THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number 24-772

SAP Number

Arrowhead Regional Medical Center

Department Contract Representative	Andrew Goldfrach
Telephone Number	(909) 580-6150
Contractor	California Department of Health Care Services
Contractor Representative	N/A
Telephone Number	N/A
Contract Term	August 20, 2024 – August 19, 2026
Original Contract Amount	Revenue
Amendment Amount	
Total Contract Amount	Revenue
Cost Center	
Grant Number (if applicable)	N/A

Briefly describe the general nature of the contract: Grant award from the California Department of Health Care Services for the Providing Access and Transforming Health – Capacity and Infrastructure Transition, Expansion and Development Program, Round 3, in an amount up to $352,638, for the performance period of August 20, 2024 through August 19, 2026.

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
►	►	►
Charles Phan, Supervising Deputy County Counsel		Andrew Goldfrach, ARMC Chief Executive Officer
Date 8/13/2024	Date	Date 8/14/2024

Application Detail

Application ID	1120707
Submitted	Feb 15, 2024
Status	In progress
Applicant(s)	Cynthia Harlowe (harlowec@armc.sbcounty.gov)
Program and cycle	CITED Application Round 3 CITED Application Round 3
Tags	No tags
Forms	CITED Terms and Conditions Round 3 Clinic

Terms and Conditions

California Providing Access and Transforming Health

Capacity and Infrastructure, Transition, Expansion and Development Program

Acknowledgement of Grant Terms and Conditions

As an express condition of receiving grant funds from the California Department of Health Care Services ("DHCS") under the Capacity and Infrastructure, Transition, Expansion and Development (CITED) Program, which is part of the California Providing Access and Transforming Health ("PATH") Initiative, the applicant named below hereby warrants and guarantees that it will comply with all applicable federal, state, and local laws and regulations, as well as with as the following terms and conditions:

Organization Name	**Street address**	**State**
San Bernardino County	385 N. Arrowhead Ave.	California
EIN	**City**	**Zip code**
95-6002748	San Bernardino	92415

I. Role of Third-Party Administrator. DHCS has designated Public Consulting Group LLC as the Third-Party Administrator (TPA), to administer the grant program and to communicate with Applicant with respect to grant administration in connection with the CITED Program. Applicant understands that the TPA is acting solely as a third-party administrator on behalf of DHCS and is not liable or responsible for DHCS decisions or actions. Applicant hereby releases and holds harmless the TPA and its officers, agents, employees, representatives, and/or designees from and against any and all liability, actions, claims, demands, or suits, and all related costs, attorney fees, and expenses arising out of, or relating to the receipt of grant funds. DHCS shall not be liable to Applicant for any incidental, indirect, special, punitive, or consequential damages, including, but not limited to, such damages arising from any type or manner of commercial, business, or financial loss, even if PCG or DHCS had actual or constructive knowledge of the possibility of such damages and regardless of whether such damages were foreseeable. Applicant hereby releases and holds harmless DHCS and its officers, agents, employees, representatives, and/or designees from and against any and all liability, actions, claims, demands, or suits, and all related costs, attorney fees, and expenses arising out of, or relating to receipt of grant funds and associated activities in connection with CITED.

II. Eligibility.

To qualify for the grant funds under this program, applicants must meet the following criteria:

a. Active Contract: Applicants must be actively contracted with a Medi-Cal Managed Care Plan (MCP) or an MCP's authorized subcontractor or other entity authorized to contract with for the provision of Enhanced Care Management (ECM) and/or Community Supports.
b. Attestation Letter: Alternatively, applicants may provide a signed attestation letter from an MCP or MCP's authorized subcontractor or other entity authorized to contract, stating a strong intent to contract with the

applicant to provide ECM and/or Community Supports within the timeframe of these Terms and Conditions.

c. Clinic Eligibility: Qualified clinics eligible for this program include:

1. Federally Qualified Health Centers (FQHCs),including Tribal FQHCs and FQHC look-alikes.
2. Community clinics and free clinics licensed under Section 1204(a) of the Health and Safety Code.
3. Indian health clinics
4. Intermittent clinics
5. Rural health clinics (RHCs) located in California.
6. Health center or primary care clinic led consortia and associations, including: regional associations, health center-controlled networks, tribal and urban Indian consortia, and statewide associations.

