) per day.

6. For clients authorized for Day Treatment Intensive Services who receive half-day services in the Day Treatment Rehabilitation Services Program as described in Paragraph I.C.4. of Exhibit A Contractor shall be paid at the rate of EIGHTY-FOUR DOLLARS AND EIGHT CENTS ($84.08) per day.

7. For Medication Support Services described in Paragraph I.C.5. of Exhibit A, County shall pay Contractor at the rate of FOUR DOLLARS AND EIGHTY-TWO CENTS ($4.82) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.G. of this Exhibit B.

8. For Mental Health Services described in Paragraph I.C.6. of Exhibit A, County shall pay Contractor at the 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.G. of this Exhibit B.

9. For Crisis Intervention Service described in Paragraph I.C.7. of Exhibit A, County shall pay Contractor at the rate of THREE DOLLARS AND EIGHTY-EIGHT CENTS ($3.88) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.G. of this Exhibit B.

10. For Day Treatment Services, Medication Support Services, Mental Health Services and Crisis Intervention payment shall be made on a monthly basis upon County's receipt of the following:
    a. All required documentation adhering to Medi-Cal guidelines,
    b. Documentation for each minute of service, and
    c. Documentation relating to each appropriate authorization.

11. Day Treatment Services and Medication Support Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

12. County shall pay rates for Day Treatment Services (Intensive and Rehabilitation), Medication Support Services, Mental Health Services, and Crisis Intervention services less any third-party payments as set forth in Paragraph I.G. of this Exhibit B.

C. In any event, the maximum amount County shall be obligated to pay for services rendered under this Agreement shall not exceed ONE HUNDRED SIXTEEN THOUSAND EIGHT HUNDRED FIFTY-EIGHT DOLLARS ($116,858).

D. Contractor's annual 2010-11 budget is attached and incorporated into this Agreement as Exhibit C.

E. Election of Third Party Billing Process

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

1. Option One

    a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. With every invoice submitted by Contractor to County, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for each such invoice.

        The County may withhold payment to Contractor for any and all services for which this required proof of third-party payments and/or denials of such payments is not provided. County may deduct from its payments to Contractor the amount of any such third-party payment. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement.

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

2. Option Two

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

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

F. Monthly Reporting

1. Payment by County to Contractor shall be monthly. Contractor shall bill County on or before the tenth (10^{th}) working day of each month for the prior month. The invoice shall include a summary of services and changes for the month of service. In addition contractor shall provide back-up to the invoice. Such back-up shall be in the form of:
   a. County provided service reporting form(s) ("Service Reporting Form(s)") completed by Contractor according to the instructions accompanying the Service Reporting Form(s), or
   b. County approved form(s) which provide detailed description of services provided including but not limited to: client name, mental health ID#, service date, type of service provided (Ex: TBS, Intensive Day Treatment, etc.), and duration of service (hour/minute format).

2. County reserves the right to change the Service Report Forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary.

G. The Chief of the Health System or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

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

I. In the event of a decrease in the State Maximum Allowance (SMA) for services provided pursuant to this Agreement, Contractor agrees to either accept rate(s) not to exceed the SMA or to discontinue provision of these services as of the effective date for the new rate(s). In the event that the SMA is less than the rate(s) established in this Agreement, it is agreed the rate(s) will be changed to the SMA. In no event shall the compensation rate(s) for services under this Agreement exceed the SMA.

J. County anticipates 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, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of the Health System or designee.

K. 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 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.

L. 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.

M. 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, and as

N. In the event this Agreement is terminated prior to June 30, 2011 the Contractor shall be paid for services already provided pursuant to this Agreement.

O. Cost Report

1. Contractor shall submit to County a year-end cost report no later than ninety (90) days after the expiration date of this Agreement. This report shall be in accordance with the principles and format outlined in the Cost Reporting/Data Collection (CR/DC) Manual. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the Cost Report.

2. If the annual Cost Report provided to County reveals that total payments to Contractor exceed the total allowable costs for all of the services rendered by Contractor to eligible clients during the reporting period, a single payment in the amount of the difference shall be made to County by Contractor, unless otherwise authorized by the Chief of the Health System or designee.

