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

Contract Number

25-171

SAP Number

Department of Behavioral Health

Department Contract Representative	Andrea Sanchez
Telephone Number	909-386-8264

Contractor	Victor Community Support Services, Inc.
Contractor Representative	Edward Hacket
Telephone Number	580-893-0758
Contract Term	April 1, 2025-June 30, 2026
Original Contract Amount	$10,180,605
Amendment Amount	N/A
Total Contract Amount	$10,180,605
Cost Center	9203242200 (SAP) 9207091000 (SATS)
Grant Number (if applicable)	N/A

THIS CONTRACT is entered into in the State of California by and between San Bernardino County, hereinafter called the County, and Victor Community Support Services, Inc. referenced above, hereinafter called Contractor.

IT IS HEREBY AGREED AS FOLLOWS:

WHEREAS, San Bernardino County (County) desires to designate a contractor of choice to ***Comprehensive Treatment Services:*** **Student Assistance Program (SAP) and School-Aged Treatment Services (SATS)**, as further described in the description of program services; and

WHEREAS, the County conducted a competitive process to find Victor Community Support Services, Inc. (Contractor) to provide these services, and

WHEREAS, based upon and in reliance on the representations of Contractor in its response to the County's Request for Proposals, the County finds Contractor qualified to provide Comprehensive Treatment Services; and

WHEREAS, the County desires that such services be provided by Contractor and Contractor agrees to perform these services as set forth below.

TABLE OF CONTENTS

	Article	Page
I.	Definition of Terminology	3
II.	General Contract Requirements	3
III.	Contract Supervision	4
IV.	Performance	5
V.	Funding and Budgetary Restrictions	14
VI.	Provisional Payment	16
VII.	Electronic Signatures	20
VIII.	Annual Cost Report Settlement	20
IX.	Fiscal Award Monitoring	23
X.	Final Settlement: Audit	24
XI.	Single Audit Requirement	25
XII.	Contract Performance Notification	26
XIII.	Probationary Status	27
XIV.	Duration and Termination	27
XV.	Accountability: Revenue	28
XVI.	Patient/Client Billing	28
XVII.	Personnel	29
XVIII.	Prohibited Affiliations	33
XIX.	Licensing, Certification and Accreditation	34
XX.	Health Information System	36
XXI.	Administrative Procedures	37
XXII.	Laws and Regulations	41
XXIII.	Patients' Rights	49
XXIV.	Confidentiality	49
XXV.	Admission Policies	49
XXVI.	Medical Records/Protected Health Information	49
XXVII.	Transfer of Care	51
XXVIII.	Quality Assurance/Utilization Review	51
XXIX.	Independent Contractor Status	51
XXX.	Subcontractor Status	51
XXXI.	Attorney Costs and Fees	53
XXXII.	Indemnification and Insurance	53
XXXIII.	Nondiscrimination	57
XXXIV.	Contract Amendments	60
XXXV.	Assignment	60
XXXVI.	Legality and Severability	60
XXXVII.	Improper Consideration	60
XXXVIII.	Venue	61
XXXIX.	Conclusion	62

Schedule A - Planning Estimates
Schedule B - Program Budget
Addendum I - Description of Program Services – Student Assistance Program
Addendum II - Description of Program Services – School-Aged Treatment Services
Attachment I - Attestation Regarding Ineligible/Excluded Persons
Attachment II - Data Security Requirements
Attachment III - Requirements for Day Treatment Intensive and Day Rehabilitation (If Applicable)

I. Definition of Terminology

A. Wherever in this document and in any attachments hereto, the terms "Contract" and/or "Agreement" are used to describe the conditions and covenants incumbent upon the parties hereto, these terms are interchangeable.

B. The terms beneficiary, client, consumer, customer, participant, or patient are used interchangeably throughout this document and refers to the individual(s) receiving services.

C. Definition of May, Shall and Should. Whenever in this document the words "may," "shall" and "should" are used, the following definitions shall apply: "may" is permissive; "shall" is mandatory; and "should" means desirable.

D. Subcontractor - An individual, company, firm, corporation, partnership or other organization, not in the employment of or owned by Contractor who is performing services on behalf of Contractor under the Contract or under a separate contract with or on behalf of Contractor.

E. The term "County's billing and transactional database system" refers to the centralized data entry system used by the Department of Behavioral Health (DBH) for patient and billing information.

F. The term "Director," unless otherwise stated, refers to the Director of DBH for San Bernardino County.

G. The term "head of service" as defined in the California Code of Regulations, Title 9, Sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.

H. The "State and/or applicable State agency" as referenced in this Contract may include the Department of Health Care Services (DHCS), the Department of State Hospitals (DSH), the Department of Social Services (DSS), the Mental Health Services Oversight and Accountability Commission (MHSOAC), the Department of Public Health (CDPH), and the Office of Statewide Health Planning and Development (OSHPD).

I. The U.S. Department of Health and Human Services (HHS) mission is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services.

J. The "provisional rates" are the interim rates established for billing and payment purposes and are subject to change upon request and approval by DBH Administrative Services - Fiscal Division.

II. General Contract Requirements

A. Recitals

The recitals set forth above are true and correct and incorporated herein by this reference.

B. Change of address

Contractor shall notify the County in writing, of any change in mailing address within ten (10) business days of the change.

C. Choice of Law

This Contract shall be governed by and construed according to the laws of the State of California.

D. Contract Exclusivity

This is not an exclusive Contract. The County reserves the right to enter into a contract with other contractors for the same or similar services. The County does not guarantee or represent that the Contractor will be permitted to perform any minimum amount of work, or receive compensation other than on a per order basis, under the terms of this Contract.

E. Material Misstatement/Misrepresentation

If during the course of the administration of this Contract, the County determines that Contractor has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, this Contract may be immediately terminated. If this Contract is terminated according to this provision, the County is entitled to pursue any available legal remedies.

F. Mutual Covenants

The parties to this Contract mutually covenant to perform all of their obligations hereunder, to exercise all discretion and rights granted hereunder, and to give all consents in a reasonable manner consistent with the standards of "good faith" and "fair dealing.

G. Notice of Delays

Except as otherwise provided herein, when either party has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this contract, that party shall, within twenty-four (24) hours, give notice thereof, including all relevant information with respect thereto, to the other party.

H. Relationship of the Parties

Nothing contained in this Contract shall be construed as creating a joint venture, partnership, or employment arrangement between the Parties hereto, nor shall either Party have the right, power or authority to create an obligation or duty, expressed or implied, on behalf of the other Party hereto.

I. Time of the Essence

Time is of the essence in performance of this Contract and of each of its provisions.

III. Contract Supervision

A. The Director or designee shall be the County employee authorized to represent the interests of the County in carrying out the terms and conditions of this Contract. The Contractor shall provide, in writing, the names of the persons who are authorized to represent the Contractor in this Contract.

B. Contractor will designate an individual to serve as the primary point of contact for this Contract. Contractor shall not change the primary contact without written notification and

acceptance of the County. Contractor shall notify DBH when the primary contact will be unavailable/out of the office for one (1) or more workdays and will also designate a back-up point of contact in the event the primary contact is not available. Contractor or designee must respond to DBH inquiries within two (2) business days.

C. Contractor shall provide DBH with contact information, specifically, name, phone number and email address of Contractor's staff member who is responsible for the following processes: Business regarding administrative issues, Technical regarding data issues, Clinical regarding program issues; and Facility.

IV. Performance

A. Under this Agreement, the Contractor shall provide those services, which are dictated by attached Addenda, Schedules and/or Attachments; specifically, contractor will provide the services listed on **Addendum I and II** School-Aged Treatment Services (SATS) and Student Assistance Program (SAP) Service Descriptions. The Contractor agrees to be knowledgeable in and apply all pertinent local, State, and Federal laws and regulations; including, but not limited to those referenced in the body of this Agreement. In the event information in the Addenda, Schedules and/or Attachments conflicts with the basic Agreement, then information in the Addenda, Schedules and/or Attachments shall take precedence to the extent permitted by law.

B. *Contractor shall provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for full scope Medi-Cal beneficiaries under age 21 in accordance with applicable provisions of law and Addendum I and II (or appropriate service description)*

C. Limitations on Moral Grounds

1. Contractor shall not be required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

2. If Contractor elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

a. To DBH:

i. After executing this Contract;

ii. Whenever Contractor adopts the policy during the term of the Contract;

b. Consistent with the provisions of 42 Code of Federal Regulations part 438.10:

i. To potential beneficiaries before and during enrollment; and

ii. To beneficiaries at least thirty (30) days prior to the effective date of the policy for any particular service.

D. Contractor is prohibited from offering Physician Incentive Plans, as defined in Title 42 CFR Sections 422.208 and 422.210, unless approved by DBH in advance that the Plan(s) complies with the regulations.

E. Contractor agrees to submit reports as requested and required by the County and/or the Department of Health Care Services (DHCS).

F. Data Collection and Performance Outcome Requirements

Contractor shall comply with all local, State, and Federal regulations regarding local, State, and Federal Performance Outcomes measurement requirements and participate in the outcomes measurement process, as required by the State and/or DBH. For Mental Health Services Act (MHSA) programs, Contractor agrees to meet the goals and intention of the program as indicated in the related MHSA Component Plan and most recent update.

Contractor shall comply with all requests regarding local, State, and Federal Performance Outcomes measurement requirements and participate in the outcomes measurement processes as requested.

MHSOAC, DHCS, OSHPD, DBH and other oversight agencies or their representatives have specific accountability and outcome requirements. Timely reporting is essential for meeting those expectations.

1. Contractor must collect, manage, maintain and update client, service and episode data as well as staffing data as required for local, State, and Federal reporting.

2. Contractor shall provide information by entering or uploading required data into:

   a. County's billing and transactional database system.

   b. DBH's client information system and, when available, its electronic health record system.

   c. The "Data Collection and Reporting" (DCR) system, which collects and manages Full Service Partnership (FSP) information.

   d. Individualized data collection applications as specified by DBH, such as Objective Arts and the Prevention and Early Intervention (PEI) Database.

   e. Any other data or information collection system identified by DBH, the MHSOAC, OSHPD or DHCS.

3. Contractor shall comply with all requirements regarding paper or online forms:

   a. Bi-Annual Client Perception Surveys (paper-based): twice annually, or as designated by DHCS. Contractor shall collect consumer perception data for clients served by the programs. The data to be collected includes, but not limited to, the client's perceptions of the quality and results of services provided by the Contractor.

   b. Client preferred language survey (paper-based), if requested by DBH.

   c. Intermittent services outcomes surveys.

   d. Surveys associated with services and/or evidence-based practices and programs intended to measure strategy, program, component, or system level outcomes and/or implementation fidelity.

   e. Network Adequacy Certification Tool (NACT) as required by DHCS and per DBH instructions.

4. Data must be entered, submitted and/or updated in a timely manner for:

   a. All FSP and non-FSP clients: this typically means that client, episode and service-related data shall be entered into the County's billing and transactional database system.

   b. All service, program, and survey data will be provided in accordance with all DBH established timelines.

   c. Required information about FSP clients, including assessment data, quarterly updates and key events shall be entered into the DCR online system by the due date or within 48 hours of the event or evaluation, whichever is sooner.

5. Contractor will ensure that data are consistent with DBH's specified operational definitions, that data are in the required format, that data is correct and complete at time of data entry, and that databases are updated when information changes.

6. Data collection requirements may be modified or expanded according to local, State, and/or Federal requirements.

7. Contractor shall submit, monthly, its own analyses of the data collected for the prior month, demonstrating how well the contracted services or functions provided satisfied the intent of the Contract, and indicating, where appropriate, changes in operations that will improve adherence to the intent of the Contract. The format for this reporting will be provided by DBH.

8. Independent research involving clients shall not be conducted without the prior written approval of the Director of DBH. Any approved research must follow the guidelines in the DBH Research Policy.

   Note: Independent research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

G. Right to Monitor and Audit Performance and Records

1. Right to Monitor

   County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, patient records, other pertinent items as requested, and shall have absolute right to monitor the performance of Contractor in the delivery of services provided under this Contract. Full cooperation shall be given by Contractor in any auditing or monitoring conducted, according to this agreement.

   Contractor shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to

Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Contract, or determinations of amounts payable available at any time for inspection, examination, or copying by DBH, the State of California or any subdivision or appointee thereof, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized Federal and State agencies. This audit right will exist for at least ten (10) years from the final date of the contract period or in the event the Contractor has been notified that an audit or investigation of this Contract has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies. Records and documents include, but are not limited to all physical and electronic records.

Contractor shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, County may audit, monitor, and/or request information from Contractor to ensure compliance with laws, regulations, and requirements, as applicable.

County reserves the right to place Contractor on probationary status, as referenced in the Probationary Status Article, should Contractor fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, timely and accurate data entry, meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Contractor may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.

2. Availability of Records

Contractor and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records, and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Contract or until such time as the matter under audit or investigation has been resolved. Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

Contractor shall maintain all records and management books pertaining to local service delivery and demonstrate accountability for contract performance and

maintain all fiscal, statistical, and management books and records pertaining to the program.

Records, should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

All records shall be complete and current and comply with all Contract requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of a Contract.

Contractor shall maintain client and community service records in compliance with all regulations set forth by local, State, and Federal requirements, laws and regulations, and provide access to clinical records by DBH staff.

Contractor shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.

Contractor shall agree to maintain and retain all appropriate service and financial records for a period of at least ten (10) years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.

Contractor shall submit audited financial reports on an annual basis to DBH. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

In the event the Contract is terminated, ends its designated term or Contractor ceases operation of its business, Contractor shall deliver or make available to DBH all financial records that may have been accumulated by Contractor or subcontractor under this Contract, whether completed, partially completed or in progress within seven (7) calendar days of said termination/end date.

3. Assistance by Contractor

Contractor shall provide all reasonable facilities and assistance for the safety and convenience of County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work of Contractor.

H. Notwithstanding any other provision of this Agreement, the County may withhold all payments due to Contractor, if Contractor has been given at least thirty (30) days notice of any deficiency(ies) and has failed to correct such deficiency(ies). Such deficiency(ies) may include, but are not limited to: failure to provide services described in this Agreement; Federal, State, and County audit exceptions resulting from noncompliance, violations of

pertinent Federal and State laws and regulations, and significant performance problems as determined by the Director or designee from monitoring visits.

I. County has the discretion to revoke full or partial provisions of the Contract, delegated activities or obligations, or application of other remedies permitted by State or Federal law when the County or DHCS determines Contractor has not performed satisfactorily.

J. Cultural Competency

The State mandates counties to develop and implement a Cultural Competency Plan (CCP). This Plan applies to all DBH services. Policies and procedures and all services must be culturally and linguistically appropriate. Contract agencies are included in the implementation process of the most recent State approved CCP for San Bernardino County and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.

1. Cultural and Linguistic Competency

Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.

a. To ensure equal access to quality care for diverse populations, Contractor shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) national standards.

b. Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.

c. Upon request, Contractor shall provide DBH with culture-specific service options available to be provided by Contractor.

d. Contractor shall have the capacity or ability to provide interpretation and translation services in threshold and prevalent non-English languages, free of charge to beneficiaries. Upon request, Contractor will provide DBH with language service options available to be provided by Contractor. Including procedures to determine competency level for multilingual/bilingual personnel.

e. Contractor shall provide cultural competency training to personnel.

NOTE: Contractor staff is required to complete cultural competency trainings. Staff who do not have direct contact providing services to

clients/consumers shall complete a minimum of two (2) hours of cultural competency training, and direct service staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Contractor shall upon request from the County, provide information and/or reports as to whether its provider staff completed cultural competency training.

f. DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing mental health and substance use disorder treatment services in a culturally appropriate and responsive manner is fundamental in any effort to ensure success of high quality and cost-effective behavioral health services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers does not reflect high quality of care and is not cost-effective.

g. To assist Contractor's efforts towards cultural and linguistic competency, DBH shall provide the following:

i. Technical assistance to Contractor regarding cultural competency implementation.

a) Monitoring activities administered by DBH may require Contractor to demonstrate documented capacity to offer services in threshold languages or contracted interpretation and translation services.

b) procedures must be in place to determine multilingual and competency level(s).

ii. Demographic information to Contractor on service area for service(s) planning.

iii. Cultural competency training for DBH and Contractor personnel, when available.

iv. Interpreter training for DBH and Contractor personnel, when available.

v. Technical assistance for Contractor in translating mental health and substance use disorder treatment services information to DBH's threshold languages. Technical assistance will consist of final review and field testing of all translated materials as needed.

vi. The Office of Equity and Inclusion (OEI) may be contacted for technical assistance and training offerings at

cultural_competency@dbh.sbcounty.gov or by phone at (909) 252-5150.

K. Access by Public Transportation

Contractor shall ensure that services provided are accessible by public transportation.

L. Accessibility/Availability of Services

Contractor shall ensure that services provided are available and accessible to beneficiaries in a timely manner including those with limited English proficiency or physical or mental disabilities. Contractor shall provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities [(42 C.F.R. § 438.206(b)(1) and (c)(3)].

M. Internal Control

Contractor must establish and maintain effective internal control over the County Fund to provide reasonable assurance that the Contractor manages the County Fund in compliance with Federal, State and County statutes, regulations, and terms and conditions of the Contract.

Fiscal practices and procedures shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Additionally, fiscal practices and procedures must comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

N. Site Inspection

Contractor shall permit authorized County, State, and/or Federal Agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

O. Disaster Response

1. In the event that a local, State, or Federal emergency is proclaimed within San Bernardino County, Contractor shall cooperate with the County in the implementation of the DBH Disaster Response Plan. This may include deployment of Contractor staff to provide services in the community, in and around county areas under mutual aid contracts, in shelters and/or other designated areas.

2. Contractor shall provide the DBH Disaster Coordinator with a roster of key administrative and response personnel including after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be kept current by quarterly reports to the County by Contractor. The County shall keep such information confidential and not release other than to authorized County personnel or as otherwise required by law.

3. Contractor shall ensure that, within three months from the Contract effective date, at least twenty-five percent (25%) of Contractor's permanent direct service staff participates in a disaster response orientation and training provided by the County or County's designee.

4. Said twenty-five percent (25%) designated Contractor permanent direct service staff shall complete the following disaster trainings as prerequisites to the DBH live trainings held annually, which are available online on the Federal Emergency Management Agency (FEMA) website at https://training.fema.gov/is/crslist.aspx.

   a. IS: 100

   b. IS: 200

   c. IS: 700

   d. IS: 800

5. The County agrees to reimburse Contractor for all necessary and reasonable expenses incurred as a result of participating in the County's disaster response at the request of County. Any reasonable and allowable expenses above the Contract maximum will be subject to negotiations.

6. Contractor shall provide the DBH with the key administrative and response personnel including after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. Updated reports are due fourteen (14) days after the close of each quarter. Please send updated reports to:

   Office of Disaster and Safety

   303 E. Vanderbilt Way

   San Bernardino, CA 92415

   safety@dbh.sbcounty.gov

P. Collections Costs

Should the Contractor owe monies to the County for reasons including, but not limited to, Quality Management review, cost-settlement, and/or fiscal audit, and the Contractor has failed to pay the balance in full or remit mutually agreed upon payment, the County may refer the debt for collection. Collection costs incurred by the County shall be recouped from the Contractor. Collection costs charged to the Contractor are not a reimbursable expenditure under the Contract.

Q. Damage to County Property, Facilities, Buildings, or Grounds (If Applicable)

Contractor shall repair, or cause to be repaired, at its own cost, all damage to County vehicles, facilities, buildings or grounds caused by the willful or negligent acts of Contractor or employees or agents of the Contractor. Contractor shall notify DBH within two (2) business days when such damage has occurred. All repairs or replacements must be approved by the County in writing, prior to the Contractor's commencement of repairs or replacement of reported damaged items. Such repairs shall be made as soon as

possible after Contractor receives written approval from DBH but no later than thirty (30) days after the DBH approval.

If the Contractor fails to make timely repairs to County vehicles, facilities, buildings, or ground caused by the willful or negligent act of Contractor or employees or agents of the Contractor, the County may make any necessary repairs. The Contractor, as determined by the County, for such repairs shall repay all costs incurred by the County, by cash payment upon demand, or County may deduct such costs from any amounts due to the Contractor from the County.

R. Damage to County Issued/Loaned Equipment (If Applicable)

1. Contractor shall repair, at its own cost, all damage to County equipment issued/loaned to Contractor for use in performance of this Contract. Such repairs shall be made immediately after Contractor becomes aware of such damage, but in no event later than thirty (30) days after the occurrence.

2. If the Contractor fails to make timely repairs, the County may make any necessary repairs. The Contractor shall repay all costs incurred by the County, by cash payment upon demand, or County may deduct such costs from any amounts due to the Contractor from the County.

3. If a virtual private network (VPN) token is lost or damaged, Contractor must contact DBH immediately and provide the user name assigned to the VPN Token. DBH will obtain a replacement token and assign it to the user account. Contractor will be responsible for the VPN token replacement fee.

S. Strict Performance

Failure by a party to insist upon the strict performance of any of the provisions of this Contract by the other party, or the failure by a party to exercise its rights upon the default of the other party, shall not constitute a waiver of such party's right to insist and demand strict compliance by the other party with the terms of this Contract thereafter.