If the intent or ability to contract with an MCP has changed, ended, or been altered, Applicant must contact the TPA within twenty-four (24) hours to advise of this change. If there is no longer a contract as enumerated above or documented intent to contract, the grant may be terminated pursuant to Section VII, below.

III. Use of Funding.

a. Project Plan. Applicant shall use grant funds exclusively to implement the project plan as outlined in Applicant's submitted and approved grant application dated _____.

Date

Mar 13, 2024

b. Program Guidance and Conditions. In using the funds to implement the project plan, Applicant must follow all terms, conditions, and guidelines provided in the CITED Program guidance, found at www.ca-path.com, and in these Terms and Conditions.

c. Changes and Modifications. Changes and modifications made to the submitted and approved grant application or to the program guidelines may be proposed by Applicant in writing and are subject to the approval of DHCS. No change or modification will be valid without the approval of DHCS.

IV. Grant Amount and Method of Payment.

a. Grant Amount. The total grant amount awarded to Applicant shall not exceed $____.

Award Amount

$352,637.37 USD

Applicant acknowledges that the grant amount has been determined by DHCS and will not be negotiated with the TPA.

b. Method of Payment. The TPA, on behalf of DHCS, shall cause payment in full sum to be deposited to the Applicant upfront via direct deposit into the Applicant's account, within sixty (60) calendar days

following receipt and approval of Applicant's Terms and Conditions and completion of banking verification process.

c. Reliance on Provided Information. DHCS and the TPA are entitled to rely on the accuracy and completeness of information provided by Applicant in the disbursement of grant funds.

V. Reporting Requirements.

a. Quarterly Reports. Applicant is required to submit quarterly progress reports to the TPA through secured data portal specified by DHCS and PCG every three (3) months until the final project milestones described in the submitted and approved grant application are met. Each progress report must include a detailed description of completed milestones, status of activities for that quarter, and any deviations from the agreed-upon milestones. Applicant should expect to include documentation providing proof that expenditures were made for permissible items and activities as described in the approved application.

b. Reporting Schedule. The reporting schedule is as follows:

Report	Due Date
July 1- September 30, 2024	October 15, 2024, at 5 PM PST
October 1- December 31, 2024	January 14, 2025, at 5 PM PST
January 1- March 31, 2025	April 14, 2025, at 5 PM PST
April 1 - June 30, 2025 (Final Evaluation)	September 28, 2025, at 5 PM PST

c. Failure to Report. If Applicant fails to submit any quarterly report within five (5) calendar days of the report becoming due, DHCS may terminate the grant pursuant to Section VI, below.

d. Final Evaluation. Applicant is required to submit a final evaluation report within 90 days after the full expenditure of funding, but no later than September 28, 2025. The final evaluation report will be considered the applicant's fourth quarterly report. The final evaluation report will be made available to the applicant no later than July 2025 and will be available until September 28, 2025. The report must include the disposition of funds, summary of all milestones met, and the number Members who received ECM and Community Supports as a result of the funding. DHCS will review and approve reports based on completion of approved milestones and permissible uses of funding. Approved applicants that do not fully encumber or expend awarded funds by June 30, 2025, must return unspent funds.

VI. Additional DHCS Terms and Conditions.

a. Funding received through the CITED Program will not duplicate or supplant1 funds received through previous CITED funding rounds; other programs or initiatives; or by other federal, state, or local funding sources.

b. DHCS may, in its reasonable discretion, modify payment dates or amounts and will notify Applicant of any such changes in writing.

c. DHCS or the TPA may conduct outreach to any Applicant to request additional information, ask questions, or seek clarification on information provided in a CITED Application or CITED Progress Report.