P. Beneficiary Billing

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

Q. 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 (day rehabilitation / day treatment intensive / EPSDT supplemental specialty mental health services) included in the claim, all requirements for Contractor payment authorization for (day rehabilitation / day treatment intensive / 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.

Attachment C
Election of Third Party Billing Process

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

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

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

We Rebekah Children's Services elect option one.

_____ _____
Signature of authorized agent Name of authorized agent

_____
Telephone number

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

We Rebekah Children's Services elect option two.

_____ _____
Signature of authorized agent Name of authorized agent

_____
Telephone number

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

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

Attachment D - Payor Financial Form

AGENCY NAME:

Client's Last Name/MH ID # (if known)	**First Name M.I.**	**Alias or other names Used**
Client Date of Birth	**Undocumented?** □ Yes □ No **If no, Social Security Number (Required)**	**26.5 (AB3632)** □ Yes □ No IEP (SELPA) start date_____

Does Client have Medi-Cal? □ Yes □ No **Share of Cost?** □ Yes □ No **Client's Medi-Cal Number** (BIC Number)? _____
Please attach copy of MEDS Screen **If client is Full scope Mcal, skip the remaining sections of this form and fax to MIS/Billing Unit – 573-2110**
Is Client Potentially Eligible for Medi-Cal Benefits? □ Yes □ No **Client Referred to Medi-Cal?** □ Yes, give date: _____ □ No
Is this a Court-ordered Placement? □ Yes □ No
Does Client have Medicare? □ Yes □ No **If yes, please check all that apply ____Part A ____Part B ____Part D (effective 1/1/06)**
What is the Client's Medicare Number? _____

Responsible Party's Information (Guarantor):

Name _____ Phone _____ Relationship to Client _____ □ Self

Address _____ City _____ State _____ Zip Code_____

□ **Refused to provide Financial Information and will be charged full cost of service.**

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

To determine family's UMDAP liability, please list any other family members currently being seen by Mental Health:

_____

_____

Gross Monthly Income (include all in the Household)

A. Self ……$ _____
B. Parents/Spouse/Domestic Partner ….$ _____
C. Other …… $ _____

Number of Persons Dependent on Income _____

Asset Amount (List all liquid assets)

A. Savings……..…….$_____
B. Checking…….…….$_____
C. Stocks……..$_____

Allowable Expenses

A. Court Ordered Monthly Obligation $_____
B. Monthly Child Care Payments (Only if Necessary for Employment) $_____
C. Monthly Dependent Support Payments $_____
D. Monthly Medical Expense Payments $_____
E. Monthly Mandated Deductions for Retirement Plan (Do not include Social Security)……$_____
F. Housing Cost (Mortgage/Rent) $_____

3rd Party HEALTH INSURANCE INFORMATION

Health Plan or Insurance Company (Not employer)

Name of Company _____

Street Address _____

City _____

State _____ Zip _____

Insurance Co. phone number_____

Policy Number _____

Group Number_____

Name of Insured Person_____

Relationship to Client_____

Social Security Number of Insured Person_____
(if other than client)

Does this Client have Healthy Families Insurance? □ Yes □ No
If Yes, complete San Mateo County Mental Health SED form.

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

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

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

_____ _____ _____
Signature of Client or Authorized Person Date Reason if client is unable to sign

Client Refused to Sign Authorization: ☐ (Please check if applicable) Date_____Reason_____

_____

Name of Interviewer _____ Phone Number _____ Best Time to Contact_____

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

San Mateo County Mental Health Services Use Only

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

Rev 06/05

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

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

Instructions for Checking Medi-Cal Eligibility Using the Internet

- Go to Internet Explorer
- Type in the URL/address box: **www.medi-cal.ca.gov**
- From the Medi-Cal Home Web Site screen, click Transaction Login
- From the Login Center Transaction Services screen, enter
  User ID: **assigned provider number (**usually five "0's" preceded by your provider #)
  Password: **assigned pin number***