T. Telehealth

Contractor shall utilize telehealth, when deemed appropriate, as a mode of delivering behavioral health services in accordance with all applicable state and federal requirements, DBH's Telehealth Policy (MDS2027) and Procedure (MDS2027-1), as well as DHCS Telehealth Policy, CMS Telehealth/Telemedicine Standards, and those related to privacy/security, efficiency, and standards of care.

DBH may at any time require documentation and/or other cooperation by Contractor to allow adequate monitoring of Contractor's adherence to telehealth practices.

V. Funding and Budgetary Restrictions

A. This Agreement shall be subject to any restrictions, limitations, or conditions imposed by State, County or Federal governments which may in any way affect the provisions or funding of this Agreement, including, but not limited to those contained in the Schedules A and B. This Agreement is also contingent upon sufficient funds being made available by State, County or Federal governments for the term of the Agreement. Funding is by fiscal year period July 1 through June 30. Costs and services are accounted for by fiscal

year. Any unspent fiscal year allocation does not roll over and is not available in future years. Each fiscal year period will be settled to Federal and/or State cost reporting accountability.

B. The maximum financial obligation of the County under this Agreement shall not exceed the sum referenced in the Schedules A and B. The maximum financial obligation is further limited by fiscal year, funding source and service modalities as delineated on the Schedules A and B. Contractor may not transfer funds between funding sources, modes of services, or exceed 10% of a budgeted line item without the prior written approval from DBH.

   1. It is understood between the parties that the Schedules A and B are budgetary guidelines. Contractor must adhere to the budget by funding outlined in the Schedule A of the Contract as well as track year-to-date expenditures. Contractor understands that costs incurred for services not listed or in excess of the funding in the Schedule A shall result in non-payment to Contractor for these costs.

C. Contractor agrees to renegotiate the dollar value of this Contract, at the option of the County, if the annualized projected units of service (minutes/hours of time/days) for any mode of service based on claims submitted through March of the operative fiscal year, is less than 90% of the projected minutes/hours of time/days for the modes of service as reported in the Schedules A and B.

D. If the annualized projected units of service (minutes/hours of time/days) for any mode of service, based on claims submitted through March of the operative fiscal year, is greater than/or equal to 110% of the projected units (minutes/hours of time/days) reported in the Schedules A and B, the County and Contractor agree to meet to discuss the feasibility of renegotiating this Agreement. Contractor must timely notify the County of Contractor's desire to meet.

E. County will take into consideration requests for changes to Contract funding, within the existing contracted amount. All requests must be submitted in writing by Contractor to DBH Fiscal no later than March 1 for the operative fiscal year. Requests must be addressed to the Fiscal Designee written on organizational letterhead, and include an explanation of the revisions being requested.

F. If the Contractor provides services under the Medi-Cal program and if the Federal government reduces its participation in the Medi-Cal program, the County agrees to meet with Contractor to discuss renegotiating the total minutes/hours of time required by this Agreement.

G. Contractor Prohibited From Redirections of Contracted Funds:

   1. Funds under this Agreement are provided for the delivery of mental health services to eligible beneficiaries under each of the funded programs identified in the Scope of Work. Each funded program has been established in accordance with the requirements imposed by each respective County, State and/or Federal payer source contributing to the funded program.

   2. Contractor may not redirect funds from one funded program to another funded program, except through a duly executed amendment to this Agreement.

3. Contractor may not charge services delivered to an eligible beneficiary under one funded program to another funded program unless the recipient is also an eligible beneficiary under the second funded program.

H. The allowable funding sources for this Contract may include: Mental Health Services Act funds (MHSA), Federal Financial Participation Medi-Cal (FFP), and 2011 Realignment. Federal funds may not be used as match funds to draw down other federal funds.

I. The maximum financial obligation under this contract shall not exceed $10,180,605 for the contract term.

VI. Provisional Payment

A. During the term of this Agreement, the County shall reimburse Contractor in arrears for eligible expenditures provided under this Agreement and in accordance with the terms. County payments to Contractor for performance of eligible services hereunder are provisional until the completion of all settlement activities.

B. County's adjustments to provisional reimbursements to Contractor will be based upon State adjudication of Medi-Cal claims, contractual limitations of this Agreement, annual cost report, application of various County, State and/or Federal reimbursement limitations, application of any County, State and/or Federal policies, procedures and regulations and/or County, State or Federal audits, all of which take precedence over monthly claim reimbursement. State adjudication of Medi-Cal claims, annual cost report and audits, as such payments, are subject to future County, State and/or Federal adjustments.

C. All expenses claimed to DBH must be specifically related to the contract. After fiscal review and approval of the billing or invoice, County shall provisionally reimburse Contractor, subject to the limitations and conditions specified in this Agreement, in accordance with the following:

1. The County will reimburse Contractor based upon Contractor's submitted and approved claims for rendered services/activities subject to claim adjustments, edits, and future settlement and audit processes.

2. Reimbursement for Outreach, Education and Support services (Modes 45 and 60) provided by Contractor will be at net cost.

3. Reimbursement Rates for Institutions for Mental Diseases: Pursuant to Section 5902 € of the WIC, Institutions for Mental Diseases (IMD), which are licensed by the DHCS, will be reimbursed at the rate(s) established by DHCS.

4. Reimbursement for mental health services claimed and billed through the DBH treatment claims processing information system will utilize provisional rates.

5. It is the responsibility of Contractor to access MyAvatar reports and make any necessary corrections to the denied Medi-Cal services and notify the County. The County will resubmit the corrected services to DHCS for adjudication.

6. In the event that the denied claims cannot be corrected, and therefore DHCS will not adjudicate and approve the denied claims, Contractor is required to follow DBH's Overpayment Policy COM0954, which has been provided or will be provided to Contractor at its request.

D. Contractor shall bill the County monthly in arrears for services provided by Contractor on claim forms provided by DBH. All claims submitted shall clearly reflect all required information specified regarding the services for which claims are made. Contractor shall submit the organizations' Profit and Loss Statement with each monthly claim. Each claim shall reflect any and all payments made to Contractor by, or on behalf of patients. Claims for Reimbursement shall be completed and forwarded to DBH within ten (10) days after the close of the month in which services were rendered. Following receipt of a complete and correct monthly claim, the County shall make payment within a reasonable period. Payment, however, for any mode of service covered hereunder, shall be limited to a maximum monthly amount, which amount shall be determined as noted.

1. For each fiscal year period (FYs 24/25,25/26), no single monthly payment for any mode of service shall exceed one-twelfth (1/12) of the maximum allocations for the mode of service unless there have been payments of less than one-twelfth (1/12) of such amount for any prior month of the Agreement. To the extent that there have been such lesser payments, then the remaining amount(s) may be used to pay monthly services claims which exceed one-twelfth (1/12) of the maximum for that mode of service. Each claim shall reflect the actual costs expended by the Contractor subject to the limitations and conditions specified in this Agreement.

E. Monthly payments for Short-Doyle Medi-Cal services will be based on actual units of time (minutes, hours, or days) reported on Charge Data Invoices claimed to the State times the provisional rates in the DBH claiming system. The provisional rates will be reviewed at least once a year throughout the life of the Contract and shall closely approximate final actual cost per unit rates for allowable costs as reported in the year-end cost report. All approved provisional rates will be superseded by actual cost per unit rate as calculated during the cost report cost settlement. In the event of a conflict between the provisional rates set forth in the most recent cost report and those contained in the Schedules A and B, the rates set forth in the most recent cost report shall prevail.

1. In accordance with WIC 14705 (c) Contractor shall ensure compliance with all requirements necessary for Medi-Cal reimbursement.

F. Contractor shall report to the County within sixty (60) calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services [42 C.F.R. § 438.608(c)(3)].

G. All approved provisional rates, including new fiscal year rates and mid-year rate changes, will only be effective upon Fiscal Designee approval.

H. Contractor shall make its best effort to ensure that the proposed provisional reimbursement rates do not exceed the following: Contractor's published charges and Contractor's actual cost.

I. Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission, if applicable.

J. Pending a final settlement between the parties based upon the post Contract audit, it is agreed that the parties shall make preliminary settlement within one hundred twenty (120)

days of the fiscal year or upon termination of this Agreement as described in the Annual Cost Report Settlement Article.

K. Contractor shall input Charge Data Invoices (CDI's) or equivalent into the County's billing and transactional database system by the seventh (7th) day of the month for the previous month's Medi-Cal based services. Contractor will be paid based on Medi-Cal claimed services in the County's billing and transactional database system for the previous month. Services cannot be billed by the County to the State until they are input into the County's billing and transactional database system.

L. Contractor shall accept all payments from County via electronic funds transfer (EFT) directly deposited into the Contractor's designated checking or other bank account. Contractor shall promptly comply with directions and accurately complete forms provided by County required to process EFT payments.

M. Contractor shall be in compliance with the Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act [42 U.S.C. 1396(a) (68)], set forth in that subsection and as the Federal Secretary of the United States Department of Health and Human Services may specify.

N. As this contract may be funded in whole or in part with Mental Health Services Act funds signed into law January 1, 2005, Contractor must verify client eligibility for other categorical funding, prior to utilizing MHSA funds. Failure to verify eligibility for other funding may result in non-payment for services. Also, if audit findings reveal Contractor failed to fulfill requirements for categorical funding, funding source will not revert to MHSA. Contractor will be required to reimburse funds to the County.

O. Contractor agrees that no part of any Federal funds provided under this Contract shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at http://www.opm.gov/ (U.S. Office of Personnel Management).

P. County is exempt from Federal excise taxes and no payment shall be made for any personal property taxes levied on Contractor or any taxes levied on employee wages. The County shall only pay for any State or local sales or use taxes on the services rendered or equipment and/or parts supplied to the County pursuant to the Contract.

Q. Contractor shall have a written policy and procedures which outline the allocation of direct and indirect costs. These policies and procedures should follow the guidelines set forth in the Uniform Grant Guidance, Cost Principles and Audit Requirements for Federal Awards. Calculation of allocation rates must be based on actual data (total direct cost, labor costs, labor hours, etc.) from current fiscal year. If current data is not available, the most recent data may be used. Contractor shall acquire actual data necessary for indirect costs allocation purpose. Estimated costs must be reconciled to actual cost. Contractor must notify DBH in writing if the indirect cost rate changes.

R. As applicable, for Federal Funded Program, Contactor shall charge the County program a de Minimis ten percent (10%) of the Modified Total Direct Cost (MTDC) as indirect cost.

If Contractor has obtained a "Federal Agency Acceptance of Negotiated Indirect Cost Rates", the contractor must also obtain concurrence in writing from DBH of such rate.

For non-Federal funded programs, indirect cost rate claimed to DBH contracts cannot exceed fifteen percent (15%) of the MTDC of the program unless pre-approved in writing by DBH or Contractor has a "Federal Agency Acceptance of Negotiated Indirect Rates."

The total cost of the program must be composed of the total allowable direct cost and allocable indirect cost less applicable credits. Cost must be consistently charged as either indirect or direct costs but, may not be double charged or inconsistently charged as both, reference Title II Code of Federal Regulations (CFR) §200.414 indirect costs. All cost must be based on actual instead of estimated costs.

S. Prohibited Payments

1. County shall make no payment to Contractor other than payment for services covered under this Contract.

2. Federal Financial Participation is not available for any amount furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

3. In accordance with Section 1903(i) of the Social Security Act, County is prohibited from paying for an item or service:

   a. Furnished under contract by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

   b. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

   c. Furnished by an individual or entity to whom the County has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the County determines there is good cause not to suspend such payments.

   d. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

T. If DHCS or the County determines there is a credible allegation of fraud, waste or abuse against government funds, the County shall suspend payments to the Contractor.

VII. Electronic Signatures

A. The State has established the requirements for electronic signatures in electronic health record systems. DBH has sole discretion to authorize contractors to use e-signatures as applicable. If Contractor desires to use e-signatures in the performance of this Contract, Contractor shall submit the request in writing to the DBH Office of Compliance (Compliance) along with the E-Signature Checklist and requested policies to the Compliance general email inbox at compliance_questions@dbh.sbcounty.gov.

Compliance will review the request and forward the submitted checklist and policies to the DBH Information Technology (IT) for review. This review period will be based on the completeness of the material submitted.

Contractor will receive a formal letter with tentative approval and the E-Signature Agreement. Contractor shall obtain all signatures for staff participating in E-Signature and submit the Agreement with signatures, as directed in the formal letter.

Once final, the DBH Office of Compliance will send a second formal letter with the DBH Director's approval and a copy of the fully executed E-Signature Agreement will be sent to Contractor.

B. DBH reserves the right to change or update the e-signature requirements as the governing State agency(ies) modifies requirements.

C. DBH reserves the right to terminate e-signature authorization at will and/or should the contract agency fail to uphold the requirements.

VIII. Annual Cost Report Settlement

A. Section 14705 (c) of the Welfare and Institutions Code (WIC) requires contractors to submit fiscal year-end cost reports. Contractor shall provide DBH with a complete and correct annual cost report not later than sixty (60) days at the end of each fiscal year and not later than sixty (60) days after the expiration date or termination of this Contract, unless otherwise notified by County.

1. Accurate and complete annual cost report shall be defined as a cost report which is completed on forms or in such formats as specified by the County and consistent with such instructions as the County may issue and based on the best available data provided by the County.

B. The cost report is a multiyear process consisting of a preliminary settlement, final settlement, and is subject to audit by DHCS pursuant to WIC 14170.

C. These cost reports shall be the basis upon which both a preliminary and a final settlement will be made between the parties to this Agreement. In the event of termination of this Contract by Contractor pursuant to Duration and Termination Article, Paragraph C, the preliminary settlement will be based upon the most updated State Medi-Cal approvals and County claims information.

1. Upon initiation and instruction by the State, County will perform the Short-Doyle/Medi-Cal Cost Report Reconciliation and Settlement with Contractor.

a. Such reconciliation and settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or Federal statutes, regulations, policies, procedures, and/or other requirements pertaining to cost reporting and settlements for Title XIX and/or Title XXI and other applicable Federal and/or State programs.

2. Contractor shall submit an annual cost report for a preliminary cost settlement. This cost report shall be submitted no later than sixty (60) days after the end of the fiscal year and it shall be based upon the actual minutes/hours/days which have been approved by DHCS up to the preliminary submission period as reported by DBH.

3. Contractor shall submit a reconciled cost report for a final settlement. The reconciled cost report shall be submitted approximately eighteen (18) months after the fiscal year-end. The eighteen (18) month timeline is an approximation as the final reconciliation process is initiated by the DHCS. The reconciliation process allows Contractor to add additional approved Medi-Cal units and reduce disallowed or denied units that have been corrected and approved subsequent to the initial cost report submission. Contractors are not permitted to increase total services or cost during this reconciliation process.

4. Each Annual Cost Report shall be prepared by Contractor in accordance with the Centers for Medicare and Medicaid Services' Publications #15-1 and #15-02; "The Providers Reimbursement Manual Parts 1 and 2;" the State Cost and Financial Reporting Systems (CFRS) Instruction Manual; and any other written guidelines that shall be provided to Contractor at the Cost Report Training, to be conducted by County on or before October 15 of the fiscal year for which the annual cost report is to be prepared.

   a. Attendance by Contractor at the County's Cost Report Training is mandatory.

   b. Failure by Contractor to attend the Cost Report Training shall be considered a breach of this Agreement.

5. Failure by Contractor to submit an annual cost report within the specified date set by the County shall constitute a breach of this Agreement. In addition to, and without limiting, any other remedy available to the County for such a breach, the County may, at its option, withhold any monetary settlements due Contractor until the cost report(s) is (are) complete.

6. Only the Director or designee may make exception to the requirement set forth in the Annual Cost Report Settlement Article, Paragraph A above, by providing Contractor written notice of the extension of the due date.

7. If Contractor does not submit the required cost report(s) when due and therefore no costs have been reported, the County may, at its option, request full payment of all funds paid Contractor under Provisional Payment Article of this Agreement. Contractor shall reimburse the full amount of all payments made by the County to Contractor within a period of time to be determined by the Director or designee.

8. No claims for reimbursement will be accepted by the County after the cost report is submitted by the contractor. The total costs reported on the cost report must match the total of all the claims submitted to DBH by Contractor as of the end of the fiscal year which includes revised and/or final claims. Any variances between the total costs reported in the cost report and fiscal year claimed costs must be justified during the cost report process in order to be considered allowable.

9. Annual Cost Report Reconciliation Settlement shall be subject to the limitations contained in this Agreement but not limited to:

   a. Available Match Funds

   b. Actual submitted and approved claims to those third-parties providing funds in support of specific funded programs.

D. As part of its annual cost report settlement, County shall identify any amounts due to Contractor by the County or due from Contractor to the County.

1. Upon issuance of the County's annual cost report settlement, Contractor may, within fourteen (14) business days, submit a written request to the County for review of the annual cost report settlement.

2. Upon receipts by the County of Contractor's written request, the County shall, within twenty (20) business days, meet with Contractor to review the annual cost report settlement and to consider any documentation or information presented by Contractor. Contractor may waive such meeting and elect to proceed based on written submission at its sole discretion.

3. Within twenty (20) business days of the meeting specified above, the County shall issue a response to Contractor including confirming or adjusting any amounts due to Contractor by the County or due from Contractor to the County.

4. In the event the Annual Cost Report Reconciliation Settlement indicates that Contractor is due payment from the County, the County shall initiate the payment process to Contractor before submitting the annual Cost report to DHCS or other State agencies.

5. In the event the Annual Cost Report Reconciliation Settlement indicates that Contractor owes payments to the County, Contractor shall make payment to the County in accordance with Paragraph E below (Method of Payments for Amounts Due to the County).

6. Regardless of any other provision of this Paragraph D, reimbursement to Contractor shall not exceed the maximum financial obligation by fiscal year, funding source, and service modalities as delineated on the Schedules A and B.

E. Method of Payments for Amounts Due to the County

1. Contractor will notify DBH-Fiscal and Compliance of overpayment within five (5) business days at the following email addresses:

DBH-Fiscal-ProviderPayments@dbh.sbcounty.gov
Compliance_questions@dbh.sbcounty.gov.

2. Within five (5) business days after the contractor identifies overpayment or after written notification by the County to Contractor of any amount due by Contractor, Contractor shall notify the County as to which payment option will be utilized. Payment options for the amount to be recovered will be outlined in the settlement letter.

3. Contractor is responsible for returning overpayments to the County within sixty (60) calendar days from the date the overpayment was identified regardless if instruction from DBH-Fiscal is received.

F. Notwithstanding Final Settlement: Audit Article, Paragraph F, County shall have the option:

1. To withhold payment, or any portion thereof, pending outcome of a termination audit to be conducted by County;

2. To withhold any sums due Contractor as a result of a preliminary and final cost settlement, pending outcome of a termination audit or similar determination regarding Contractor's indebtedness to County and to offset such withholdings as to any indebtedness to County.

G. Preliminary and Final Cost Settlement: The cost of services rendered shall be adjusted to the lowest of the following:

1. Actual net cost (for non-Short-Doyle/Medi-Cal services);

2. Published charges;

3. Maximum allowable minutes/hours/days of time provided for each service functions for approved Short-Doyle/Medi-Cal services; or,

4. Maximum Contract amount.

IX. Fiscal Award Monitoring

A. County has the right to monitor the Contract during the award period to ensure accuracy of claim for reimbursement and compliance with applicable laws and regulations.

B. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records and to disclose to State and County representatives all financial records necessary to review or audit Contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Contractor shall attain a signed confidentiality statement from said County or State representative when access to any patient records is being requested for research and/or auditing purposes. Contractor will retain the confidentiality statement for its records.

C. If the appropriate agency of the State of California, or the County, determines that all, or any part of, the payments made by the County to Contractor pursuant hereto are not reimbursable in accordance with this Agreement, said payments will be repaid by Contractor to the County. In the event such payment is not made on demand, the County may withhold monthly payment on Contractor's claims until such disallowances are paid by Contractor.

X. Final Settlement: Audit

A. Contractor agrees to maintain and retain all appropriate service and financial records for a period of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. This is not to be construed to relieve Contractor of the obligations concerning retention of medical records as set forth in Medical Records/Protected Health Information Article.

B. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records and to disclose to State and County representatives all financial records necessary to review or audit Contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Contractor shall attain a signed confidentiality statement from said County or State representative when access to any patient record is being requested for research and/or auditing purposes. Contractor will retain the confidentiality statement for its records.

C. If the appropriate agency of the State of California, or the County, determines that all, or any part of, the payments made by the County to Contractor pursuant hereto are not reimbursable in accordance with this Agreement, said payments will be repaid by Contractor to the County. In the event such payment is not made on demand, the County may withhold monthly payment on Contractor's claims until such disallowances are paid by Contractor, may refer for collections, and/or the County may terminate and/or indefinitely suspend this Agreement immediately upon serving written notice to the Contractor.

D. The eligibility determination and the fees charged to, and collected from, patients whose treatment is provided for hereunder may be audited periodically by the County, DBH and the State.

E. Contractor expressly acknowledges and will comply with all audit requirements contained in the Contract documents. These requirements include, but are not limited to, the agreement that the County or its designated representative shall have the right to audit, to review, and to copy any records and supporting documentation pertaining to the performance of this Agreement. The Contractor shall have fourteen (14) days to provide a response and additional supporting documentation upon receipt of the draft post Contract audit report. DBH – Administration Audits will review the response(s) and supporting documentation for reasonableness and consider updating the audit information. After said time, the post Contract audit report will be final.