If outreach is conducted by DHCS or the TPA, the applicant must respond within three (3) business days, unless an alternative timeline is approved by DHCS or the TPA. Failure to respond within this time frame may result in delay or deferment fund disbursement.

d. Applicant may be subject to audit or inquiry with respect to the receipt and use of grant funds at any time. Applicant must respond to inquiries, communications, and reasonable requests for additional information or documentation from DHCS or the TPA within one (1) business day of receipt and must provide any requested information within three (3) business days, unless an alternative timeline is approved by DHCS or the TPA.

e. Applicant must alert DHCS and the TPA within twenty-four (24) hours of identifying any circumstances that prevent carrying out any of the activities described in the submitted and approved grant application. In such cases, Applicant may be required to return unused funds to DHCS if an alternative solution cannot be reached.

f. All inquiries and notices relating to this Agreement should be directed to the representatives listed below:

Department of Health Care Services, Managed Care Quality & Monitoring Division	Public Consulting Group, LLC
Branch Chief, Value-Based Quality Programs Branch	CITED Grant Manager
Attention: Michel Huizar	Attention: Katherine Thomas
Email: 1115path@dhcsca.gov	Email: cited@ca-path.com

Applicant Name *

No answer

Title:

No answer

Attention *

No answer

Email *

No answer

g. DHCS and the TPA may rely on the authority of the above-named individual to speak and act on behalf of Applicant. Either party may make changes to the information above by giving written notices to the other party within twenty-four (24) hours. Said changes shall not require an amendment to this Agreement. Applicant will retain all records and documentation related to the receipt and use of PATH grant funds, including all documentation used to support and detail expenditures, for no less than three (3) years beyond the date of final payment and will make such records available for complete inspection by DHCS upon request.

h.DHCS reserves the right to receive, use, and reproduce all reports and data produced, delivered, or generated by or about Applicant and its activities pursuant to this grant and may authorize others to do so without limitation, except as restricted by applicable law.

i. Applicant will not unlawfully discriminate against any person because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex,

gender, gender identity, gender expression, age, sexual orientation, or military and veteran status in the conduct of any activity funded by DHCS.

j. Applicant expressly agrees and acknowledges that DHCS is a direct beneficiary of the Terms and Conditions with respect to all obligations and functions undertaken pursuant to the Terms and Conditions, and DHCS may directly enforce any and all provisions of the Terms and Conditions.

k. Applicants are required to provide a signed contract with an MCP or an MCP's authorized subcontractor or other entity authorized to contract with to provide ECM and/or Community Supports services. Alternatively, the Applicant may submit a signed agreement indicating that the MCP or the MCP's authorized subcontractor or other entity authorized to contract with intends to contract with the applicant for the provision of ECM and/or Community Supports.

l. If the applicant's existing ECM/Community Supports contract with an MCP or an MCP's authorized subcontractor or other entity authorized to contract with is terminated and the applicant does have an approved contract or intent-to-contract with another MCP or an MCP's authorized subcontractor or other entity authorized to contract with, the applicant is precluded from receiving additional CITED funding until they provide the TPA and/or DHCS proof of an existing ECM/Community Supports contract or intent to contract with an MCP or an MCP's authorized subcontractor or other entity authorized to contract with.

VII. Termination. Upon written notice to Applicant, DHCS may terminate the grant award in any of the following circumstances:

a. If Applicant fails to perform any one or more of the requirements set forth in these Terms and Conditions;

b. If any of the information provided by Applicant to DHCS or to the TPA is untruthful, incomplete, or inaccurate;

c. Upon Applicant's debarment or suspension by competent authority, if such debarment or suspension precludes any activity funded by the grant;

d. Upon Applicant's indictment in any criminal proceeding;

e. If Applicant is reasonably suspected of fraud, forgery, embezzlement, theft, or any other misuse of public funds;

f. If DHCS does not receive or maintain sufficient funds to administer the program;

g. If any restriction, limitation, or condition is enacted by Congress or by any other governing body or agency that impedes the funding or administration of the grant; or

h. For any other purpose deemed necessary or advisable by DHCS.

In the case of early termination, Applicant may be subject to audit, recoupment by DHCS of unused or misused funds, and/or preclusion from receiving additional funding, dependent upon the circumstances of the termination.

IN WITNESS THEREOF, APPLICANT has executed this Acknowledgment as of the date set forth below.

Name: *

No answer

Title: *

No answer

Date

No answer

Other Federal, state or local funding sources and programs that are complementary to or enhance PATH funds will not be considered supplanted by PATH funds or duplicate reimbursement. If applicable, applicants must describe how similar or related services and activities supported by other Federal, state or local funding sources are complemented or enhanced by efforts funded by PATH. For example, if other funding 1) does not fully reimburse activities, 2) may allow additional/different populations to be served or 3) may allow additional/different services to be provided beyond those funded by PATH. To the extent otherwise allowable PATH activities are reimbursed by other Federal, state or local programs, PATH funding must not duplicate such reimbursement.