  ***NOTE:**
  - ***If you are already a Medi-Cal provider and don't know your provider pin number (password):*** *your Program Director will need to write a letter* ***to Cathy Bishop, Staff Services Analyst Medi-Cal Oversight****. The letter should be faxed to Cathy at* ***(916) 654-6394.*** *On the letter, state the reason why you are requesting it, i.e., lost, never received, etc. and provide your phone number so that she can call you with your provider pin number.*
  - ***If you are already a Medi-Cal provider and this is the first time you are accessing the Medi-Cal Transaction Services:*** *you will need to complete the Medi-Cal Point Of Service (POS) Network/Internet Agreement form (attached) and mail it to the address on the form. This agreement is required for all providers who intend to use the POS Network for clearing SOC.*

- Click on Submit
- From the Transaction Services screen, click on Single Subscriber
- From Perform Eligibility Transaction screen fill in the following fields:

  - *Subscriber ID* – enter the client's Social Security # (without dashes)
  - *Subscriber Birth Date* – enter the client's DOB (mm/dd/yyyy)
  - *Issue Date* – if unknown, enter today's date (mm/dd/yyyy)
  - *Service Date* – enter the date on which the service is to be performed (mm/dd/yyyy)
  - Click on Submit

Helpful Hints:

Click on Back - to return to Transaction Services screen

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

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

Instructions for Clearing Medi-Cal Share of Cost Using the Internet

- Go to Internet Explorer
- Type in the URL/address box: **www.medi-cal.ca.gov**
- From the Medi-Cal Home Web Site screen, click Transaction Login
- From the Login Center Transaction Services screen, enter
  User ID: **assigned provider number (**usually five "0's" preceded by your provider #)
  Password: **assigned pin number***

  ***NOTE:**
  - ***If you are already a Medi-Cal provider and don't know your provider pin number (password):*** *your Program Director will need to write a letter* ***to Cathy Bishop, Staff Services Analyst Medi-Cal Oversight****. The letter should be faxed to Cathy at* ***(916) 654-6394.*** *On the letter, state the reason why you are requesting it, i.e., lost, never received, etc. and provide your phone number so that she can call you with your provider pin number.*
  - ***If you are already a Medi-Cal provider and this is the first time you are accessing the Medi-Cal Transaction Services:*** *you will need to complete the Medi-Cal Point Of Service (POS) Network/Internet Agreement form (attached) and mail it to the address on the form. This agreement is required for all providers who intend to use the POS Network for clearing SOC.*

- Click on Submit
- From the Transaction Services screen, click Perform SOC (Spend Down) Transactions
- From Perform SOC (Spend Down) Transaction screen fill in the following fields:

  - *Subscriber ID* – enter the client's Social Security # (without dashes)
  - *Subscriber Birth Date* – enter the client's DOB (mm/dd/yyyy)
  - *Issue Date* – if unknown, and clearing service for the current month, enter today's date. If you are clearing a retroactive service, you must have the BIC issue date. (mm/dd/yyyy)
  - *Service Date* – enter service date for the "SOC Clearance." (mm/dd/yyyy)
  - *Procedure Code* – enter the procedure code for which the SOC is being cleared. The procedure code is required. (90862, 90841, 90882, etc.)
  - *Total Claim Charge Amount* – enter the amount in dollars and cents of the total bill for the procedure code. (ex. 100 dollars would be entered as 100.00). If you do not specify a decimal point, a decimal followed by two zeros will be added to the end of the amount entered.
  - *Case Number* – optional unless applying towards family member's SOC case
  - *Amount of SOC (Spend Down)* – optional unless a SOC case number was entered
  - Click on Submit
  - Print SOC (Spend Down) Response screen and attached to the Unbillable SD Mcal Billing Services – SOC Has Not Been Met SOC report and return to MIS.

Helpful Hints:

Click on Back - to return to Transaction Services screen

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

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

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

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

ATTACHMENT E

FINGERPRINTING CERTIFICATION

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

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

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

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

_____Rebekah Children's Services____
Name of Contractor

_____
Signature of Authorized Official

_____
Name (please print)

_____
Title (please print)

_____
Date