F. If a post Contract audit finds that funds reimbursed to Contractor under this Agreement were in excess of actual costs or in excess of claimed costs (depending upon State of California reimbursement/audit policies) of furnishing the services, the difference shall be reimbursed on demand by Contractor to the County using one of the following methods, which shall be at the election of the County:

1. Payment of total.

2. Payment on a monthly schedule of reimbursement agreed upon by both the Contractor and the County.

G. If there is a conflict between a State of California audit of this Agreement and a County audit of this Agreement, the State audit shall take precedence.

H. In the event this Agreement is terminated, the last reimbursement claim shall be submitted within sixty (60) days after the Contractor discontinues operating under the terms of this Agreement. When such termination occurs, the County shall conduct a final audit of the Contractor within the ninety (90) day period following the termination date, and final reimbursement to the Contractor by the County shall not be made until audit results are known and all accounts are reconciled. No claims for reimbursement shall be accepted after the sixtieth (60th) day following the date of contract termination.

I. If the Contractor has been approved by the County to submit Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal claims, audit exceptions of Medi-Cal eligibility will be based on a statistically valid sample of EPSDT Medi-Cal claims by mode of service for the fiscal year projected across all EPSDT Medi-Cal claims by mode of service.

XI. Single Audit Requirement

Pursuant to CFR, Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Contractors expending the threshold amount or more in Federal funds within the Contractor's fiscal year must have a single or program-specific audit performed in accordance with Subpart F, Audit Requirements. The audit shall comply with the following requirements:

A. The audit shall be performed by a licensed Certified Public Accountant (CPA).

B. The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, latest revision, issued by the Comptroller General of the United States.

C. At the completion of the audit, the Contractor must prepare, in a separate document from the auditor's findings, a corrective action plan to address each audit finding included in the auditor's report(s). The corrective action plan must provide the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If Contractor does not agree with the audit findings or believes corrective action is not required, then the corrective action plan must include an explanation and specific reasons.

D. Contractor is responsible for follow-up on all audit findings. As part of this responsibility, the Contractor must prepare a summary schedule of prior audit findings. The summary schedule of prior audit findings must report the status of all audit findings included in the prior audit's schedule of findings and questioned costs. When audit findings were fully corrected, the summary schedule need only list the audit findings and state that corrective action was taken.

E. Contractor must electronically submit within thirty (30) calendar days after receipt of the auditor's report(s), but no later than nine (9) months following the end of the Contractor's fiscal year, to the Federal Audit Clearinghouse (FAC) the Data Collection Form SF-SAC (available on the FAC Web site) and the reporting package which must include the following:

1. Financial statements and schedule of expenditures of Federal awards
2. Summary schedule of prior audit findings
3. Auditor's report(s)
4. Corrective action plan

Contractor must keep one copy of the data collection form and one copy of the reporting package described above on file for ten (10) years from the date of submission to the FAC or from the date of completion of any audit, whichever is later.

F. The cost of the audit made in accordance with the provisions of Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards can be charged to applicable Federal awards. However, the following audit costs are unallowable:

1. Any costs when audits required by the Single Audit Act that have not been conducted or have been conducted but not in accordance with the Single Audit requirement.
2. Any costs of auditing that is exempted from having an audit conducted under the Single Audit Act and Subpart F – Audit Requirements because its expenditures under Federal awards are less than the threshold amount during the Contractor's fiscal year.

Where apportionment of the audit is necessary, such apportionment shall be made in accordance with generally accepted accounting principles, but shall not exceed the proportionate amount that the Federal funds represent of the Contractor's total revenue.

The costs of a financial statement audit of Contractor's that do not have a Federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

G. Contractor must prepare appropriate financial statements, including Schedule of Expenditures for Federal Awards (SEFA).

H. The work papers and the audit reports shall be retained for a minimum of ten (10) years from the date of the final audit report, and longer if the independent auditor is notified in writing by the County to extend the retention period.

I. Audit work papers shall be made available upon request to the County, and copies shall be made as reasonable and necessary.

XII. Contract Performance Notification

A. In the event of a problem or potential problem that will impact the quality or quantity of work or the level of performance under this Contract, Contractor shall provide notification within one (1) working day, in writing and by telephone, to DBH.

B. Contractor shall notify DBH in writing of any change in mailing address within ten (10) calendar days of the address change.

XIII. Probationary Status

A. In accordance with the Performance Article of this Agreement, the County may place Contractor on probationary status in an effort to allow the Contractor to correct deficiencies, improve practices, and receive technical assistance from the County.

B. County shall give notice to Contractor of change to probationary status. The effective date of probationary status shall be five (5) business days from date of notice.

C. The duration of probationary status is determined by the Director or designee(s).

D. Contractor shall develop and implement a corrective action plan, to be approved by DBH, no later than ten (10) business days from date of notice to become compliant.

E. Should the Contractor refuse to be placed on probationary status or comply with the corrective action plan within the designated timeframe, the County reserves the right to terminate this Agreement as outlined in the Duration and Termination Article.

F. Placement on probationary status requires the Contractor disclose probationary status on any Request for Proposal responses to the County.

G. County reserves the right to place Contractor on probationary status or to terminate this Agreement as outlined in the Duration and Termination Article.

XIV. Duration and Termination

A. The term of this Agreement shall be from April 1, 2025 through June 30, 2026 inclusive. The County may, but is not obligated to, extend awarded contract(s) for up to three (3) additional one-year periods contingent on the availability of funds and Contractor performance.

B. This Agreement may be terminated immediately by the Director at any time if:

1. The appropriate office of the State of California indicates that this Agreement is not subject to reimbursement under law; or
2. There are insufficient funds available to County; or
3. There is evidence of fraud or misuse of funds by Contractor; or
4. There is an immediate threat to the health and safety of Medi-Cal beneficiaries; or
5. Contractor is found not to be in compliance with any or all of the terms of the herein incorporated Articles of this Agreement or any other material terms of the Contract, including the corrective action plan; or
6. During the course of the administration of this Agreement, the County determines that the Contractor has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, this Contract may be immediately terminated. If this Contract is terminated according to this provision, the County is entitled to pursue any available legal remedies.

C. Either the Contractor or Director may terminate this Agreement at any time for any reason or no reason by serving thirty (30) days written notice upon the other party.

D. This Agreement may be terminated at any time by the mutual written concurrence of both the Contractor and the Director.

E. Contractor must immediately notify DBH when a facility operated by Contractor as part of this Agreement is sold or leased to another party. In the event a facility operated by Contractor as part of this Agreement is sold or leased to another party, the Director has the option to terminate this Agreement immediately.

XV. Accountability: Revenue

A. Total revenue collected pursuant to this Agreement from fees collected for services rendered and/or claims for reimbursement from the County cannot exceed the cost of services delivered by the Contractor. In no event shall the amount reimbursed exceed the cost of delivering services.

B. Charges for services to either patients or other responsible persons shall be at actual costs.

C. Under the terms and conditions of this Agreement, where billing accounts have crossover Medicare and/or Insurance along with Medi-Cal, Contractor shall first bill Medicare and/or the applicable insurance, then provide to the DBH Business Office copies of Contractor's bill and the remittance advice (RA) that show that the bill was either paid or denied. The DBH Business Office, upon receipt of these two items, will proceed to have the remainder of the claim submitted to Medi-Cal. Without these two items, the accounts with the crossover Medicare and/or Insurance along with Medi-Cal will not be billed. Projected Medicare revenue to be collected during the Contract period is zero ($0), which is shown on Line 7 of the Schedule A. Contractor acknowledges that it is obligated to report all revenue received from any source, including Medicare revenue, in its monthly claim for reimbursement, pursuant to Provisional Payment Article, and in its cost report in accordance with Annual Cost Report Settlement Article.

XVI. Patient/Client Billing

A. Contractor shall comply with all County, State and Federal requirements and procedures relating to:

1. The determination and collection of patient/client fees for services hereunder based on the Uniform Method of Determining Payment (UMDAP), in accordance with State guidelines and WIC Sections 5709 and 5710.

2. The eligibility of patients/clients for Short-Doyle/Medi-Cal, Medicare, private insurance, or other third-party revenue, and the collection, reporting and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. Contractor shall pursue and report collection of all patient/client and other revenue.

3. Contractor shall not retain any fees paid by any sources for, or on behalf of, Medi-Cal beneficiaries without deducting those fees from the cost of providing those mental health services for which fees were paid.

4. Failure of Contractor to report in all its claims and its annual cost report all fees paid by patients/clients receiving services hereunder, all fees paid on behalf of Medi-Cal beneficiaries receiving services hereunder shall result in:

   a. Contractor's submission of revised claim statement showing all such non-reported revenue.

   b. A report by the County to DHCS of all such non-reported revenue including any such unreported revenue paid by any sources for or on behalf of Medi-Cal beneficiaries.

   c. Any appropriate financial adjustment to Contractor's reimbursement.

B. Any covered services provided by Contractor or subcontractor shall not be billed to patients/clients for an amount greater than the County rate [42 C.F.R. § 438.106(c)].

C. Consumer/Client Liability for Payment

Pursuant to California Code of Regulations, Title 9, Section 1810.365, Contractor or subcontractor of Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from the consumer/client or persons acting on behalf of the consumer/client 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. Consistent with 42 C.F.R., Section 438.106, Contractor or sub-contractor of Contractor shall not hold the consumer/client liable for debts in the event that Contractor becomes insolvent for costs of covered services for which DBH does not pay Contractor; for costs of covered services for which DBH or Contractor does not pay Contractor's subcontractors; for costs of covered services provided under a contract, referral or other arrangement rather than from DBH; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a consumer/client with an emergency psychiatric condition.

XVII. Personnel

A. Contractor shall operate continuously throughout the term of this Agreement with at least the minimum number of staff as required by Title 9 of the California Code of Regulations for the mode(s) of service described in this Agreement. Contractor shall also satisfy any other staffing requirements necessary to participate in the Short-Doyle/Medi-Cal program, if so funded.

B. Contractor must follow DBH's credentialing and re-credentialing policy that is based on DHCS' uniform policy. Contractor must follow a documented process for credentialing and re-credentialing of Contractor's staff [42 C.F.R. §§ 438.12(a)(2) and 438.214(b)].

C. Contractor shall ensure the Staff Master is updated regularly for each service provider with the current employment and license/certification/registration/waiver status in order to bill for services and determine provider network capacity. Updates to the Staff Master shall be completed, including, but not limited to, the following events: new registration number obtained, licensure obtained, licensure renewed, and employment terminated. When updating the Staff Master, provider information shall include, but not limited to, the following: employee name; professional discipline; license, registration or certification

number; National Provider Identifier (NPI) number and NPI taxonomy code; County's billing and transactional database system number; date of hire; and date of termination (when applicable).

D. Contractor shall comply with DBH's request(s) for provider information that is not readily available on the Staff Master form or the Management Information System as DBH is required by Federal regulation to update its paper and electronic provider directory, which includes contract agencies and hospitals, at least monthly.

E. Contractor agrees to provide or has already provided information on former San Bernardino County administrative officials (as defined below) who are employed by or represent Contractor. The information provided includes a list of former County administrative officials who terminated County employment within the last five years and who are now officers, principals, partners, associates or members of the business. The information also includes the employment with or representation of Contractor. For purposes of this provision, "County administrative official" is defined as a member of the Board of Supervisors or such officer's staff, Chief Executive Officer or member of such officer's staff, County department or group head, assistant department or group head, or any employee in the Exempt Group, Management Unit or Safety Management Unit.

F. Statements of Disclosure

1. Contractor shall submit a statement of disclosure of ownership, control and relationship information regarding its providers, managing employees, including agents and managing agents as required in Title 42 of the Code of Federal Regulations, Sections 455.104 and 455.105 for those having five percent (5%) or more ownership or control interest. This statement relates to the provision of information about provider business transactions and provider ownership and control and must be completed prior to entering into a contract, during certification or re-certification of the provider; within thirty-five (35) days after any change in ownership; annually; and/or upon request of the County. The disclosures to provide are as follows:

   a. Name and address of any person (individual or corporation) with an ownership or control interest in Contractor's agency. The address for corporate entities shall include, as applicable, a primary business address, every business location and a P.O. box address;

   b. Date of birth and Social Security Number (if an individual);

   c. Other tax identification number (if a corporation or other entity);

   d. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's agency is related to another person with ownership or control in the same or any other network provider of the Contractor as a spouse, parent, child or sibling;

   e. The name of any other disclosing entity in which the Contractor has an ownership or control interest; and

f. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.

2. Contractor shall also submit disclosures related to business transactions as follows:

a. Ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5) year period ending on the date of a request by County.

3. Contractor shall submit disclosures related to persons convicted of crimes regarding the Contractor's management as follows:

a. The identity of any person who is a managing employee, owner or person with controlling interest of the Contractor who has been convicted of a crime related to Federal health care programs;

b. The identity of any person who is an agent of the Contractor who has been convicted of a crime related to Federal health care programs. Agent is described in 42 C.F.R. §455.101; and

c. The Contractor shall supply the disclosures before entering into a contract and at any time upon the County's request.

G. Contractor shall confirm the identity of its providers, employees, DBH-funded network providers, contractors and any person with an ownership or controlling interest, or who is an agent or managing employee by developing and implementing a process to conduct a review of applicable Federal databases in accordance with Title 42 of the Code of Federal Regulations, Section 455.436. In addition to any background check or Department of Justice clearance, the Contractor shall review and verify the following databases:

1. Pursuant to Title 42 of the Code of Federal Regulations, Section 455.410, all health care providers including all ordering or referring physicians or other professionals providing services, are required to be screened via the Social Security Administration's Death Master File to ensure new and current providers are not listed. Contractor shall conduct the review prior to hire and upon contract renewal (for contractor employees not hired at the time of contract commencement).

2. National Plan and Provider Enumeration System (NPPES) to ensure the provider has a NPI number, confirm the NPI number belongs to the provider, verify the accuracy of the providers' information and confirm the taxonomy code selected is correct for the discipline of the provider.

3. List of Excluded Individuals/Entities and General Services Administration's System for Award Management (SAM), the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), and DHCS Suspended and Ineligible Provider (S&I) List (if Medi-Cal reimbursement is received under this Contract), to ensure providers, employees, DBH-funded network providers, contractors and any

person with an ownership or controlling interest, or who is an agent or managing employee are not excluded, suspended, debarred or otherwise ineligible to participate in the Federal and State health care programs. See the Licensing, Certification and Accreditation section of this Contract for further information on Excluded and Ineligible Person checks.

H. Contractor shall obtain records from the Department of Justice of all convictions of persons offered employment or volunteers as specified in Penal Code Section 11105.3.

I. Contractor shall inform DBH within twenty-four (24) hours or next business day of any allegations of sexual harassment, physical abuse, etc., committed by Contractor's employees against clients served under this Contract. Contractor shall report incident as outlined in Notification of Unusual Occurrences or Incident/Injury Reports paragraph in the Administrative Procedures Article.

J. Iran Contracting Act of 2010

IRAN CONTRACTING ACT OF 2010, Public Contract Code sections 2200 et seq. (Applicable for all Contracts of one million dollars ($1,000,000) or more) In accordance with Public Contract Code Section 2204(a), the Contractor certifies that at the time the Contract is signed, the Contractor signing the Contract is not identified on a list created pursuant to subdivision (b) of Public Contract Code Section 2203 as a person [as defined in Public Contract Code Section 2202(e)] engaging in investment activities in Iran described in subdivision (a) of Public Contract Code Section 2202.5, or as a person described in subdivision (b) of Public Contract Code Section 2202.5, as applicable.

Contractors are cautioned that making a false certification may subject the Contractor to civil penalties, termination of existing contract, and ineligibility to bid on a contract for a period of three (3) years in accordance with Public Contract Code Section 2205.

K. Trafficking Victims Protection Act of 2000

In accordance with the Trafficking Victims Protection Act (TVPA) of 2000, the Contractor certifies that at the time the Contract is signed, the Contractor will remain in compliance with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). For access to the full text of the award term, go to: http://www.samhsa.gov/grants/grants-management/policies-regulations/additional-directives.

The TVPA strictly prohibits any Contractor or Contractor employee from:

1. Engaging in severe forms of trafficking in persons during the duration of the Contract;
2. Procuring a commercial sex act during the duration of the Contract; and
3. Using forced labor in the performance of the Contract.

Any violation of the TVPA may result in payment withholding and/or a unilateral termination of this Contract without penalty in accordance with 2 CFR Part 175. The TVPA applies to Contractor and Contractor's employees and/or agents.

L. Executive Order N-6-22 Russia Sanctions

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine (https://home.treasury.gov/policy-issues/financial-sanctions/sanctions-programs-and-country-information/ukraine-russia-related-sanctions), as well as any sanctions imposed under state law (https://www.dgs.ca.gov/OLS/Ukraine-Russia). The EO directs state agencies and their contractors (including by agreement or receipt of a grant) to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should it be determined that Contractor is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. Contractor shall be provided advance written notice of such termination, allowing Contractor at least 30 calendar days to provide a written response. Termination shall be at the sole discretion of the County.

XVIII. Prohibited Affiliations

A. Contractor shall not knowingly have any prohibited type of relationship with the following:

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610(a)(1)].

2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in this section [42 C.F.R. § 438.610(a)(2)].

B. Contractor shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act [42 C.F.R. §§ 438.214(d)(1), 438.610(b); 42 U.S.C. § 1320c-5].

C. Contractor shall not have any types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity as follows:

1. A director, officer, agent, managing employee, or partner of the Contractor [42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1)].

2. A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230. [42 C.F.R. § 438.610(c)(2)].

3. A person with beneficial ownership of 5 percent (5%) or more of the Contractor's equity [(42 C.F.R. § 438.610(c)(3)].

4. An individual convicted of crimes described in section 1128(b)(8)(B) of the Act [42 C.F.R. § 438.808(b)(2)].

5. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract [42 C.F.R. § 438.610(c)(4)].

6. Contractor shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services, or the establishment of policies or provision of operational support for such services [42 C.F.R. § 438.808(b)(3)].

D. Conflict of Interest

1. Contractor shall comply with the conflict of interest safeguards described in 42 Code of Federal Regulations part 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Act [42 C.F.R. § 438.3(f)(2)].

2. Contractor shall not utilize in the performance of this Contract any County officer or employee or other appointed County official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular County employment [Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2)].

a. Contractor shall submit documentation to the County of current and former County employees who may present a conflict of interest.

XIX. Licensing, Certification and Accreditation

A. Contractor shall operate continuously throughout the term of this Agreement with all licenses, certifications and/or permits as are necessary to the performance hereunder. Failure to maintain a required license, certification, and/or permit may result in immediate termination of this Contract.

B. Contractor shall maintain for inpatient and residential services the necessary licensing and certification or mental health program approval throughout the term of this Contract.

C. Contractor shall inform DBH whether it has been accredited by a private independent accrediting entity [42 C.F.R. 438.332(a)]. If Contractor has received accreditation by a private independent accrediting entity, Contractor shall authorize the private independent accrediting entity to provide the County a copy of its most recent accreditation review, including:

1. Its accreditation status, survey type, and level (as applicable); and

2. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3. The expiration date of the accreditation [42 C.F.R. § 438.332(b)].

D. Contractor shall be knowledgeable of and compliant with State law and DBH policy/procedure regarding Medi-Cal Certification and ensure that the head of service is a licensed mental health professional or other appropriate individual.

E. Contractor shall ensure all service providers apply for, obtain and maintain the appropriate certification, licensure, registration or waiver prior to rendering services. Service providers

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

must work within their scope of practice and may not render and/or claim services without a valid certification, licensure, registration or waiver. Contractor shall develop and implement a policy and procedure for all applicable staff to notify Contractor of a change in licensure/certification/waiver status, and Contractor is responsible for notifying DBH of such change.

F. Contractor shall develop and implement a documented process for continued employment of pre-licensed clinical therapist staff, who have not obtained licensure within six (6) years of their original date of registration. This process must be in accordance with DBH Registration and Licensure Requirements for Pre-Licensed Staff Policy (HR4012). Contractor shall be responsible for accepting, reviewing and determining whether to grant a one (1) year extensions [up to a maximum of three (3) one-year extensions], to an employee who has not obtained licensure within six (6) years following the first California Board of Behavioral Health Sciences (BBS) registration receipt date. Prior to granting said extension, Contractor must ensure the pre-licensed staff is actively pursuing licensure, and that licensure can be obtained within the determined extension period. Contractor shall ensure all licensed and pre-licensed staff maintain valid Board registration and adhere to all applicable professional regulations, including – but not limited to - clearance from ineligible/excluded status as described herein.

Contractor approved extension letters shall be submitted to DBH Office of Compliance via email to Compliance_Questions@dbh.sbcounty.gov.

G. Contractor shall comply with applicable provisions of the:

1. California Code of Regulations, Title 9;
2. California Business and Professions Code, Division 2; and
3. California Code of Regulations, Title 16.

H. Contractor shall comply with the United States Department of Health and Human Services OIG requirements related to eligibility for participation in Federal and State health care programs.

1. Ineligible Persons may include both entities and individuals and are defined as any individual or entity who:

   a. Is currently excluded, suspended, debarred or otherwise ineligible to participate in the Federal and State health care programs; or

   b. 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 and State health care programs after a period of exclusion, suspension, debarment, or ineligibility.