CalPATH

Application Detail

Application ID	1120707
Submitted	Feb 15, 2024
Status	In progress
Applicant(s)	Cynthia Harlowe (harlowec@armc.sbcounty.gov)
Program and cycle	CITED Application Round 3 CITED Application Round 3
Tags	No tags
Forms	CA CITED Banking form

Page One

Instructions

This form is meant to collect banking and tax information from organizations receiving funds from California Department of Health Care Services (DHCS) in support of the Capacity and Infrastructure Transition, Expansion, and Development (CITED) initiative.

Please complete all fields included in this form. It is necessary to have the applying organization's banking information and W-9 for reference while completing this form.

For assistance in completing this form, please contact our Technical Assistance team at **cited@ca-path.com** or **(866) 529-7550.**

Representative Information

Name of Awarded Entity's Authorized Representative *
First and last name

No answer

Email of Authorized Representative *

No answer

Title of Authorized Representative *
Position of person completing this form.

No answer

Telephone Number of Authorized Representative *

No answer

Entity Demographics

Legal Business Name of Awarded Entity *
As name appears on tax forms.

No answer

Mailing Address of Awarded Entity *
Street address

No answer

Street address line 2

No answer

City *

No answer

State *

No answer

Zip code *

No answer

Tax Information

Legal Entity Type *
Select one

No answer

NOTE: Nonprofit corporations exempt under IRS Code Section 501(c)(3) should select "Other" above and enter "501(c)(3)" into the text box.

Taxpayer Identification Number (TIN) *
Employer Identification number

No answer

Taxpayer Identification Number (TIN) *
Re-enter for verification

No answer

Please upload a completed and signed W-9 form below.

No file uploaded

Banking Information

Banking Institution *
ex. Bank of America

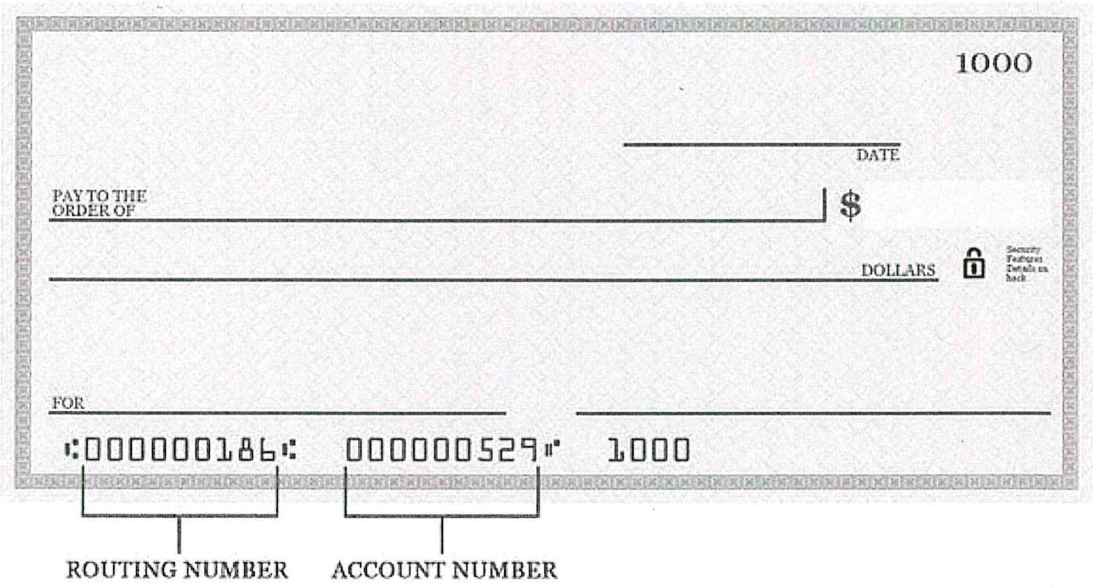
No answer

Banking account type *

No answer

Banking account holder name *
Account holder name should be the legal name of the organization or entity applying to receive DHCS funds.