2. Contractor shall review the organization and all its employees, subcontractors, agents, physicians and persons having five percent (5%) or more of direct or indirect ownership or controlling interest of the Contractor for eligibility against the following databases: SAM and the OIG's LEIE respectively to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract. Contractor shall conduct these reviews before hire or contract start date and then

no less than once a month thereafter.

a. SAM can be accessed at https://www.sam.gov/SAM/.

b. LEIE can be accessed at http://oig.hhs.gov/exclusions/index.asp.

3. If Contractor receives Medi-Cal reimbursement, Contractor shall review the organization and all its employees, subcontractors, agents and physicians for eligibility against the DHCS S&I List to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract. Contractor shall conduct this review before hire or contract start date and then no less than once a month thereafter.

a. S&I List can be accessed at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

4. Contractor shall certify or attest that no staff member, officer, director, partner or principal, or sub-contractor is "excluded" or "suspended" from any Federal health care program, federally funded contract, state health care program or state funded contract. This certification shall be documented by completing the Attestation Regarding Ineligible/Excluded Persons (**Attachment I**) at time of the initial contract execution and annually thereafter. Contractor shall not certify or attest any excluded person working/contracting for its agency and acknowledges that the County shall not pay the Contractor for any excluded person. The Attestation Regarding Ineligible/Excluded Persons shall be submitted to the following program and address:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415-0026

Or send via email to: Compliance_Questions@dbh.sbcounty.gov

5. Contractor acknowledges that Ineligible Persons are precluded from employment and from providing Federal and State funded health care services by contract with County.

6. Contractor shall have a policy regarding the employment of sanctioned or excluded employees that includes the requirement for employees to notify the Contractor should the employee become sanctioned or excluded by the OIG, General Services Administration (GSA), and/or DHCS.

7. Contractor acknowledges any payment received for an excluded person may be subject to recovery and/or considered an overpayment by DBH/DHCS and/or be the basis for other sanctions by DHCS.

8. Contractor shall immediately notify DBH should an employee become sanctioned or excluded by the OIG, GSA, and/or DHCS.

XX. Health Information System

A. Should Contractor have a health information system, it shall maintain a system that collects, analyzes, integrates, and reports data (42 C.F.R. § 438.242(a); Cal. Code Regs.,

tit. 9, § 1810.376.) The system shall provide information on areas including, but not limited to, utilization, claims, grievances, and appeals [42 C.F.R. § 438.242(a)]. Contractor shall comply with Section 6504(a) of the Affordable Care Act [42 C.F.R. § 438.242(b)(1)].

B. Contractor's health information system shall, at a minimum:

1. Collect data on beneficiary and Contractor characteristics as specified by the County, and on services furnished to beneficiaries as specified by the County; [42 C.F.R. § 438.242(b)(2)].

2. Ensure that data received is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data.

b. Screening the data for completeness, logic, and consistency.

c. Collecting service information in standardized formats to the extent feasible and appropriate.

C. Contractor shall make all collected data available to DBH and, upon request, to DHCS and/or CMS [42 C.F.R. § 438.242(b)(4)].

D. Contractor's health information system is not required to collect and analyze all elements in electronic formats [Cal. Code Regs., tit. 9, § 1810.376(c)].

XXI. Administrative Procedures

A. Contractor agrees to adhere to all applicable provisions of:

1. State Notices,

2. DBH Policies and Procedures on Advance Directives, and;

3. County DBH Standard Practice Manual (SPM). Both the State Notices and the DBH SPM are included as a part of this Contract by reference.

B. Contractor shall have a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required State or Federal notices (Deficit Reduction Act), and procedures for reporting unusual occurrences relating to health and safety issues.

C. All written materials for potential beneficiaries and beneficiaries with disabilities must utilize easily understood language and a format which is typically at 5th or 6th grade reading level, in a font size no smaller than 12 point, be available in alternative formats and through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of potential beneficiaries or beneficiaries with disabilities or limited English proficiency and include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats [42 C.F.R. 438.10(d)(6)(ii)]. The aforementioned written materials may only be provided electronically by the Contractor if all of the following conditions are met:

1. The format is readily accessible;

2. The information is placed in a location on the Contractor's website that is prominent and readily accessible;

3. The information is provided in an electronic form which can be electronically retained and printed;

4. The information is consistent with the content and language requirements of this Attachment; and

5. The beneficiary is informed that the information is available in paper form without charge upon request and Contractor provides it upon request within five (5) business days [42 C.F.R. 438.10(c)(6)].

D. Contractor shall ensure its written materials are available in alternative formats, including large print, upon request of the potential beneficiary or beneficiary with disabilities at no cost. Large print means printed in a font size no smaller than 18 point [42 C.F.R. § 438.10(d)(3)].

E. Contractor shall provide the required information in this section to each beneficiary when first receiving Specialty Mental Health Services and upon request [1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), p. 26, attachments 3 and 4; Cal. Code Regs., tit. 9, § 1810.360(e)].

F. Provider List

Contractor shall ensure that staff is knowledgeable of and compliant with State and DBH policy/procedure regarding DBH Provider Directories. Contractor agrees to demonstrate that staff knows how to access Provider List as required by DBH.

G. Beneficiary Informing Materials

Contractor shall ensure that staff is knowledgeable of and compliant with State and DBH policy/procedure regarding Beneficiary Informing Materials which includes, but is not limited to the Guide to Medi-Cal Mental Health Services. Contractor shall only use the DBH and DHCS developed and approved handbooks, guides and notices.

H. If a dispute arises between the parties to this Agreement concerning the interpretation of any State Notice or a policy/procedure within the DBH SPM, the parties agree to meet with the Director to attempt to resolve the dispute.

I. State Notices shall take precedence in the event of conflict with the terms and conditions of this Agreement.

J. In the event the County determines that service is unsatisfactory, or in the event of any other dispute, claim, question or disagreement arising from or relating to this Contract or breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect, they shall consult and negotiate with each other in good faith and, recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties.

K. Grievance and Complaint Procedures

Contractor shall ensure that staff are knowledgeable of and compliant with the San Bernardino County Beneficiary Grievance and Appeals Procedures and ensure that any complaints by recipients are referred to DBH in accordance with the procedure.

L. Notice of Adverse Benefit Determination Procedures

Contractor shall ensure that staff is knowledgeable of and compliant with State law and DBH policy/procedure regarding the issuance of Notice of Adverse Benefit Determinations (NOABDs).

M. Notification of Unusual Occurrences or Incident/Injury Reports

1. Contractor shall notify DBH, within twenty-four (24) hours or next business day, of any unusual incident(s) or event(s) that occur while providing services under this Contract, which may result in reputational harm to either the Contractor or the County. Notice shall be made to the assigned contract oversight DBH Program Manager with a follow-up call to the applicable Deputy Director.

2. Contractor shall submit a written report to DBH within three (3) business days of occurrence on DBH Unusual Occurrence/Incident Report form or on Contractor's own form preapproved by DBH Program Manager or designee.

3. If Contractor is required to report occurrences, incidents or injuries as part of licensing requirements, Contractor shall provide DBH Program Manager or designee with a copy of report submitted to applicable State agency.

4. Written reports shall not be made via email unless encryption is used.

N. Copyright

County shall have a royalty-free, non-exclusive and irrevocable license to publish, disclose, copy, translate, and otherwise use, copyright or patent, now and hereafter, all reports, studies, information, data, statistics, forms, designs, plans, procedures, systems, and any other materials or properties developed under this Contract including those covered by copyright, and reserves the right to authorize others to use or reproduce such material. All such materials developed under the terms of this Contract shall acknowledge San Bernardino County Department of Behavioral Health as the funding agency and Contractor as the creator of the publication. No such materials or properties produced in whole or in part under this Contract shall be subject to private use, copyright or patent right by Contractor in the United States or in any other country without the express written consent of County. Copies of all educational and training materials, curricula, audio/visual aids, printed material, and periodicals, assembled pursuant to this Contract must be filed with and approved by the County prior to publication. Contractor shall receive written permission from DBH prior to publication of said training materials.

O. Release of Information

No news releases, advertisements, public announcements or photographs arising out of this Contract or Contractor's relationship with the County may be made or used without prior written approval of DBH.

P. Ownership of Documents

All documents, data, products, graphics, computer programs and reports prepared by Contractor or subcontractor pursuant to the Agreement shall be considered property of the County upon payment for services. All such items shall be delivered to DBH at the completion of work under the Agreement. Unless otherwise directed by DBH, Contractor may retain copies of such items.

Q. Equipment and Other Property

All equipment, materials, supplies or property of any kind (including vehicles, publications, copyrights, etc.) purchased with funds received under the terms of this Agreement which has a life expectancy of one (1) year or more shall be the property of DBH, unless mandated otherwise by Funding Source, and shall be subject to the provisions of this paragraph. The disposition of equipment or property of any kind shall be determined by DBH when the Agreement is terminated. Additional terms are as follows:

1. The purchase of any furniture or equipment which was not included in Contractor's approved budget, shall require the prior written approval of DBH, and shall fulfill the provisions of this Agreement which are appropriate and directly related to Contractor's services or activities under the terms of the Agreement. DBH may refuse reimbursement for any cost resulting from such items purchased, which are incurred by Contractor, if prior written approval has not been obtained from DBH.

2. Before equipment purchases made by Contractor are reimbursed by DBH, Contractor must submit paid vendor receipts identifying the purchase price, description of the item, serial numbers, model number and location where equipment will be used during the term of this Agreement.

3. All equipment purchased/reimbursed with funds from this Agreement shall only be used for performance of this Agreement.

4. Assets purchased with Medi-Cal Federal Financial Participation (FFP) funds shall be capitalized and expensed according to Medi-Cal (Centers for Medicare and Medicaid Services) regulation.

5. Contractor shall submit an inventory of equipment purchased under the terms of this Agreement as part of the monthly activity report for the month in which the equipment is purchased. Contractor must also maintain an inventory of equipment purchased that, at a minimum, includes the description of the property, serial number or other identification number, source of funding, title holder, acquisition date, cost of the equipment, location, use and condition of the property, and ultimate disposition data. A physical inventory of the property must be reconciled annually. Equipment should be adequately maintained and a control system in place to prevent loss, damage, or theft. Equipment with cost exceeding County's capitalization threshold of $5,000 must be depreciated.

6. Upon termination of this Agreement, Contractor will provide a final inventory to DBH and shall at that time query DBH as to requirements, including the manner and method in returning equipment to DBH. Final disposition of such equipment shall be in accordance with instructions from DBH.

R. Contractor agrees to and shall comply with all requirements and procedures established by the State, County, and Federal Governments, including those for quality improvement, and including, but not limited to, submission of periodic reports to DBH for coordination, contract compliance, and quality assurance.

S. Travel

Contractor shall adhere to the County's Travel Management Policy (8-02) when travel is pursuant to this Agreement and for which reimbursement is sought from the County. In addition, Contractor shall, to the fullest extent practicable, utilize local transportation services, including but not limited to Ontario Airport, for all such travel.

T. Political contributions and lobbying activities are not allowable costs. This includes contributions made indirectly through other individuals, committees, associations or other organizations for campaign or other political purposes. The costs of any lobbying activities however conducted, either directly or indirectly, are not allowable.

U. Contractors that provide day treatment intensive or day rehabilitation shall have a written description of the day treatment intensive and/or day rehabilitation program that complies with **Attachment III** of this Contract.

XXII. Laws and Regulations

A. Contractor agrees to comply with all relevant Federal and State laws and regulations, including, but not limited to those listed below, inclusive of future revisions, and comply with all applicable provisions of:

1. Mental Health Plan (MHP) Contract with the State;
2. California Code of Regulations, Title 9;
3. California Code of Regulations, Title 22;
4. California Welfare and Institutions Code, Division 5;
5. Code of Federal Regulations, Title 42, including, but not limited to, Parts 438 and 455;
6. Code of Federal Regulations, Title 45;
7. United States Code, Title 42, as applicable;
8. Balanced Budget Act of 1997; and
9. Applicable Medi-Cal laws, regulations, including applicable sub-regulatory guidance and contract provisions.

B. Health and Safety

Contractor shall comply with all applicable State and local health and safety requirements and clearances for each site where program services are provided under the terms of the Contract:

1. Any space owned, leased or operated by the Contractor and used for services or staff must meet local fire codes.
2. The physical plant of any site owned, leased or operated by the Contractor and used for services or staff is clean, sanitary and in good repair.
3. Contractor shall establish and implement maintenance policies for any site owned, leased or operated that is used for services or staff to ensure the safety and well-being of beneficiaries and staff.

C. Drug and Alcohol-Free Workplace

In recognition of individual rights to work in a safe, healthful and productive work place, as a material condition of this Contract, Contractor agrees that Contractor and Contractor's employees, while performing service for the County, on County property, or while using County equipment:

1. Shall not be in any way impaired because of being under the influence of alcohol or a drug.

2. Shall not possess an open container of alcohol or consume alcohol or possess or be under the influence of any substance.

3. Shall not sell, offer, or provide alcohol or a drug to another person. This shall not be applicable to Contractor or Contractor's employees who, as part of the performance of normal job duties and responsibilities, prescribes or administers medically prescribed drugs.

4. Contractor shall inform all employees that are performing service for the County on County property, or using County equipment, of the County's objective of a safe, healthful and productive work place and the prohibition of drug or alcohol use or impairment from same while performing such service for the County.

5. The County may terminate for default or breach of this Contract and any other contract Contractor has with County, if Contractor or Contractor's employees are determined by the County not to be in compliance with above.

D. Pro-Children Act of 1994

Contractor will comply with Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

E. Privacy and Security

1. Contractor shall comply with all applicable State and Federal regulations pertaining to privacy and security of client information including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), as incorporated in the American Recovery and Reinvestment Act of 2009. Regulations have been promulgated governing the privacy and security of Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI) or electronic Protected Health Information (ePHI).

2. In addition to the aforementioned protection of IIHI, PHI and e-PHI, the County requires Contractor to adhere to the protection of Personally Identifiable Information (PII) and Medi-Cal PII. PII includes any information that can be used to search for or identify individuals such as but not limited to name, social security number or date of birth. Whereas Medi-Cal PII is the information that is directly obtained in the course of performing an administrative function on behalf of Medi-Cal, such as determining or verifying eligibility that can be used alone or in conjunction with any other information to identify an individual.

3. Contractor shall comply with the HIPAA Privacy and Security Rules, which includes but is not limited to implementing administrative, physical and technical safeguards

that reasonably protect the confidentiality, integrity and availability of PHI; implementing and providing a copy to DBH of reasonable and appropriate written policies and procedures to comply with the standards; conducting a risk analysis regarding the potential risks and vulnerabilities of the confidentiality, integrity and availability of PHI; conducting privacy and security awareness and training at least annually and retain training records for at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, and limiting access to those persons who have a business need.

4. Contractor shall comply with the data security requirements set forth by the County as referenced in **Attachment II**.

5. Reporting of Improper Access, Use or Disclosure or Breach

   Contractor shall report to DBH Office of Compliance any unauthorized use, access or disclosure of unsecured Protected Health Information or any other security incident with respect to Protected Health Information no later than one (1) business day upon the discovery of a potential breach consistent with the regulations promulgated under HITECH by the United States Department of Health and Human Services, 45 CFR Part 164, Subpart D. Upon discovery of the potential breach, the Contractor shall complete the following actions:

   a. Notify DBH Office of Compliance in writing, by mail, fax, or electronically, of such incident no later than one (1) business day and provide DBH Office of Compliance with the following information to include but not limited to:

      i. Date the potential breach occurred;

      ii. Date the potential breach was discovered;

      iii. Number of staff, employees, subcontractors, agents or other third parties and the titles of each person allegedly involved;

      iv. Number of potentially affected patients/clients; and

      v. Description of how the potential breach allegedly occurred.

   b. Provide an update of applicable information to the extent known at that time without reasonable delay and in no case later than three (3) calendar days of discovery of the potential breach.

   c. Provide completed risk assessment and investigation documentation to DBH Office of Compliance within ten (10) calendar days of discovery of the potential breach with decision whether a breach has occurred, including the following information:

      i. The nature and extent of the PHI involved, including the types of identifiers and likelihood of re-identification;

      ii. The unauthorized person who used PHI or to whom it was made;

      iii. Whether the PHI was actually acquired or viewed; and

      iv. The extent to which the risk to PHI has been mitigated.

   d. Contractor is responsible for notifying the client and for any associated costs that are not reimbursable under this Contract, if a breach has

occurred. Contractor must provide the client notification letter to DBH for review and approval prior to sending to the affected client(s).

e. Make available to the County and governing State and Federal agencies in a time and manner designated by the County or governing State and Federal agencies, any policies, procedures, internal practices and records relating to a potential breach for the purposes of audit or should the County reserve the right to conduct its own investigation and analysis.

F. Program Integrity Requirements

1. General Requirement

As a condition for receiving payment under a Medi-Cal managed care program, Contractor shall comply with the provisions of Title 42 C.F.R. Sections 438.604, 438.606, 438.608 and 438.610. Contractor must have administrative and management processes or procedures, including a mandatory compliance plan, that are designed to detect and prevent fraud, waste or abuse.

a. If Contractor identifies an issue or receives notification of a complaint concerning an incident of possible fraud, waste, or abuse, Contractor shall immediately notify DBH; conduct an internal investigation to determine the validity of the issue/complaint; and develop and implement corrective action if needed.

b. If Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue if egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall immediately report to the DBH Office of Compliance for investigation, review and/or disposition.

c. Contractor shall immediately report to DBH any overpayments identified or recovered, specifying the overpayments due to potential fraud.

d. Contractor shall immediately report any information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility, including changes in the beneficiary's residence or the death of the beneficiary.

e. Contractor shall immediately report any information about a change in contractor's or contractor's staff circumstances that may affect eligibility to participate in the managed care program.

f. Contractor shall implement and maintain processes or procedures designed to detect and prevent fraud, waste or abuse that includes provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Contractor were actually furnished to beneficiaries, demonstrate the results to DBH, and apply such verification procedures on a regular basis.

g. Contractor understands DBH, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk.

2. Compliance Plan and Program

DBH has established an Office of Compliance for purposes of ensuring adherence to all standards, rules and regulations related to the provision of services and expenditure of funds in Federal and State health care programs. Contractor shall either adopt DBH's Compliance Plan/Program or establish its own Compliance Plan/Program and provide documentation to DBH to evaluate whether the Program is consistent with the elements of a Compliance Program as recommended by the United States Department of Health and Human Services, Office of Inspector General.

Contractor's Compliance Program must include the following elements:

a. Designation of a compliance officer who reports directly to the Chief Executive Officer and the Contactor's Board of Directors and compliance committee comprised of senior management who are charged with overseeing the Contractor's compliance program and compliance with the requirements of this account. The committee shall be accountable to the Contractor's Board of Directors.

b. Policies and Procedures

Written policies and procedures that articulate the Contractor's commitment to comply with all applicable Federal and State standards. Contractor shall adhere to applicable DBH Policies and Procedures relating to the Compliance Program or develop its own compliance related policies and procedures.

i. Contractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they arise, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

ii. Contractor shall implement and maintain written policies for all DBH funded employees, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.

iii. Contractor shall maintain documentation, verification or acknowledgement that the Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors are aware of these Policies and Procedures and the Compliance Program.

iv. Contractor shall have a Compliance Plan demonstrating the seven

(7) elements of a Compliance Plan. Contractor has the option to develop its own or adopt DBH's Compliance Plan. Should Contractor develop its own Plan, Contractor shall submit the Plan prior to implementation for review and approval to:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415-0026

Or send via email to: Compliance_Questions@dbh.sbcounty.gov

c. Code of Conduct

Contractor shall either adopt the DBH Code of Conduct or develop its own Code of Conduct.

i. Should the Contractor develop its own Code of Conduct, Contractor shall submit the Code prior to implementation to the following DBH Program for review and approval:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415-0026

Or send via email to: Compliance_Questions@dbh.sbcounty.gov.

ii. Contractor shall distribute to all Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors a copy of the Code of Conduct. Contractor shall document annually that such persons have received, read, understand and will abide by said Code.

d. Excluded/Ineligible Persons

Contractor shall comply with Licensing, Certification and Accreditation Article in this Contract related to excluded and ineligible status in Federal and State health care programs.

e. Internal Monitoring and Auditing

Contractor shall be responsible for conducting internal monitoring and auditing of its agency. Internal monitoring and auditing include, but are not limited to billing and coding practices, licensure/credential/registration/waiver verification and adherence to County, State and Federal regulations.

i. Contractor shall take reasonable precaution to ensure that the coding of health care claims and billing for same are prepared and submitted in an accurate and timely manner and are consistent with Federal, State and County laws and regulations as well as DBH's policies and/or agreements with third party payers. This includes compliance with Federal and State health care program regulations and procedures or instructions otherwise communicated by

regulatory agencies including the Centers for Medicare and Medicaid Services or its agents.

ii. Contractor shall not submit false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.

iii. Contractor shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, Contractor shall use only correct billing codes that accurately describe the services provided.

iv. Contractor shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified by the County, Contractor, outside auditors, etc.

v. Contractor shall ensure all employees/service providers maintain current licensure/credential/registration/waiver status as required by the respective licensing Board, applicable governing State agency(ies) and Title 9 of the California Code of Regulations.

vi. Should Contractor identify improper procedures, actions or circumstances, including fraud/waste/abuse and/or systemic issue(s), Contractor shall take prompt steps to correct said problem(s). Contractor shall report to DBH Office of Compliance and Fiscal Administration any overpayments discovered as a result of such problems no later than five (5) business days from the date of discovery, with the appropriate documentation, and a thorough explanation of the reason for the overpayment. Prompt mitigation, corrective action and reporting shall be in accordance with the DBH Overpayment Policy (COM0954), which has been provided or will be provided to Contractor at its request.

f. Response to Detected Offenses

Contractor shall respond to and correct detected health care program offenses relating to this Contract promptly. Contractor shall be responsible for developing corrective action initiatives for offenses to mitigate the potential for recurrence.

g. Compliance Training

Contractor is responsible for ensuring its Compliance Officer, and the agency's senior management, employees and contractors attend trainings regarding Federal and State standards and requirements. The Compliance Officer must attend effective training and education related to compliance, including but not limited to, seven elements of a compliance program and fraud, waste and abuse. Contractor is responsible for conducting and tracking Compliance Training for its agency staff. Contractor is encouraged to attend DBH Compliance trainings, as offered and available.

h. Enforcement of Standards

Contractor shall enforce compliance standards uniformly and through well-publicized disciplinary guidelines. If Contractor does not have its own standards, the County requires the Contractor utilize DBH policies and procedures as guidelines when enforcing compliance standards.

i. Communication

Contractor shall establish and maintain effective lines of communication between its Compliance Officer and Contractor's employees and subcontractors. Contractor's employees may use Contractor's approved Compliance Hotline or DBH's Compliance Hotline (800) 398-9736 to report fraud, waste, abuse or unethical practices. Contractor shall ensure its Compliance Officer establishes and maintains effective lines of communication with DBH's Compliance Officer and program.

j. Subpoena

In the event that a subpoena or other legal process commenced by a third party in any way concerning the Services provided under this Contract is served upon Contractor or County, such party agrees to notify the other party in the most expeditious fashion possible following receipt of such subpoena or other legal process. Contractor and County further agree to cooperate with the other party in any lawful effort by such other party to contest the legal validity of such subpoena or other legal process commenced by a third party as may be reasonably required and at the expense of the party to whom the legal process is directed, except as otherwise provided herein in connection with defense obligations by Contractor for County.

k. In accordance with the Termination paragraph of this Agreement, the County may terminate this Agreement upon thirty (30) days written notice if Contractor fails to perform any of the terms of this Compliance paragraph. At the County's sole discretion, Contractor may be allowed up to thirty (30) days for corrective action.