No answer



Bank routing number *

No answer

Bank routing number *
Reenter for verification

No answer

Bank account number *

No answer

Bank account number *
Re-enter for verification

No answer

Attestations

As a condition of receiving funds distributed by the State of California, Department of Health Care Services (DHCS), through its contracted fiscal intermediary, Public Consulting Group LLC (PCG), on behalf of the below listed entity, I agree to the following and any applicable federal or state statutes and regulations associated with the funding received:

I am an agent of the entity applying for the PATH Capacity and Infrastructure Transition, Expansion, and Development Program (CITED) payments and am authorized by the entity to complete and sign this attestation on its behalf.

I authorize PCG to initiate ACH deposits to the bank account provided on a recurring basis.

The entity agrees that it is fully responsible for any and all tax consequences as a result of receiving DHCS payments and does not rely on anything that the State of California, DHCS, or PCG, state about this issue.

The entity agrees that the bank account information that it provides to receive the DHCS payments is accurate and is the account used by the entity for payment of business expenses. The entity agrees that it will not hold the State of California, DHCS, or PCG, responsible if the incorrect bank account information is provided and the DHCS funds are transferred to such account; the State of California, DHCS, and PCG, will accept the bank account information 'as is.'

The entity agrees it may be subject to federal or state reporting and/or auditing requirements. It agrees to maintain and report detailed financial information, as required, and to make its staff available to answer any questions or provide any documents about the DHCS payments and how it used the payments, upon request by any agency of the State of California, including DHCS or any other government agency at any time.

The entity agrees that it may receive DHCS payments while simultaneously receiving funding from other sources, including but not limited to federal or state programs. But the entity agrees that it cannot use the DHCS payments for expenses that are reimbursed or paid for by other federal or state programs or agencies. As a result, the entity is solely and exclusively responsible for abiding by all applicable terms, conditions, rules, and regulations concerning the receipt of federal or state payments. In addition, the entity will not hold the State of California, DHCS, or PCG, responsible in any way if the receipt of DHCS payments is prohibited or restricted as a result of other funding that the entity has received.

I agree to the terms and conditions outlined above. *

No answer

Confirmation Page

Confirmation Page

Please review your information below prior to submitting this form. If errors are identified, please use the 'Back' button or utilize the form navigation tabs to correct your information. Banking information provided in this form will be relied upon to issue direct deposit payments into your entity's bank account. **Failure to provide accurate banking information will delay your receipt of funds.**

Once this form is signed and submitted, the next step is to participate in the Penny Test Process conducted through the PATH Third Party Administrator (TPA) Finance Team. To verify the authenticity of your bank account, the PATH TPA Finance Team will perform a “Penny Test” process. You will receive an email notification from **finance@capath.com** with additional guidance. Please note, action is required on your part to complete this process.

Here's how it will work:
1. The TPA will make two small deposits (less than $0.50 each) in your account. The transaction detail on each deposit will show as CA PATH.
2. Access your bank account and view your transactions. Identify the two transactions from CA PATH and make note of the exact amounts of the transaction. If you do not see the transaction, wait 24 hours and check your bank account again.
3. Respond to the finance@ca-path.com email and provide the following information:
    1. The name of your organization
    2. The exact two amounts that were deposited into your account from CA PATH

    *****This process must be completed before funds can be disbursed.*****

    If you have a change in banking information in the future, you can request to update your banking information by emailing the CITED team at CITED@ca-path.com and we will initiate a repeat of the aforementioned process for your organization within GrantsConnect.

Representative Information

Name of awarded entity's authorized representative confirmation
First and last name

No answer

Email of authorized representative confirmation

No answer

Title of authorized representative confirmation
Position of person completing this form.

No answer

Telephone Number of Authorized Representative

No answer

Entity Demographics

Legal business name confirmation

No answer

Mailing Address of Awarded Entity confirmation
Street address

No answer

Street address line 2 confirmation

No answer

City confirmation

No answer

State confirmation

No answer

Zip code confirmation

No answer

Tax Information

Legal entity type confirmation
Select one

No answer

Taxpayer Identification Number (TIN) Confirmation
Employer Identification number

No answer

Banking Information

Banking Institution
ex. Bank of America

No answer

Banking account type confirmation

No answer

Bank routing number confirmation

No answer

Bank account number confirmation

No answer

I've reviewed the information above and it is accurate to the best of my knowledge. *

No answer

Date

Jul 10, 2024