G. Sex Offender Requirements

Contractor shall ensure client registration protocols for non-DBH referrals include, a screening process to ensure clients ever convicted of a sex offense against a minor or currently registered as a sex offender with violations of CA Penal Code (PC) § 208 or 208.5, are not accepting into housing or treatment in facilities within one-half (1/2) mile (2640 feet) of any school, including any or all of kindergarten and grades 1 to 12, as required by PC § 3003, subdivision (g). Contractor shall obtain criminal history information for any client residing longer than twenty-four (24) hours, prior to rendering services.

Additionally, if Contractor's facility(ies) is a licensed community care facility and within one (1) mile of an elementary school, Contractor must seek/obtain disclosure from each client to confirm client has not been convicted of a sex offense of a minor as described

herein, and assure residence in Contractor facility (for the duration of treatment and/or housing) is not prohibited, pursuant to CA Health and Safety Code (HSC) § 1564

XXIII. Patients' Rights

Contractor shall take all appropriate steps to fully protect patients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq; Title 9 California Code of Regulations (CCR), Sections 861, 862, 883, 884; and Title 22 CCR, Sections 72453 and 72527.

XXIV. Confidentiality

Contractor agrees to comply with confidentiality requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), commencing with Subchapter C, and all State and Federal statutes and regulations regarding confidentiality, including but not limited to applicable provisions of Welfare and Institutions Code Sections 5328 et seq. and 14100.2, Title 22, California Code of Regulations Section 51009 and Title 42, Code of Federal Regulations Part 2.

A. Contractor shall have all employees acknowledge an Oath of Confidentiality mirroring that of DBH's, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance. Contractor shall have all employees sign acknowledgement of the Oath on an annual basis.

B. Contractor shall not use or disclose PHI other than as permitted or required by law.

XXV. Admission Policies

A. Contractor shall develop patient/client admission policies, which are in writing and available to the public.

B. Contractor's admission policies shall adhere to policies that are compatible with Department of Behavioral Health service priorities, and Contractor shall admit clients according to procedures and time frames established by DBH.

C. If Contractor is found not to be in compliance with the terms of Admission Policies Article, this Agreement may be subject to termination.

XXVI. Medical Records/Protected Health Information

A. Contractor agrees to maintain and retain medical records according to the following:

1. The minimum maintenance requirement of medical records is:

a. The information contained in the medical record shall be confidential and shall be disclosed only to authorized persons in accordance to local, State and Federal laws.

b. Documents contained in the medical record shall be written legibly in ink or typewritten, be capable of being photocopied and shall be kept for all clients accepted for care or admitted, if applicable.

c. If the medical record is electronic, the Contractor shall make the computerized records accessible for the County's review.

2. The minimum contractual requirement for the retention of medical records is:

a. For adults and emancipated minors, ten (10) years following discharge (last date of service), the final date of the contract period or from the date of completion of any audit, whichever is later;

b. For unemancipated minors, a minimum of ten (10) years after they have attained the age of 18, but in no event less than ten (10) years following discharge (last date of service), the final date of the contract period or from the date of completion of any audit, whichever is later.

c. County shall be informed within three (3) business days, in writing, if client medical records are defaced or destroyed prior to the expiration of the required retention period.

B. Should patient/client records be misplaced and cannot be located after the Contractor has performed due diligence, the Contractor shall report to DBH as a possible breach of PHI in violation of HIPAA. Should the County and Contractor determine the chart cannot be located, all billable services shall be disallowed/rejected.

C. Contractor shall ensure that all patient/client records are stored in a secure manner and access to records is limited to those employees of Contractor who have a business need. Security and access of records shall occur at all times, during and after business hours.

D. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records.

E. The IIHI or PHI under this Contract shall be and remain the property of the County. The Contractor agrees that it acquires no title or rights to any of the types of client information.

F. The County shall store the medical records for all the Contractor's County funded clients when a Contract ends its designated term, a Contract is terminated, a Contractor relinquishes its contracts or if the Contractor ceases operations.

1. Contractor shall deliver to DBH all data, reports, records and other such information and materials (in electronic or hard copy format) pertaining to the medical records that may have been accumulated by Contractor or subcontractor under this Contract, whether completed, partially completed or in progress within seven (7) calendar days of said termination/end date.

2. Contractor shall be responsible for the boxing, indexing and delivery of any and all records that will be stored by DBH Medical Records Unit. Contractor shall arrange for delivery of any and all records to DBH Medical Records Unit within seven (7) calendar days (this may be extended to thirty (30) calendar days with approval of DBH) of cessation of business operations.

3. Should the Contractor fail to relinquish the medical records to the County, the County shall report the Contractor and its qualified professional personnel to the applicable licensing or certifying board(s).

4. Contractor shall maintain responsibility for the medical records of non-county funded clients.

XXVII. Transfer of Care

Prior to the termination or expiration of this Contract, and upon request by the County, the Contractor shall assist the County in the orderly transfer of behavioral health care for beneficiaries in San Bernardino County. In doing this, the Contractor shall make available to DBH copies of medical records and any other pertinent information, including information maintained by any subcontractor that is necessary for efficient case management of beneficiaries. Under no circumstances will the costs for reproduction of records to the County from the Contractor be the responsibility of the client.

XXVIII. Quality Assurance/Utilization Review

A. Contractor agrees to be in compliance with the Laws and Regulations Article of this Contract.

B. County shall establish standards and implement processes for Contractor that will support understanding of, compliance with, documentation standards set forth by the State. The County has the right to monitor performance so that the documentation of care provided will satisfy the requirements set forth. The documentation standards for beneficiary care are minimum standards to support claims for the delivery of specialty mental health services. All documentation shall be addressed in the beneficiary record.

C. Contractor agrees to implement a Quality Improvement Program as part of program operations. This program will be responsible for monitoring documentation, quality improvement and quality care issues. Contractor will work with DBH Quality Management Division on a regular basis, and provide any tools/documents used to evaluate Contractor's documentation, quality of care and the quality improvement process.

D. When quality of care documentation or issues are found to exist by DBH, Contractor shall submit a plan of correction to be approved by DBH Quality Management.

E. Contractor agrees to be part of the County Quality Improvement planning process through the annual submission of Quality Improvement Outcomes in County identified areas.

XXIX. Independent Contractor Status

Contractor understands and agrees that the services performed hereunder by its officers, agents, employees, or contracting persons or entities are performed in an independent capacity and not in the capacity of officers, agents or employees of the County.

All personnel, supplies, equipment, furniture, quarters, and operating expenses of any kind required for the performance of this Contract shall be provided by Contractor.

XXX. Subcontractor Status

A. If Contractor intends to subcontract any part of the services provided under this Contract to an individual, company, firm, corporation, partnership or other organization, not in the employment of or owned by Contractor who is performing services on behalf of Contractor under the Contract or under a separate contract with or on behalf of Contractor, Contractor must submit a written Memorandum of Understanding (MOU) with that agency or agencies with original signatures to DBH. The MOU must clearly define the following:

   1. The name of the subcontracting agency.

2. The amount (units, minutes, etc.) and types of services to be rendered under the MOU.
3. The amount of funding to be paid to the subcontracting agency.
4. The subcontracting agency's role and responsibilities as it relates to this Contract.
5. A detailed description of the methods by which the Contractor will insure that all subcontracting agencies meet the monitoring requirements associated with funding regulations.
6. A budget sheet outlining how the subcontracting agency will spend the allocation.
7. Additionally, each MOU shall contain the following requirements:
   a. Subcontractor shall comply with the Right to Monitor and Audit Performance and Records requirements, as referenced in the Performance Article.
   b. Subcontractor agrees to comply with Personnel Article related to the review of applicable Federal databases in accordance with Title 42 of the Code of Federal Regulations, Section 455.436, and applicable professional disciplines' and licensing and/or certifying boards' code of ethics and conduct.
   c. Subcontractor shall operate continuously throughout the term of the MOU with all licenses, certifications, and/or permits as are necessary to perform services and comply with Licensing, Certification, and Accreditation Article related to excluded and ineligible status.
   d. Subcontractor agrees to perform work under this MOU in compliance with confidentiality requirements, as referenced in the Confidentiality and Laws and Regulations Articles.
   e. MOU is governed by, and construed in accordance with, all laws and regulations, and all contractual obligations of the Contractor under the primary contract.
   f. Subcontractor's delegated activities and reporting responsibilities follow the Contractor's obligations in the primary contract.
   g. Subcontractor shall be knowledgeable in and adhere to primary contractor's program integrity requirements and compliance program, as referenced in the Laws and Regulations Article.
   h. Subcontractor agrees to not engage in unlawful discriminatory practices, as referenced in the Nondiscrimination Article.

B. Any subcontracting agency must be approved in writing by DBH and shall be subject to all applicable provisions of this Contract. The Contractor will be fully responsible for the performance, duties and obligations of a subcontracting agency, including the determination of the subcontractor selected and the ability to comply with the requirements of this Contract. DBH will not reimburse contractor or subcontractor for any expenses

rendered without DBH approval of MOU in writing in the fiscal year the subcontracting services started.

C. At DBH's request, Contractor shall provide information regarding the subcontractor's qualifications and a listing of a subcontractor's key personnel including, if requested by DBH, resumes of proposed subcontractor personnel.

D. Contractor shall remain directly responsible to DBH for its subcontractors and shall indemnify the County for the actions or omissions of its subcontractors under the terms and conditions specified in Indemnification and Insurance Article.

E. Ineligible Persons

Contractor shall adhere to Prohibited Affiliations and Licensing, Certification and Accreditation Articles regarding Ineligible Persons or Excluded Parties for its subcontractors.

F. Upon expiration or termination of this Contract for any reason, DBH will have the right to enter into direct Contracts with any of the Subcontractors. Contractor agrees that its arrangements with Subcontractors will not prohibit or restrict such Subcontractors from entering into direct Contracts with DBH.

XXXI. Attorney Costs & Fees

If any legal action is instituted to enforce any party's rights hereunder, each party shall bear its own costs and attorneys' fees, regardless of who is the prevailing party. This paragraph shall not apply to those costs and attorney fees directly arising from a third-party legal action against a party hereto and payable under Indemnification and Insurance Article, Part A.

XXXII. Indemnification and Insurance

A. Indemnification

Contractor agrees to indemnify, defend (with counsel reasonably approved by the County) and hold harmless the County and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this Contract from any cause whatsoever, including the acts, errors or omissions of any person and for any costs or expenses incurred by the County on account of any claim except where such indemnification is prohibited by law. This indemnification provision shall apply regardless of the existence or degree of fault of indemnitees. The Contractor's indemnification obligation applies to the County's "active" as well as "passive" negligence but does not apply to the County's "sole negligence" or "willful misconduct" within the meaning of Civil Code Section 2782.

B. Additional Insured

All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies, shall contain endorsements naming the County and its officers, employees, agents and volunteers as additional insured with respect to liabilities arising out of the performance of services hereunder. The additional insured endorsements shall not limit the scope of coverage for the County to vicarious liability but shall allow coverage for the County to the full extent provided by the policy. Such

additional insured coverage shall be at least as broad as Additional Insured (Form B) endorsement form ISO, CG 2010.11 85.

C. Waiver of Subrogation Rights

Contractor shall require the carriers of required coverages to waive all rights of subrogation against the County, its officers, employees, agents, volunteers, contractors, and subcontractors. All general or auto liability insurance coverage provided shall not prohibit the Contractor and Contractor's employees or agents from waiving the right of subrogation prior to a loss or claim. The Contractor hereby waives all rights of subrogation against the County.

D. Policies Primary and Non-Contributory

All policies required herein are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by the County.

E. Severability of Interests

Contractor agrees to ensure that coverage provided to meet these requirements is applicable separately to each insured and there will be no cross liability exclusions that preclude coverage for suits between the Contractor and the County or between the County and any other insured or additional insured under the policy.

F. Proof of Coverage

Contractor shall furnish Certificates of Insurance to the County Department administering the Contract evidencing the insurance coverage at the time the contract is executed. Additional endorsements, as required, shall be provided prior to the commencement of performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the Department, and Contractor shall maintain such insurance from the time Contractor commences performance of services hereunder until the completion of such services. Within fifteen (15) days of the commencement of this Contract, the Contractor shall furnish a copy of the Declaration page for all applicable policies and will provide complete certified copies of the policies and all endorsements immediately upon request.

G. Acceptability of Insurance Carrier

Unless otherwise approved by Risk Management, insurance shall be written by insurers authorized to do business in the State of California and with a minimum "Best" Insurance Guide rating of "A-VII".

H. Deductibles and Self-Insured Retention

Any and all deductibles or self-insured retentions in excess of $10,000 shall be declared to and approved by Risk Management.

I. Failure to Procure Coverage

In the event that any policy of insurance required under this Contract does not comply with the requirements, is not procured, or is canceled and not replaced, the County has the right but not the obligation or duty to cancel the Contract or obtain insurance if it deems necessary and any premiums paid by the County will be promptly reimbursed by the

Contractor or County payments to the Contractor will be reduced to pay for County purchased insurance.

J. Insurance Review

Insurance requirements are subject to periodic review by the County. The Director of Risk Management or designee is authorized, but not required, to reduce, waive or suspend any insurance requirements whenever Risk Management determines that any of the required insurance is not available, is unreasonably priced, or is not needed to protect the interests of the County. In addition, if the Department of Risk Management determines that heretofore unreasonably priced or unavailable types of insurance coverage or coverage limits become reasonably priced or available, the Director of Risk Management or designee is authorized, but not required, to change the above insurance requirements to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of past claims against the County, inflation, or any other item reasonably related to the County's risk.

Any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this Contract. Contractor agrees to execute any such amendment within thirty (30) days of receipt.

Any failure, actual or alleged, on the part of the County to monitor or enforce compliance with any of the insurance and indemnification requirements will not be deemed as a waiver of any rights on the part of the County.

K. Insurance Specifications

Contractor agrees to provide insurance set forth in accordance with the requirements herein. If the Contractor uses existing coverage to comply with these requirements and that coverage does not meet the specified requirements, the Contractor agrees to amend, supplement or endorse the existing coverage to do so. The type(s) of insurance required is determined by the scope of the contract services.

Without in anyway affecting the indemnity herein provided and in addition thereto, the Contractor shall secure and maintain throughout the contract term the following types of insurance with limits as shown:

1. Workers' Compensation/Employers Liability

A program of Workers' Compensation insurance or a State-approved, Self-Insurance Program in an amount and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with $250,000 limits, covering all persons including volunteers providing services on behalf of the Contractor and all risks to such persons under this Contract.

If Contractor has no employees, it may certify or warrant to the County that it does not currently have any employees or individuals who are defined as "employees" under the Labor Code and the requirement for Workers' Compensation coverage will be waived by the County's Director of Risk Management.

With respect to Contractors that are non-profit corporations organized under California or Federal law, volunteers for such entities are required to be covered by Workers' Compensation insurance.

2. Commercial/General Liability Insurance

Contractor shall carry General Liability Insurance covering all operations performed by or on behalf of the Contractor providing coverage for bodily injury and property damage with a combined single limit of not less than one million dollars ($1,000,000), per occurrence. The policy coverage shall include:

a. Premises operations and mobile equipment.

b. Products and completed operations.

c. Broad form property damage (including completed operations).

d. Explosion, collapse and underground hazards.

e. Personal Injury.

f. Contractual liability.

g. $2,000,000 general aggregate limit.

3. Automobile Liability Insurance

Primary insurance coverage shall be written on ISO Business Auto coverage form for all owned, hired and non-owned automobiles or symbol 1 (any auto). The policy shall have a combined single limit of not less than one million dollars ($1,000,000) for bodily injury and property damage, per occurrence.

If the Contractor is transporting one or more non-employee passengers in performance of contract services, the automobile liability policy shall have a combined single limit of two million dollars ($2,000,000) for bodily injury and property damage per occurrence.

If the Contractor owns no autos, a non-owned auto endorsement to the General Liability policy described above is acceptable.

4. Umbrella Liability Insurance

An umbrella (over primary) or excess policy may be used to comply with limits or other primary coverage requirements. When used, the umbrella policy shall apply to bodily injury/property damage, personal injury/advertising injury and shall include a "dropdown" provision providing primary coverage for any liability not covered by the primary policy. The coverage shall also apply to automobile liability.

5. Cyber Liability Insurance

Cyber Liability Insurance with limits of not less than $1,000,000 for each occurrence or event with an annual aggregate of $2,000,000 covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security.

The policy shall protect the involved County entities and cover breach response cost as well as regulatory fines and penalties.

L. Professional Services Requirements

1. Professional Liability Insurance with limits of not less than one million ($1,000,000) per claim or occurrence and two million ($2,000,000) aggregate.

   or

   Errors and Omissions Liability Insurance with limits of not less than one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate.

   or

   Directors and Officers Insurance coverage with limits of not less than one million ($1,000,000) shall be required for contracts with charter labor committees or other not-for-profit organizations advising or acting on behalf of the County.

2. Abuse/Molestation Insurance – The Contractor shall have abuse or molestation insurance providing coverage for all employees for the actual or threatened abuse or molestation by anyone of any person in the care, custody, or control of any insured, including negligent employment, investigation, and supervision. The policy shall provide coverage for both defense and indemnity with liability limits of not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate.

3. If insurance coverage is provided on a "claims made" policy, the "retroactive date" shall be shown and must be before the date of the start of the contract work. The "claims made" insurance shall be maintained or "tail" coverage provided for a minimum of five (5) years after contract completion.

XXXIII. Nondiscrimination

A. General

Contractor agrees to serve all clients without regard to race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability pursuant to the Civil Rights Act of 1964, as amended (42 U.S.C., Section 2000d), Executive Order No. 11246, September 24, 1965, as amended, Title IX of the Education Amendments of 1972, and Age Discrimination Act of 1975.

Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability.

B. Americans with Disabilities Act/Individuals with Disabilities

Contractor agrees to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) which prohibits discrimination on the basis of disability, as well as all applicable Federal and State laws and regulations, guidelines and interpretations issued pursuant thereto. Contractor shall report to the applicable DBH Program Manager if its

offices/facilities have accommodations for people with physical disabilities, including offices, exam rooms, and equipment.

C. Employment and Civil Rights

Contractor agrees to and shall comply with the County's Equal Employment Opportunity Program and Civil Rights Compliance requirements:

1. Equal Employment Opportunity Program

Contractor agrees to comply with the provisions of the Equal Employment Opportunity Program of San Bernardino County and rules and regulations adopted pursuant thereto: Executive Orders 11246, 11375, 11625, 12138, 12432, 12250, and 13672; Title VII of the Civil Rights Act of 1964 (and Division 21 of the California Department of Social Services Manual of Policies and Procedures and California Welfare and Institutions Code, Section 10000); the California Fair Employment and Housing Act; and other applicable Federal, State, and County laws, regulations and policies relating to equal employment or social services to welfare recipients, including laws and regulations hereafter enacted.

During the term of the Contract, Contractor shall not discriminate against any employee, applicant for employment, or service recipient on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, age, political affiliation or military and veteran status.

2. Civil Rights Compliance

a. Contractor shall develop and maintain internal policies and procedures to assure compliance with each factor outlined by State regulation. Consistent with the requirements of applicable Federal or State law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical disabilities. The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified individuals with disabilities in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of the United States Department of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977. The Contractor shall include the nondiscrimination and compliance provisions of this Contract in all subcontracts to perform work under this Contract. Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205, Section 1830.205 or Section 1830.210, prior to providing covered services to a beneficiary.

b. Contractor shall prohibit discrimination on the basis of race, color, national origin, sex, gender identity, age, disability, or limited English proficiency (LEP) in accordance with Section 1557 of the Affordable Care Act (ACA), appropriate notices, publications, and DBH Non-Discrimination-Section 1557 of the Affordable Care Act Policy (COM0953).

D. Sexual Harassment

Contractor agrees that clients have the right to be free from sexual harassment and sexual contact by all staff members and other professional affiliates.

E. Contractor shall not discriminate against beneficiaries on the basis of health status or need for health care services, pursuant to 42 C.F.R. Section 438.6(d)(3).

F. Contractor shall not discriminate against Medi-Cal eligible individuals who require an assessment or meet medical necessity criteria for specialty mental health services on the basis of race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability [42 C.F.R. § 438.3(d)(4)].

G. Policy Prohibiting Discrimination, Harassment, and Retaliation

1. Contractor shall adhere to the County's Policy Prohibiting Discrimination, Harassment and Retaliation (07-01). This policy prohibits discrimination, harassment, and retaliation by all persons involved in or related to the County's business operations.

   The County prohibits discrimination, harassment, and/or retaliation on the basis Race, Religion, Color, National Origin, Ancestry, Disability, Sex/Gender, Gender Identity/Gender Expression/Sex Stereotype/Transgender, Sexual Orientation, Age, Military and Veteran Status. These classes and/or categories are Covered Classes covered under this policy; more information is available at www.dfeh.ca.gov/employment.

   The County prohibits discrimination against any employee, job applicant, unpaid intern in hiring, promotions, assignments, termination, or any other term, condition, or privilege of employment on the basis of a Protected Class. The County prohibits verbal harassment, physical harassment, visual harassment, and sexual harassment directed to a Protected Class.

2. Contractor shall comply with 45 C.F.R. § 160.316 to refrain from intimidation or retaliation. Contractors may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any individual or other person for:

   a) Filing of a complaint

   b) Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing

c) Opposing any unlawful act of practice, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information.

XXXIV. Contract Amendments

Contractor agrees that any alterations, variations, modifications, or waivers of the provisions of the Contract shall be valid only when they have been reduced to writing, duly signed by both parties and attached to the original of the Contract and approved by the required persons and organizations.

XXXV. Assignment

A. This Agreement shall not be assigned by Contractor, either in whole or in part, without the prior written consent of the Director.

B. This Contract and all terms, conditions and covenants hereto shall insure to the benefit of, and binding upon, the successors and assigns of the parties hereto.

C. If the ownership of the Contractor changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the State and DBH with written documentation stating:

1. That the new licensee shall have custody of the clients' records and that these records or copies shall be available to the former licensee, the new licensee and the County; or
2. That arrangements have been made by the licensee for the safe preservation and the location of the clients' records, and that they are available to both the new and former licensees and the County; or
3. The reason for the unavailability of such records.

XXXVI. Legality and Severability

The parties' actions under the Contract shall comply with all applicable laws, rules, regulations, court orders and governmental agency orders. The provisions of this Contract are specifically made severable. If a provision of the Contract is terminated or held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall remain in full effect.

XXXVII. Improper Consideration

A. Contractor shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or any items of value to any officer, employee or agent of the County in an attempt to secure favorable treatment regarding this Contract.

B. The County, by written notice, may immediately terminate any Contract if it determines that any improper consideration as described in the preceding paragraph was offered to any officer, employee or agent of the County with respect to the proposal and award process or any solicitation for consideration was not reported. This prohibition shall apply to any amendment, extension or evaluation process once a Contract has been awarded.

C. Contractor shall immediately report any attempt by a County officer, employee or agent to solicit (either directly or through an intermediary) improper consideration from Contractor. The report shall be made to the supervisor or manager charged with supervision of the employee or to the County Administrative Office. In the event of a termination under this provision, the County is entitled to pursue any available legal remedies.

XXXVIII. Venue

The venue of any action or claim brought by any party to the Contract will be the Superior Court of California, County of San Bernardino, San Bernardino District. Each party hereby waives any law or rule of the court, which would allow them to request or demand a change of venue. If any action or claim concerning the Contract is brought by any third-party and filed in another venue, the parties hereto agree to use their best efforts to obtain a change of venue to the Superior Court of California, County of San Bernardino, San Bernardino District.

XXXIX. Conclusion

A. This Agreement consisting of sixty-two (62) pages, Schedules, Addenda, and Attachments inclusive is the full and complete document describing the services to be rendered by Contractor to the County, including all covenants, conditions and benefits.

B. IN WITNESS WHEREOF, the Board of Supervisors of San Bernardino County has caused this Agreement to be subscribed by the Clerk thereof, and Contractor has caused this Agreement to be subscribed on its behalf by its duly authorized officers, the day, month, and year first above written.

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Agreement upon request.

SAN BERNARDINO COUNTY

► Dawn Rowe

Dawn Rowe, Chair, Board of Supervisors

Dated: MAR 25 2025

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Lynna Monell
Clerk of the Board of Supervisors
San Bernardino County

By ______________________ Deputy

Victor Community Support Services, Inc.
(Print or type name of corporation, company, contractor, etc.)

By ► Signed by: Edward E. Hackett
8638AE882AA84D1
(Authorized signature - sign in blue ink)

Name Edward Hacket
(Print or type name of person signing contract)

Tite Chief Financial Officer
(Print or Type)

Dated: 3/13/2025

Address 1360 East Lassen Avenue

Chico, CA 95973

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
► Signed by: Dawn Martin	► Signed by: Michael Shin	► DocuSigned by: Georgina Yoshioka
Dawn Martin, Deputy County Counsel	Michael Shin, Contracts Manager	Georgina Yoshioka, Director
Date 3/13/2025	Date 3/13/2025	Date 3/14/2025

SCHEDULE A

SCHEDULE A - Planning Estimates

SAN BERNARDINO COUNTY

DEPARTMENT OF BEHAVIORAL HEALTH

Student Assistance Program (SAP)

Actual Cost Contract (cost reimbursement)

FY 2024 - 2025
April 1 - June 30, 2025

Contractor Name: Victor Community Support Services
Provider #: 36 FSSA
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave, Chico, CA 95973
Date Form Completed: 2/18/25
Date Form Revised:

Prepared by: Matt Jafari
Title: Senior Financial Analyst

LINE				Early Intervention Services		Prevention Services		
		MODE OF SERVICE		15-Outpatient		45 - Outreach		
#		SERVICE FUNCTION		Case Mgmt and ICC (01-09)	Mental Health Services (10-50)	Mental Health Promotion (10-19)	Community Client Services (20-29)	TOTAL
1	100%	Distribution %		5.00%	70.00%	10.00%	15.00%	
		EXPENSES						
2		SALARIES		6,567	91,932	13,133	19,700	131,332
3		BENEFITS		2,030	28,414	4,059	6,089	40,592
		(2+3 must equal total staffing costs)		8,596	120,347	17,192	25,789	171,924
4		OPERATING EXPENSES		2,669	37,368	5,336	8,007	53,383
5		TOTAL EXPENSES (2+3+4)		11,265	157,715	22,531	33,796	225,307
		AGENCY REVENUES						
6		PATIENT FEES						0
7		PATIENT INSURANCE						0
8		MEDI-CARE						0
9		GRANTS/OTHER						0
10		TOTAL AGENCY REVENUES (6+7+8+9)		0	0	0	0	0
11		CONTRACT AMOUNT (5-10)		11,265	157,715	22,531	33,796	225,307
	Max %	FUNDING	Share %					
12	88.33%	MEDI-CAL (FFP)	56.50%	5,622	78,713			84,335
13		MHSA Match		4,329	60,602			64,930
14		MHSA		1,314	18,401	22,531	33,796	76,042
		FUNDING TOTAL		11,265	157,715	22,531	33,796	225,307
15		NET COUNTY FUNDS (Local Cost) MUST = ZERO		0	0	0	0	0
16		STATE FUNDING (Including Realignment)		5,643	79,002	22,531	33,796	140,972
17		AGENCY FUNDING (non-DBH)						0
18		FEDERAL FUNDING		5,622	78,713	0	0	84,335
		TOTAL FUNDING		11,265	157,715	22,531	33,796	225,307
19		UNITS OF TIME (MINUTES)		4,968	53,604			58,572
20		TARGET COST PER UNIT OF SERVICE		$ 2.27	$ 2.94			
21		COST PER UNDUPLICATED PARTICIPANT				$ 173.23	$ 86.61	

Client Days

APPROVED:

Angie Wiechert (signature) — Angie Wiechert (Feb 28, 2025 13:53 PST)	Feb 28, 2025	Christopher M. Lukachie (signature) — Christopher M. Lukachie (Mar 3, 2025 10:22 PST)	Mar 3, 2025	Sonia Navarro (signature) — Sonia Navarro (Mar 5, 2025 09:03 PST)	Mar 5, 2025
PROVIDER AUTHORIZED SIGNATURE	DATE	DBH FISCAL SERVICES	DATE	DBH PROGRAM MANAGER SIGNATURE	DATE

Angie Wiechert	Christopher M. Lukachie	Sonia Navarro
PROVIDER AUTHORIZED SIGNER (PRINT NAME)	DBH FISCAL SERVICES (PRINT NAME)	DBH PROGRAM MANAGER (PRINT NAME)

SCHEDULE A

SCHEDULE A - Planning Estimates

SAN BERNARDINO COUNTY

DEPARTMENT OF BEHAVIORAL HEALTH

Student Assistance Program (SAP)

Actual Cost Contract (cost reimbursement)

FY 2025-2026
July 1, 2025 - June 30, 2026

Contractor Name: Victor Community Support Services
Provider #: 36 FSSA
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave, Chico, CA 95973
Date Form Completed: 2/18/25
Date Form Revised:

Prepared by: Matt Jafari
Title: Senior Financial Analyst

LINE #			MODE OF SERVICE / SERVICE FUNCTION		Early Intervention Services 15-Outpatient: Case Mgmt and ICC (01-09)	Early Intervention Services 15-Outpatient: Mental Health Services (10-50)	Prevention Services 45 - Outreach: Mental Health Promotion (10-19)	Prevention Services 45 - Outreach: Community Client Services (20-29)	TOTAL
1	100%		Distribution %		5.00%	70.00%	10.00%	15.00%	
			EXPENSES						
2			SALARIES		26,266	367,730	52,533	78,799	525,328
3			BENEFITS		8,118	113,658	16,237	24,355	162,368
			(2+3 must equal total staffing costs)		34,385	481,387	68,770	103,154	687,696
4			OPERATING EXPENSES		10,677	149,472	21,353	32,030	213,532
5			TOTAL EXPENSES (2+3+4)		45,061	630,860	90,123	135,184	901,228
			AGENCY REVENUES						
6			PATIENT FEES						0
7			PATIENT INSURANCE						0
8			MEDI-CARE						0
9			GRANTS/OTHER						0
10			TOTAL AGENCY REVENUES (6+7+8+9)		0	0	0	0	0
11			CONTRACT AMOUNT (5-10)		45,061	630,860	90,123	135,184	901,228
	Mix %		FUNDING	Share %					
12	88.33%		MEDI-CAL (FFP)	56.50%	22,489	314,850			337,340
13			MHSA Match		17,315	242,407			259,722
14			MHSA		2,629	36,801	45,061	67,592	152,083
15			BHSA		2,629	36,801	45,061	67,592	152,083
			FUNDING TOTAL		45,061	630,860	90,123	135,184	901,228
16			NET COUNTY FUNDS (Local Cost) MUST = ZERO		0	0	0	0	0
17			STATE FUNDING (Including Realignment)		22,572	316,009	90,123	135,184	563,888
18			AGENCY FUNDING (non-DBH)						0
19			FEDERAL FUNDING		22,489	314,850	0	0	337,340
			TOTAL FUNDING		45,061	630,860	90,123	135,184	901,228
21			UNITS OF TIME (MINUTES)		19,872	214,415			234,287
22			TARGET COST PER UNIT OF SERVICE		$ 2.27	$ 2.94			
23			COST PER UNDUPLICATED PARTICIPANT				$ 173.23	$ 86.61	

Client Days

APPROVED:

Angie Wiechert (Angie Wiechert (Mar 4, 2025 08:18 PST))	Mar 4, 2025	Christopher M. Lukachie (Christopher M. Lukachie (Mar 4, 2025 08:20 PST))	Mar 4, 2025	Sonia Navarro (Sonia Navarro (Mar 4, 2025 23:21 PST))	Mar 4, 2025
PROVIDER AUTHORIZED SIGNATURE	DATE	DBH FISCAL SERVICES	DATE	DBH PROGRAM MANAGER SIGNATURE	DATE
Angie Wiechert		Christopher M. Lukachie		Sonia Navarro	
PROVIDER AUTHORIZED SIGNER (PRINT NAME)		DBH FISCAL SERVICES (PRINT NAME)		DBH PROGRAM MANAGER (PRINT NAME)	

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SCHEDULE A - Planning Estimates

Actual Cost Contract (cost reimbursement)

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
School-Aged Treatment Services (SATS)

FY 2024-2025
April 1 to June 30, 2025

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Contractor Name: Victor Community Support Services
Provider #: East Valley Region RU# 36FSE
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25
Date Form Revised:

LINE		MODE OF SERVICE	15-Outpatient					
#		SERVICE FUNCTION	Case Management (01-06 & 08-09)	Intensive Care Coordination (07)	Mental Health Services (10-50)	Medication Support (60)	Crisis Intervention (70)	TOTAL
1	100%	Distribution %	3.95%	15.81%	78.98%	1.20%	0.06%	
		EXPENSES						
2		SALARIES	41,062	164,247	820,620	12,445	616	1,038,990
3		BENEFITS	12,688	50,752	253,569	3,845	190	321,044
		(2+3 must equal total staffing costs)	53,750	214,999	1,074,189	16,290	806	1,360,034
4		OPERATING EXPENSES	17,815	71,261	356,037	5,399	267	450,780
5		TOTAL EXPENSES (2+3+4)	71,565	286,260	1,430,226	21,690	1,074	1,810,814
		AGENCY REVENUES						
6		PATIENT FEES						0
7		PATIENT INSURANCE						0
8		MEDI-CARE						0
9		GRANTS/OTHER						0
10		TOTAL AGENCY REVENUES (6+7+8+9)	0	0	0	0	0	0
11		CONTRACT AMOUNT (5-10)	71,565	286,260	1,430,226	21,690	1,074	1,810,814
	Mix %	FUNDING — Share %						
12	100.00%	MEDI-CAL (FFP) — 56.50%	40,434	161,737	808,078	12,255	607	1,023,111
13	100.00%	EPSDT (2011 Realignment) — 29.50%	21,112	84,447	421,917	6,398	317	534,191
14		1991 Realignment — 14.00%	10,019	40,076	200,231	3,037	150	253,512
15		FUNDING TOTAL	71,565	286,260	1,430,226	21,690	1,074	1,810,814
16		NET COUNTY FUNDS (Local Cost) MUST = ZERO	0	0	0	0	0	0
17		STATE FUNDING (Including Realignment)	31,131	124,523	622,148	9,435	467	787,703
18		FEDERAL FUNDING	40,434	161,737	808,078	12,255	607	1,023,111
19		TOTAL FUNDING	71,565	286,260	1,430,226	21,690	1,074	1,810,814
20		TARGET COST PER UNIT OF SERVICE	$2.87	$4.02	$7.04	$7.04	$4.88	
21		UNITS OF TIME (Minutes)	24,968	71,159	203,157	3,081	220	302,585

APPROVED:

Angie Wiechert
Angie Wiechert (Feb 26, 2025 15:18 PST)
PROVIDER AUTHORIZED SIGNATURE — Feb 26, 2025 DATE

Christopher M. Lukachie
Christopher M. Lukachie (Feb 26, 2025 15:19 PST)
DBH FISCAL SERVICES — Feb 26, 2025

Jill Smith
DBH PROGRAM MANAGER — Feb 26, 2025 DATE

Angie Wiechert
PROVIDER AUTHORIZED SIGNER (PRINT NAME)

Christopher M. Lukachie
DBH FISCAL SERVICES (PRINT NAME)

Jill Smith
DBH PROGRAM MANAGER (PRINT NAME)

SCHEDULE A

SCHEDULE A - Planning Estimates

Actual Cost Contract (cost reimbursement)

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
School-Aged Treatment Services (SATS)

FY 2025-2026
July 1, 2025 to June 30, 2026

Contractor Name: Victor Community Support Services
Provider # East Valley Region RU# 36FSE
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25
Date Form Revised:

Prepared by: Matt Jafari
Title: Senior Financial Analyst

LINE #	Mix %	MODE OF SERVICE / SERVICE FUNCTION	Share %	15-Outpatient: Case Management (01-06 & 08-09)	Intensive Care Coordination (07)	Mental Health Services (10-50)	Medication Support (60)	Crisis Intervention (70)	TOTAL
1	100%	Distribution %		3.95%	15.81%	78.98%	1.20%	0.06%	
		EXPENSES							
2		SALARIES		164,246	656,988	3,282,474	49,779	2,464	4,155,951
3		BENEFITS		50,752	203,009	1,014,280	15,382	761	1,284,184
		(2+3 must equal total staffing costs)		214,998	859,997	4,296,754	65,161	3,225	5,440,135
4		OPERATING EXPENSES		71,261	285,044	1,424,150	21,597	1,069	1,803,121
5		TOTAL EXPENSES (2+3+4)		286,259	1,145,041	5,720,904	86,758	4,294	7,243,256
		AGENCY REVENUES							
6		PATIENT FEES							0
7		PATIENT INSURANCE							0
8		MEDI-CARE							0
9		GRANTS/OTHER							0
10		TOTAL AGENCY REVENUES (6+7+8+9)		0	0	0	0	0	0
11		CONTRACT AMOUNT (5-10)		286,259	1,145,041	5,720,904	86,758	4,294	7,243,256
	Mix %	FUNDING	Share %						
12	100.00%	MEDI-CAL (FFP)	56.50%	161,736	646,948	3,232,311	49,018	2,426	4,092,439
13	100.00%	EPSDT (2011 Realignment)	29.50%	84,446	337,787	1,687,667	25,594	1,267	2,136,761
14		1991 Realignment	14.00%	40,077	160,306	800,926	12,146	601	1,014,056
15		FUNDING TOTAL		286,259	1,145,041	5,720,904	86,758	4,294	7,243,256
16		NET COUNTY FUNDS (Local Cost) MUST = ZERO		0	0	0	0	0	0
17		STATE FUNDING (Including Realignment)		124,523	498,093	2,488,593	37,740	1,868	3,150,817
18		FEDERAL FUNDING		161,736	646,948	3,232,311	49,018	2,426	4,092,439
19		TOTAL FUNDING		286,259	1,145,041	5,720,904	86,758	4,294	7,243,256
20		TARGET COST PER UNIT OF SERVICE		$2.87	$4.02	$7.04	$7.04	$4.88	
21		UNITS OF TIME (Minutes)		99,871	284,634	812,629	12,324	880	1,210,339

APPROVED:

Angie Wiechert
Angie Wiechert (Feb 26, 2025 15:18 PST)
PROVIDER AUTHORIZED SIGNATURE — DATE: Feb 26, 2025

Christopher M. Lukachie
Christopher M. Lukachie (Feb 26, 2025 15:19 PST)
DBH FISCAL SERVICES — DATE: Feb 26, 2025

Jill Smith
DBH PROGRAM MANAGER — DATE: Feb 26, 2025

Angie Wiechert
PROVIDER AUTHORIZED SIGNER (PRINT NAME)

Christopher M. Lukachie
DBH FISCAL SERVICES (PRINT NAME)

Jill Smith
DBH PROGRAM MANAGER (PRINT NAME)

SCHEDULE B

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Schedule B

STAFFING DETAIL
FY 2024 - 2025
April 1 - June 30, 2025 (12 months)

Contractor Name: Victor Community Support Services
Provider #: 36 FSSA
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave
Date Form Completed: 2/18/25
Date Form Revised: 1/0/1900

Staffing Detail - Personnel (Includes Personal Services Contracts for Professional Services)

CONTRACTOR NAME: Victor Community Support Services

Name	Degree/ License	Position Title	If Staff Position is not Clinical FTE Providing SMHS, change to "N"	D/I/C [1]	Full Time Annual Salary*	Full Time Fringe Benefits*	Total Full Time Salaries & Benefits*	% Cost Allocated Contract Services	Total Salaries and Benefits Charged to Contract Services	Total Salaries Charged to Contract Services	Total Benefits Charged to Contract Services
Diana Saunders	MS-counseling marriage & f	Executive Director	N	D	134,127	41,445	175,572	2%	3,134	2,394	740
Vacant		CQI Supervisor	N	D	102,362	31,630	133,992	2%	2,392	1,827	565
Vicki Davis	MS- counseling psychology/f	Clinical Supervisor (Clinic Supervisor)	N	D	97,495	30,126	127,621	16%	20,738	15,843	4,895
Vanessa Inzunza	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	89,616	27,691	117,308	25%	29,327	22,404	6,923
Pablo Ponce	MS-clinical mental health co	Clinician (Clinical Therapist)	Y	D	78,628	24,296	102,924	25%	25,731	19,657	6,074
Vacant		Clinician (Clinical Therapist)	Y	D	90,110	27,844	117,954	25%	29,489	22,528	6,961
Oscar Barrientos	MS- Social work/ ACSW	Mental Health Specialist	Y	D	69,480	21,469	90,950	25%	22,737	17,370	5,367
Vacant		Mental Health Specialist	Y	D	47,821	14,777	62,597	25%	15,649	11,955	3,694
Mutiple Staff		Program Support (Tech Support, Quality)	N	D	94,940	29,336	124,276	5%	6,117	4,673	1,444
Mutiple Staff		Program Support Team (Admin Associate	N	D	51,169	15,811	66,980	23%	15,552	11,881	3,671
Mutiple Staff		On Call Support	Y	D	3,200	1,031	4,231	25%	1,058	800	258
							0		0	0	0
							0		0	0	0
							0		0	0	0
										131,332	40,592

TOTAL COST: 171,925

*Clinical Therapist are contracted employees that are part time but 85% their time is towards the MH services

Detail of Fringe Benefits: Employer FICA/Medicare, Workers Compensation, Unemployment, Vacation Pay, Sick Pay, Pension and Health Benefits

[1] **Input "D" to indicate a direct staffing position and input "I" for an indirect staffing position**

Note, administrative and clerical staff are normally treated as indirect cost. For any administrative or clerical staff that are identified as direct, please ensure the required documentation is maintained to fill CFR 200.413 (c)(1) – (4)

[2] Contracted positions need to be Clinical positions only. Any Non-clinical contracted position need to be included on the Operating Expense schedule only.

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B

FY 2024 - 2025

Contractor Name: **Victor Community Support Services**
Provider # **36 FSSA**
Contract/RFP# **22-149**
Address: **1360 East Lassen Ave**
Chico, CA 95973
Date Form Completed: **2/18/25**

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Operating Expenses - Please list all operating costs charged to this program, including administrative support costs and management fees along with a detail explanation of the categories below.

April 1 - June 30, 2025

	ITEM	TOTAL COST TO ORGANIZATION	% CHARGED TO OTHER FUNDING SOURCE	TOTAL COST TO OTHER FUNDING SOURCE	PERCENT CHARGED TO PROGRAM	TOTAL COST TO PROGRAM
1	Professional Fees	$3,380	75%	$2,535	25%	$845
2	Software Maintenance	$9,392	75%	$7,044	25%	$2,348
3	Employment Expenses	$5,435	75%	$4,076	25%	$1,359
4	Office Supplies	$5,248	75%	$3,936	25%	$1,312
5	Program Supplies	$17,113	75%	$12,835	25%	$4,278
6	Rent	$24,129	75%	$18,096	25%	$6,032
7	Utilities	$13,375	75%	$10,031	25%	$3,344
8	Building Maintenance	$5,040	75%	$3,780	25%	$1,260
9	Equipment Expense	$14,581	75%	$10,936	25%	$3,645
10	Transportaton	$11,747	75%	$8,810	25%	$2,937
11	General & Administrative Costs	$1,585	75%	$1,188	25%	$396
12	Conference & Meetings	$10,936	75%	$8,202	25%	$2,734
13	Taxes & Insurance	$2,262	75%	$1,696	25%	$565
14	Indirect Expenses	$89,311	75%	$66,983	25%	$22,328
15			100%	$0		$0
SUBTOTAL B:		$213,532		$160,149		$53,383
GROSS COSTS TOTAL STAFFING AND OPERATING EXPENSES:						$225,308

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
BUDGET NARRATIVE
FY 2024 - 2025

Contractor Name: Victor Community Support Services
Provider # 36 FSSA
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/18/25

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Budget Narrative for Operating Expenses. Explain each expense by line item. Provide an explanation for determination of all figures (rate, duration, quantity, Benefits, FTE's, etc.) for example explain how overhead or indirect cost were calculated.

April 1 - June 30, 2025

ITEM	Justification of Cost
1 Professional Fees	Budgeted for any professional service needs associated with program operations, interpreter services, staff training materials, and guest speakers for trainings.
2 Software Maintenance	Budgeted for technical support services as well as annual software licenses and maintenance costs. Software maintenance includes costs associated with our EHR, as well as correcting, updating and enhancing our other agency software.
3 Employment Expenses	Budgeted for costs associated with recruiting, advertising, completion of a 3rd party physical, drug testing, fingerprinting, clinical license renewals, and continuing education.
4 Office Supplies	Budgeted for costs associated with general office supplies, such as paper, pens, pencils, envelopes, folders, tape, printed brochures, checks, business cards, kitchen supplies, toner for copier, fax machine, paper for fax machine, copier and computer printers, postage and shipping costs, and subscription expense.
5 Program Supplies	Budgeted for costs associated with general program support supplies. Which may include bilingual materials, orientation and treatment packets, therapeutic supplies, toys and materials, group snack packs, and instructional supplies. This also includes curriculums and required assessment measures such as: PCIT, PSC-35, Trauma focused CBT, Solution Focused Brief Therapy materials, Seeking Safety, Love and Logic, Incredible Years, Nurturing Parenting, Why Try, NCTI Crossroads, and Real Colors Curriculum.
6 Rent	Budgeted for the rental cost of a leased building and depreciation costs related to leasehold improvements.
7 Utilities	Budgeted for costs associated with general utility costs, such as telephone, water, natural gas, electricity, cable, internet, and garbage service.
8 Building Maintenance	Budgeted for costs associated with janitorial, maintenance, building and ground supplies, licenses and permits.
9 Equipment Expense	Budgeted for costs associated with equipment maintenance, office equipment, furnishings, computer equipment, and equipment lease expenses such as postage and copier machines.
10 Transportaton	Budgeted for costs associated with staff mileage reimbursements as well as agency vehicle operating, repair, maintenance, and licensing costs. This is budgeted to cover the cost of staff travel related to service delivery, training, and meetings. The mileage reimbursement rate is reviewed and set by management annually. The annual rate will not exceed the IRS mileage reimbursement rate.
11 General & Administrative Costs	Budgeted for all other operating expenses including bank fees, interest expense, dues and memberships.
12 Conference & Meetings	Budgeted for costs associated with meetings, staff events, and conferences; such as conference fees, airfare, food and lodging to attend conferences and trainings.
13 Taxes & Insurance	Budgeted for property taxes and insurance costs including liability, property and vehicle insurance.
14 Indirect Expenses	Budgeted for the indirect costs that supports VCSS administrative services which includes, but may not be limited to, the following: CEO, COO, CFO, Agency-wide Human Resource functions, Agency-wide Administrative and Executive support functions, Agency-wide Technology services, Agency-wide Fiscal and Accounting functions, along with the operating expenses associated with supporting these positions. This is calculated at an estimated rate of 12% of total direct costs. This estimated rate is trued-up to the Agency's actual indirect cost rate as part of our yearend closing procedure.
15	

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2024 - 2025
Service Projections (Mode 15)

Prior fiscal year Rates (Completed by DBH)				
Old County Contract (CCR) Rates	$2.20	$2.99	$5.56	$4.20
Productivity Expectation: 60%	CM Rate per Min.	MHS Rate/Min	MSS Rate/Min	Crisis Rate/Min
Agency Per Min Rates:	$2.42	$3.14		
Target Cost Per Unit of Service	$2.27	$2.94		

NOTE: If no estabalished agency per minute rates, please input the CCR rates in the highlighed cells

ALL YELLOW HIGHLIGHTED AREAS REQUIRE INPUT BY PROVIDER

Contractor Name:	Victor Community Support Services
Provider #	36 FSSA
Contract/RFP#	22-149
Address:	1360 East Lassen Ave
	Chico, CA 95973
Date Form Completed:	2/18/25
Date Form Revised:	

MONTH	Estimated Units of Service (Minutes)	Planned Clinical FTE's	Projected Revenue Generated by Service Type: Case Management/ ICC (01-09)	Mental Health Services (10-50)						Clients Served: Starting Census: Admissions (Episodes Opened)	Discharges (Episodes Closed)	75 Monthly Census
Jul-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Aug-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Sep-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Oct-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Nov-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Dec-24		1.50	$0	$0	$0	$0	$0	$0	$0			75
Jan-25		1.50	$0	$0	$0	$0	$0	$0	$0			75
Feb-25		1.50	$0	$0	$0	$0	$0	$0	$0			75
Mar-25		1.50	$0	$0	$0	$0	$0	$0	$0			75
Apr-25	19,524	1.50	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	111
May-25	19,524	1.50	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	147
Jun-25	19,524	1.50	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	183
TOTAL	58,572		$11,265	$157,715						215	108	
			Total Revenue					$168,980		Unduplicated Clients Served		290
								Estimated Cost Per Client:		$582		

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2024 - 2025

April 1 - June 30, 2025

Contractor Name: Victor Community Support Services
Region 36 FSSA
Contract # 22-149
Address: 1360 East Lassen Ave

Date Form Completed: 2/18/25
Updated 1/0/1900

Year to Date Unduplicated Participant Count (Mode 45)		
Mental Health Promotion	Comm. Client Services	Program
130	390	520

PEI County Program: STUDENT ASSISTANCE PROGRAM

State Defined Program: PREVENTION & EARLY INTERVENTION (Mode 45 Services)

Unduplicated Participant Count	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	TOTAL
Mental Health Promotion										43	43	43	130
Community Client Services										130	130	130	390
TOTAL	0	0	0	0	0	0	0	0	0	173	173	173	520

NOTE: Unduplicated Participant Count means that each child is 150

Service Projections for:	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	TOTAL
Mental Health Promotion										87	87	87	260
Community Client Services										260	260	260	781
TOTAL	0	0	0	0	0	0	0	0	0	347	347	347	1041

NOTE: Services Projections are counts of services, not counts of children. So a child receiving multiple services would be counted more than once.

Cost per unduplicated participant for:	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	TOTAL
Mental Health Promotion										$ 173.23	$ 173.23	$ 173.23	$ 173.23
Community Client Services										$ 86.61	$ 86.61	$ 86.61	$ 86.61

Cost Projections for:	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	TOTAL
Mental Health Promotion										$ 7,510	$ 7,510	$ 7,510	$ 22,531
Community Client Services										$ 11,265	$ 11,265	$ 11,265	$ 33,796
TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,776	$ 18,776	$ 18,776	$ 56,327

SCHEDULE B

	15-Outpatient	15-Outpatient	
	Case Management	Mental Health Services	TOTAL
Total Minutes of Services	4,968	53,604	58,572
Total Monthly Minutes of Services (Average)	414.00	4466.99	4880.99
Dosage (minutes) per client per month	4.45	48.06	52.52
Dosage (hours) per client per month	0.07	0.80	0.88

Total Hours Per Unduplicated Client for Duration of the Program: 2.63

Avg Monthly Census	Expected Length of Program (months)
93	3

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SCHEDULE B

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Schedule B

STAFFING DETAIL
FY 2025-2026
July 1, 2025 - June 30, 2026 (12 months)

Contractor Name: Victor Community Support Services
Provider #: 36 FSSA
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave
Date Form Completed: 2/18/25
Date Form Revised: 1/0/1900

Staffing Detail - Personnel (Includes Personal Services Contracts for Professional Services)

CONTRACTOR NAME: Victor Community Support Services

Name	Degree/ License	Position Title	If staff Position is not Clinical FTE Providing SMHS, change to "N"	D/I/C [1]	Full Time Annual Salary*	Full Time Fringe Benefits*	Total Full Time Salaries & Benefits*	% Cost Allocated Contract Services	Total Salaries and Benefits Charged to Contract Services	Total Salaries Charged to Contract Services	Total Benefits Charged to Contract Services
Diana Saunders	MS-counseling marriage & family/LMFT	Executive Director	N	D	134,127	41,445	175,572	7%	12,535	9,576	2,959
Vacant		OCI Supervisor	N	D	102,362	31,630	133,992	7%	9,567	7,308	[illegible]
Vicki Davis	MS- counseling psychology/LMFT	Clinical Supervisor (Clinic Supervisor)	N	D	97,495	30,126	127,621	65%	82,953	63,372	19,582
Vanessa Inzunza	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	89,616	27,691	117,308	100%	117,308	89,616	27,691
Pablo Ponce	MS-clinical mental health counseling/ APCC	Clinician (Clinical Therapist)	Y	D	78,628	24,296	102,924	100%	102,924	78,628	24,296
Vacant		Clinician (Clinical Therapist)	Y	D	90,110	27,844	117,954	100%	117,954	90,110	27,844
Oscar Barrientos	MS- Social work/ ACSW	Mental Health Specialist	Y	D	69,480	21,469	90,950	100%	90,950	69,480	21,469
Vacant		Mental Health Specialist	Y	D	47,821	14,777	62,597	100%	62,597	47,821	14,777
Multiple Staff		Program Support (Tech Support, Quality)	N	D	94,940	29,336	124,276	20%	24,470	18,693	5,776
Multiple Staff		Program Support Team (Admin Associates, Fiscal Oversight, Regional Support)	N	D	51,169	15,811	66,980	93%	62,209	47,524	14,685
Multiple Staff		On Call Support	Y	D	3,200	1,031	4,231	100%	4,231	3,200	1,031
							0		0	0	0
										[illegible]	[illegible]

TOTAL COST: 687,698

*Clinical Therapist are contracted employees that are part time but 65% their time is towards the MH services

Detail of Fringe Benefits: Employer FICA/Medicare, Workers Compensation, Unemployment, Vacation Pay, Sick Pay, Pension and Health Benefits

[1] **Input "D" to indicate a direct staffing position and input "I" for an indirect staffing position**

Note, administrative and clerical staff are normally treated as indirect cost. For any administrative or clerical staff that are identified as direct, please ensure the required documentation is maintained to fill CFR 200.413 (c)(1) – (4)

[2] **Contracted positions need to be Clinical positions only. Any Non-clinical contracted position need to be included on the Operating Expense schedule only.**

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B

FY 2025-2026

Contractor Name: Victor Community Support Services
Provider # 36 FSSA
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/18/25

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Operating Expenses - Please list all operating costs charged to this program, including administrative support costs and management fees along with a detail explanation of the categories below.

July 1, 2025 - June 30, 2026

	ITEM	TOTAL COST TO ORGANIZATION	% CHARGED TO OTHER FUNDING SOURCE	TOTAL COST TO OTHER FUNDING SOURCE	PERCENT CHARGED TO PROGRAM	TOTAL COST TO PROGRAM
1	Professional Fees	$3,380	0%	$0	100%	$3,380
2	Software Maintenance	$9,392	0%	$0	100%	$9,392
3	Employment Expenses	$5,435	0%	$0	100%	$5,435
4	Office Supplies	$5,248	0%	$0	100%	$5,248
5	Program Supplies	$17,113	0%	$0	100%	$17,113
6	Rent	$24,129	0%	$0	100%	$24,129
7	Utilities	$13,375	0%	$0	100%	$13,375
8	Building Maintenance	$5,040	0%	$0	100%	$5,040
9	Equipment Expense	$14,581	0%	$0	100%	$14,581
10	Transportaton	$11,747	0%	$0	100%	$11,747
11	General & Administrative Costs	$1,585	0%	$0	100%	$1,585
12	Conference & Meetings	$10,936	0%	$0	100%	$10,936
13	Taxes & Insurance	$2,262	0%	$0	100%	$2,262
14	Indirect Expenses	$89,311	0%	$0	100%	$89,311
15			100%	$0		$0
SUBTOTAL B:		$213,532		$0		$213,532
GROSS COSTS TOTAL STAFFING AND OPERATING EXPENSES:						$901,230

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
BUDGET NARRATIVE
FY 2025-2026

Contractor Name: **Victor Community Support Services**
Provider # **36 FSSA**
Contract/RFP# **22-149**
Address: **1360 East Lassen Ave**
Chico, CA 95973
Date Form Completed: **2/18/25**

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Budget Narrative for Operating Expenses. Explain each expense by line item. Provide an explanation for determination of all figures (rate, duration, quantity, Benefits, FTE's, etc.) for example explain how overhead or indirect cost were calculated.

July 1, 2025 - June 30, 2026

ITEM	Justification of Cost
1 Professional Fees	Budgeted for any professional service needs associated with program operations, interpreter services, staff training materials, and guest speakers for trainings.
2 Software Maintenance	Budgeted for technical support services as well as annual software licenses and maintenance costs. Software maintenance includes costs associated with our EHR, as well as correcting, updating and enhancing our other agency software.
3 Employment Expenses	Budgeted for costs associated with recruiting, advertising, completion of a 3rd party physical, drug testing, fingerprinting, clinical license renewals, and continuing education.
4 Office Supplies	Budgeted for costs associated with general office supplies, such as paper, pens, pencils, envelopes, folders, tape, printed brochures, checks, business cards, kitchen supplies, toner for copier, fax machine, paper for fax machine, copier and computer printers, postage and shipping costs, and subscription expense.
5 Program Supplies	Budgeted for costs associated with general program support supplies. Which may include bilingual materials, orientation and treatment packets, therapeutic supplies, toys and materials, group snack packs, and instructional supplies. This also includes curriculums and required assessment measures such as: PCIT, PSC-35, Trauma focused CBT, Solution Focused Brief Therapy materials, Seeking Safety, Love and Logic, Incredible Years, Nurturing Parenting, Why Try, NCTI Crossroads, and Real Colors Curriculum.
6 Rent	Budgeted for the rental cost of a leased building and depreciation costs related to leasehold improvements.
7 Utilities	Budgeted for costs associated with general utility costs, such as telephone, water, natural gas, electricity, cable, internet, and garbage service.
8 Building Maintenance	Budgeted for costs associated with janitorial, maintenance, building and ground supplies, licenses and permits.
9 Equipment Expense	Budgeted for costs associated with equipment maintenance, office equipment, furnishings, computer equipment, and equipment lease expenses such as postage and copier machines.
10 Transportaton	Budgeted for costs associated with staff mileage reimbursements as well as agency vehicle operating, repair, maintenance, and licensing costs. This is budgeted to cover the cost of staff travel related to service delivery, training, and meetings. The mileage reimbursement rate is reviewed and set by management annually. The annual rate will not exceed the IRS mileage reimbursement rate.
11 General & Administrative Costs	Budgeted for all other operating expenses including bank fees, interest expense, dues and memberships.
12 Conference & Meetings	Budgeted for costs associated with meetings, staff events, and conferences; such as conference fees, airfare, food and lodging to attend conferences and trainings.
13 Taxes & Insurance	Budgeted for property taxes and insurance costs including liability, property and vehicle insurance.
14 Indirect Expenses	Budgeted for the indirect costs that supports VCSS administrative services which includes, but may not be limited to, the following: CEO, COO, CFO, Agency-wide Human Resource functions, Agency-wide Administrative and Executive support functions, Agency-wide Technology services, Agency-wide Fiscal and Accounting functions, along with the operating expenses associated with supporting these positions. This is calculated at an estimated rate of 12% of total direct costs. This estimated rate is trued-up to the Agency's actual indirect cost rate as part of our yearend closing procedure.
15	

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2025-2026
Service Projections (Mode 15)

Prior fiscal year Rates (Completed by DBH)				
Old County Contract (CCR) Rates	$2.20	$2.99	$5.56	$4.20
Productivity Expectation: 60%	CM Rate per Min.	MHS Rate/Min	MSS Rate/Min	Crisis Rate/Min
Agency Per Min Rates:	$2.42	$3.14		
Target Cost Per Unit of Service	$2.27	$2.94		

NOTE: If no estabalished agency per minute rates, please input the CCR rates in the highlighed cells

Contractor Name:	Victor Community Support Services
Provider #	36 FSSA
Contract/RFP#	22-149
Address:	1360 East Lassen Ave
	Chico, CA 95973
Date Form Completed:	2/18/25
Date Form Revised:	

ALL YELLOW HIGHLIGHTED AREAS REQUIRE INPUT BY PROVIDER

			Projected Revenue Generated by Service Type							Clients Served		
										Starting Census		300
MONTH	Estimated Units of Service (Minutes)	Planned Clinical FTE's	Case Management/ ICC (01-09)	Mental Health Services (10-50)						Admissions (Episodes Opened)	Discharges (Episodes Closed)	Monthly Census
Jul-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	336
Aug-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	372
Sep-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	408
Oct-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	444
Nov-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	479
Dec-25	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	515
Jan-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	551
Feb-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	587
Mar-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	623
Apr-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	659
May-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	695
Jun-26	19,524	6.00	$3,755	$52,572	$0	$0	$0	$0	$0	72	36	731
TOTAL	234,287		$45,061	$630,860						861	431	
			Total Revenue					$675,921		Unduplicated Clients Served		1,161
								Estimated Cost Per Client:		$582		

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2025-2026

July 1, 2025 - June 30, 2026

Contractor Name: Victor Community Support Services
Region 36 FSSA
Contract # 22-149
Address: 1360 East Lassen Ave

Date Form Completed: 2/18/25
Updated 1/0/1900

Year to Date Unduplicated Participant Count (Mode 45)		
Mental Health Promotion	Comm. Client Services	Program
520	1,561	2,081

PEI County Program: STUDENT ASSISTANCE PROGRAM
State Defined Program: PREVENTION & EARLY INTERVENTION (Mode 45 Services)

Unduplicated Participant Count	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	TOTAL
Mental Health Promotion	43	43	43	43	43	43	43	43	43	43	43	43	520
Community Client Services	130	130	130	130	130	130	130	130	130	130	130	130	1561
TOTAL	173	173	173	173	173	173	173	173	173	173	173	173	2081

NOTE: Unduplicated Participant Count means that each child is 150

Service Projections for:	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	TOTAL
Mental Health Promotion	87	87	87	87	87	87	87	87	87	87	87	87	1040
Community Client Services	260	260	260	260	260	260	260	260	260	260	260	260	3122
TOTAL	347	347	347	347	347	347	347	347	347	347	347	347	4162

NOTE: Services Projections are counts of services, not counts of children. So a child receiving multiple services would be counted more than once.

Cost per unduplicated participant for:	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	TOTAL
Mental Health Promotion	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23	$ 173.23
Community Client Services	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61	$ 86.61

Cost Projections for:	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	TOTAL
Mental Health Promotion	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 7,510	$ 90,123
Community Client Services	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 11,265	$ 135,184
TOTAL	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 18,776	$ 225,307

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

	15-Outpatient	15-Outpatient	
	Case Management	Mental Health Services	TOTAL
Total Minutes of Services	19,872	214,415	234,287
Total Monthly Minutes of Services (Average)	1656.00	17867.95	19523.95
Dosage (minutes) per client per month	3.11	33.51	36.62
Dosage (hours) per client per month	0.05	0.56	0.61

Avg Monthly Census	Expected Length of Program (months)
533	3

Total Hours Per Unduplicated Client for Duration of the Program: 1.83

SCHEDULE B

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
STAFFING DETAIL
FY 2024-2025
April 1 to June 30, 2025 (12 months)

Schedule B

Contractor Name: Victor Community Support Se
Provider # East Valley Region RU# 36FSI
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Staffing Detail - Personnel (Includes Personal Services Contracts for Professional Services)

CONTRACTOR NAME: Victor Community Support Services

Name	Degree/ License	Position Title	If Staff Position is not Clinical FTE Providing SMHS, change to "N"	D/I/C [1]	Full Time Annual Salary*	Full Time Fringe Benefits*	Total Full Time Salaries & Benefits*	% Cost Allocated Contract Services	Total Salaries and Benefits Charged to Contract Services	Total Salaries Charged to Contract Services	Total Benefits Charged to Contract Services
Diana Saunders	MS-counseling marriage & family/LMFT	Executive Director	N	D	134,127	41445.148	175,572	14%	25,072	19,154	5,919
Vacant		CQI Supervisor	N	D	102,362	31629.938	133,992	14%	19,135	14,618	4,517
Krystal Zielen	MS-psychology/LMFT	Clinical Supervisor (Clinic Supervisor)	N	D	93,653	28938.728	122,592	13%	15,324	11,707	3,617
Kamisha Ford	MS-marriage & family/LMFT	Clinical Supervisor (Clinic Supervisor)	N	D	103,504	31982.819	135,487	25%	33,872	25,876	7,996
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	97,495	30125.875	127,621	9%	11,167	8,531	2,636
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	107,372	33177.913	140,550	13%	17,569	13,421	4,147
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	114,559	35398.808	149,958	50%	74,979	57,280	17,699
Diana Zing-Sandoval	MA- clinical mental health counseling/ APCC	Clinician (Clinical Therapist)	Y	D	88,883	27464.71	116,347	25%	29,087	22,221	6,866
Alexandra Owusu	MA Social Work/ ACSW	Clinician (Clinical Therapist)	Y	D	77,206	23856.684	101,063	25%	25,266	19,302	5,964
Andrea Brito	MA Counseling Psychology /AMFT	Clinician (Clinical Therapist)	Y	D	86,491	26725.65	113,216	25%	28,304	21,623	6,681
Luisa Melendez	MS- counseling/ AMFT	Clinician (Clinical Therapist)	Y	D	91,347	28226.07	119,573	10%	11,957	9,135	2,823
Maribel Plasencia	Master of ed-marriage and family therapy/ AMFT	Clinician (Clinical Therapist)	Y	D	81,381	25146.602	106,527	25%	26,632	20,345	6,287
Melissa Rodriguez	MS- Social work/ ACSW	Clinician (Clinical Therapist)	Y	D	98,876	30552.75	129,429	25%	32,357	24,719	7,638
Anahi Vasquez Garcia	MS Social Work /ACSW	Clinician (Clinical Therapist)	Y	D	84,161	26005.609	110,166	25%	27,542	21,040	6,501
Arianna Fuentes	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	91,434	28252.983	119,687	25%	29,922	22,858	7,063
Melissa Montes Camacho	MA Counseling Psychology (Applied for AMFT/PC	Clinician (Clinical Therapist)	Y	D	100,036	30910.796	130,946	25%	32,736	25,009	7,728
Vanessa Inzunza	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	78,628	24296.048	102,924	6%	6,433	4,914	1,519
Elva A. Silva	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	76,189	23542.447	99,732	25%	24,933	19,047	5,886
Shanice Edwards	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	75,273	23259.363	98,532	25%	24,633	18,818	5,815
Vacant		Clinician (Clinical Therapist)	Y	D	75,815	23426.83	99,242	25%	24,810	18,954	5,856
Tracy Fradue	MS- counseling psychology/ AMFT	Clinician (Clinical Therapist)	Y	D	84,478	26103.703	110,582	25%	27,645	21,120	6,525
Vacant		Clinician (Clinical Therapist)	Y	D	88,578	27370.734	115,949	25%	28,987	22,145	6,842
Marjani Huezo	M.S- Social work/ACSW	Clinician (Clinical Therapist)	Y	D	83,331	25749.141	109,080	25%	27,270	20,833	6,437
Vacant 7 FTE	7 Positions/FTE	Clinician (Clinical Therapist)	Y	D	90,110	27844.046	117,954	350%	412,840	315,386	97,454
Ashley Simpson	BA- sociology	Mental Health Specialist	Y	D	63,341	19572.284	82,913	25%	20,728	15,835	4,893
Daisy Acosta	BA	Mental Health Specialist	Y	D	46,207	14278.025	60,485	25%	15,121	11,552	3,569
Sintia Chincoya	BA-psychology	Mental Health Specialist	Y	D	50,711	15669.589	66,380	19%	12,446	9,508	2,938
Vacants (3.38 FTE)	3.38 Positions/FTE	Mental Health Specialist	Y	D	47,821	14776.588	62,597	169%	105,633	80,697	24,936
Mutiple Staff (1.25 FTE)	1.25 Positions/FTE	Referral Coordinator	N	D	47,821	14776.588	62,597	63%	39,123	29,888	9,235
Mutiple Staff		Program Support (Tech Support, Quality)	N	D	94,940	29336.46	124,276	39%	48,942	37,389	11,553
Mutiple Staff	2.02 Positions/FTE	Program Support Team (Admin Associates, Fisc	N	D	51,169	15811.221	66,980	146%	97,850	74,752	23,098
Mutiple Staff		On Call Support	N	D	54,621	16877.827	71,499	2%	1,719	1,313	406
Dr Patel	MD	Psychiatrist	Y	C	53,708		53,708	0%	0	0	0
							0		0	0	0
							0		0	0	0
										1,038,990	321,044

TOTAL COST: 1,360,034

*Clinical Therapist are contracted employees that are part time but 65% their time is towards the MH services

Detail of Fringe Benefits: Employer FICA/Medicare, Workers Compensation, Unemployment, Vacation Pay, Sick Pay, Pension and Health Benefits

[1] **Input "D" to indicate a direct staffing position, "I" for an indirect staffing position, and "C" for Contract position**

Note, administrative and clerical staff are normally treated as indirect cost. For any administrative or clerical staff that are identified as direct, please ensure the required documentation is maintained to fill CFR 200.413 (c)(1) – (4)

[2] **Contracted positions need to be Clinical positions only. Any Non-clinical contracted position need to be included on the Operating Expense schedule only.**

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B

FY 2024-2025
April 1 to June 30, 2025

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Contractor Name: Victor Community Support Services
Provider # East Valley Region RU# 36FSE
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Operating Expenses - Please list all operating costs charged to this program, including administrative support costs and management fees along with a detail explanation of the categories below.

April 1 to June 30, 2025

	ITEM	TOTAL COST TO ORGANIZATION	% CHARGED TO OTHER FUNDING SOURCE	TOTAL COST TO OTHER FUNDING SOURCE	PERCENT CHARGED TO PROGRAM	TOTAL COST TO PROGRAM
1	Professional Fees	$27,651	75%	$20,739	25%	$6,913
2	Software Maintenance	$76,801	75%	$57,600	25%	$19,200
3	Employment Expenses	$29,113	75%	$21,835	25%	$7,278
4	Office Supplies	$42,914	75%	$32,185	25%	$10,728
5	Program Supplies	$10,215	75%	$7,661	25%	$2,554
6	Rent	$197,308	75%	$147,981	25%	$49,327
7	Utilities	$105,286	75%	$78,964	25%	$26,321
8	Building Maintenance	$41,211	75%	$30,908	25%	$10,303
9	Equipment Expense	$119,234	75%	$89,426	25%	$29,809
10	Transportaton	$129,234	75%	$96,926	25%	$32,309
11	General & Administrative Costs	$12,958	75%	$9,718	25%	$3,239
12	Conference & Meetings	$64,769	75%	$48,577	25%	$16,192
13	Taxes & Insurance	$13,795	75%	$10,347	25%	$3,449
14	Indirect Expenses	$717,800	75%	$538,350	25%	$179,450
15	Contractors	$214,833	75%	$161,125	25%	$53,708
16			100%	$0		$0
17			100%	$0		$0
SUBTOTAL B:		$1,803,121		$1,352,341		$450,780
GROSS COSTS TOTAL STAFFING AND OPERATING EXPENSES:						$1,810,814

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
BUDGET NARRATIVE
FY 2024-2025

Contractor Name: Victor Community Support Services
Provider #: East Valley Region RU# 36FSE
Contract/RFP#: 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Budget Narrative for Operating Expenses. Explain each expense by line item. Provide an explanation for determination of all figures (rate, duration, quantity, Benefits, FTE's, etc.) for example explain how overhead or indirect cost were calculated.

April 1 to June 30, 2025

ITEM	Justification of Cost
1 Professional Fees	Budgeted for any professional service needs associated with program operations, interpreter services, staff training materials, and guest speakers for trainings.
2 Software Maintenance	Budgeted for technical support services as well as annual software licenses and maintenance costs. Software maintenance includes costs associated with VCSS's EHR, as well as correcting, updating and enhancing other agency software.
3 Employment Expenses	Budgeted for costs associated with recruiting, advertising, completion of a 3rd party physical, drug testing, fingerprinting, clinical license renewals, and continuing education.
4 Office Supplies	Budgeted for costs associated with general office supplies, such as paper, pens, pencils, envelopes, folders, tape, printed brochures, checks, business cards, kitchen supplies, toner for copier, fax machine, paper for fax machine, copier and computer printers, postage and shipping costs, and subscription expense.
5 Program Supplies	Budgeted for costs associated with general program support supplies. Which may include bilingual materials, orientation and treatment packets, therapeutic supplies, toys and materials, group snack packs, and instructional supplies. This also includes curriculums and required assessment measures such as: PCIT, PSC-35, Trauma focused CBT, Solution Focused Brief Therapy materials, Seeking Safety, Love and Logic, Incredible Years, Nurturing Parenting, Why Try, NCTI Crossroads, and Real Colors Curriculum.
6 Rent	Budgeted for the rental cost of a leased building and depreciation costs related to leasehold improvements.
7 Utilities	Budgeted for costs associated with general utility costs, such as telephone, water, natural gas, electricity, cable, internet, and garbage service.
8 Building Maintenance	Budgeted for costs associated with janitorial, maintenance, building and ground supplies, licenses and permits.
9 Equipment Expense	Budgeted for costs associated with equipment maintenance, office equipment, furnishings, computer equipment, and equipment lease expenses such as postage and copier machines.
10 Transportation	Budgeted for costs associated with staff mileage reimbursements as well as agency vehicle operating, repair, maintenance, and licensing costs. This is budgeted to cover the cost of staff travel related to service delivery, training, and meetings. The mileage reimbursement rate is reviewed and set by management annually. The annual rate will not exceed the IRS mileage reimbursement rate.
11 General & Administrative Costs	Budgeted for all other operating expenses including bank fees, interest expense, dues and memberships.
12 Conference & Meetings	Budgeted for costs associated with meetings, staff events, and conferences, such as conference fees, airfare, food and lodging to attend conferences and trainings.
13 Taxes & Insurance	Budgeted for property taxes and insurance costs including liability, property and vehicle insurance.
14 Indirect Expenses	Budgeted for the indirect costs that supports VCSS administrative services which includes, but may not be limited to, the following: CEO, COO, CFO, Agency-wide Human Resource functions, Agency-wide Administrative and Executive support functions, Agency-wide Technology services, Agency-wide Fiscal and Accounting functions, along with the operating expenses associated with supporting these positions. This is calculated at an estimated rate of 12% of total direct costs. This estimated rate is trued-up to the Agency's actual indirect cost rate as part of our yearend closing procedure.
15 Contractors	Direct Costs associated with contractors providing direct service to clients. Includes: Psychiatrist (Dr Patel @$240 an hour not to exceed $214,833).
16	

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2024-2025
Service Projections (Mode 15)

Prior fiscal year Rates (Completed by DBH)				
Old County Contract (CCR) Rates	$2.20	$2.99	$5.56	$4.20
Productivity Expectation: 60%	CM Rate per Min.	MHS Rate/Min	MSS Rate/Min	Crisis Rate/Min
NOTE: If no estabalished agency per minute rates, please input the CCR rates in the highlighed cells				
Target Cost Per Unit of Service	$2.87	$7.04	$7.04	$4.88

Contractor Name:	Victor Community Support Services
Provider #	East Valley Region RU# 36FSE
Contract/RFP#	22-149
	Chico, CA 95973
Date Form Completed:	2/13/25
Date Form Revised:	

ALL YELLOW HIGHLIGHTED AREAS REQUIRE INPUT BY PROVIDER

MONTH	Estimated Units of Service (Minutes)	Planned Clinical FTE's	Projected Revenue Generated by Service Type: Case Management (01-06 & 08-09)	Intensive Care Coordination (07)	Mental Health Services (10-50)			Medication Support (60)	Crisis Intervention (70)	Clients Served: Admissions (Episodes Opened)	Discharges (Episodes Closed)	Monthly Census (Starting Census 74.992654)
Jul-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Aug-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Sep-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Oct-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Nov-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Dec-24		9.54	$0	$0	$0	$0	$0	$0	$0			75
Jan-25		9.54	$0	$0	$0	$0	$0	$0	$0			75
Feb-25		9.54	$0	$0	$0	$0	$0	$0	$0			75
Mar-25		9.54	$0	$0	$0	$0	$0	$0	$0			75
Apr-25	100,862	9.54	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	100
May-25	100,862	9.54	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	126
Jun-25	100,862	9.54	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	151
TOTAL	302,585		$71,565	$286,260	$1,430,226			$21,690	$1,074	196	120	
			Total Revenue					$1,810,814	Unduplicated Clients Served			271
								Estimated Cost Per Client:		$6,676		

SCHEDULE B

	15-Outpatient	15-Outpatient	15-Outpatient	15-Outpatient	
	Case Management	Mental Health Services	Medication Support Services	Crisis Intervention	TOTAL
Total Minutes of Services	96,126	203,157	3,081	220	**302,585**
Total Monthly Minutes of Services (Average)	8011	16930	257	18	**25215**
Dosage (minutes) per client per month	91	193	3	0	**288**
Dosage (hours) per client per month	1.52	3.22	0.05	0.00	**4.79**

Total Hours Per Unduplicated Client for Duration of the Program: 43.13

Avg Monthly Census	Expected Length of Program (months)
88	9

SCHEDULE B

Schedule B

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
STAFFING DETAIL
FY 2025-2026
July 1, 2025 to June 30, 2026 (12 months)

Contractor Name: Victor Community Support Se
Provider # East Valley Region RU# 36FSI
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Staffing Detail - Personnel (Includes Personal Services Contracts for Professional Services)

CONTRACTOR NAME: Victor Community Support Services

Name	Degree/ License	Position Title	If Staff Position is not Clinical FTE Providing SMHS change to "N"	D/I/C [1]	Full Time Annual Salary*	Full Time Fringe Benefits*	Total Full Time Salaries & Benefits*	% Cost Allocated Contract Services	Total Salaries and Benefits Charged to Contract Services	Total Salaries Charged to Contract Services	Total Benefits Charged to Contract Services
Diana Saunders	MS-counseling marriage & family/LMFT	Executive Director	N	D	134,127	41446.148	175,572	57%	100,289	76,615	23,674
Vacant		CQI Supervisor	N	D	102,362	31629.936	133,992	57%	76,536	58,471	18,067
Krystal Zielen	MS-psychology/LMFT	Clinical Supervisor (Clinic Supervisor)	N	D	93,653	28938.726	122,592	50%	61,296	46,826	14,469
Kamisha Ford	MS-marriage & family/LMFT	Clinical Supervisor (Clinic Supervisor)	N	D	103,504	31982.919	135,487	100%	135,487	103,504	31,983
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	97,495	30125.975	127,621	35%	44,667	34,123	10,544
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	107,372	33177.913	140,550	50%	70,275	53,686	16,589
Vacant		Clinical Supervisor (Clinic Supervisor)	N	D	114,559	35398.808	149,958	200%	299,916	229,119	70,797
Diana Zing-Sandoval	MA- clinical mental health counseling/ APCC	Clinician (Clinical Therapist)	Y	D	88,883	27464.71	116,347	100%	116,347	88,883	27,464
Alexandra Owusu	MA Social Work/ ACSW	Clinician (Clinical Therapist)	Y	D	77,208	23856.884	101,063	100%	101,063	77,206	23,857
Andrea Brito	MA Counseling Psychology /AMFT	Clinician (Clinical Therapist)	Y	D	86,491	26725.65	113,216	100%	113,216	86,491	26,725
Luisa Melendez	MS- counseling/ AMFT	Clinician (Clinical Therapist)	Y	D	91,347	28226.07	119,573	40%	47,829	36,539	11,290
Maribel Plasencia	Master of ed-marriage and family therapy/ AMFT	Clinician (Clinical Therapist)	Y	D	81,381	25146.602	106,527	100%	106,527	81,381	25,146
Melissa Rodriguez	MS- Social work/ ACSW	Clinician (Clinical Therapist)	Y	D	98,876	30562.75	129,429	100%	129,429	98,876	30,553
Anahi Vasquez Garcia	MS Social Work /ACSW	Clinician (Clinical Therapist)	Y	D	84,161	26005.609	110,166	100%	110,166	84,161	26,006
Arianna Fuentes	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	91,434	28252.963	119,687	100%	119,687	91,434	28,253
Melissa Montes Camacho	MA Counseling Psychology (Applied for AMFT/PCC registration	Clinician (Clinical Therapist)	Y	D	100,035	30910.798	130,946	100%	130,946	100,035	30,911
Vanessa Inzunza	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	78,628	24296.046	102,924	25%	25,731	19,657	6,074
Elva A. Silva	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	76,189	23542.447	99,732	100%	99,732	76,189	23,542
Sharice Edwards	MS Social Work/ACSW	Clinician (Clinical Therapist)	Y	D	75,273	23259.353	98,532	100%	98,532	75,273	23,259
Vacant		Clinician (Clinical Therapist)	Y	D	75,815	23426.83	99,242	100%	99,242	75,815	23,427
Tracy Fradiue	MS- counseling psychology/ AMFT	Clinician (Clinical Therapist)	Y	D	84,478	26103.703	110,582	100%	110,582	84,478	26,104
Vacant		Clinician (Clinical Therapist)	Y	D	88,578	27370.734	115,949	100%	115,949	88,578	27,371
Mariani Hueso	M.S- Social work/ACSW	Clinician (Clinical Therapist)	Y	D	83,331	25749.141	109,080	100%	109,080	83,331	25,749
Vacant 7 FTE	7 Positions/FTE	Clinician (Clinical Therapist)	Y	D	90,110	27844.046	117,954	1400%	1,651,359	1,261,543	389,817
Ashley Sampson	BA- sociology	Mental Health Specialist	Y	D	63,341	19572.264	82,913	100%	82,913	63,341	19,572
Daisy Acosta	BA	Mental Health Specialist	Y	D	46,207	14278.025	60,485	100%	60,485	46,207	14,278
Sintia Chincoya	BA-psychology	Mental Health Specialist	Y	D	50,711	15669.529	66,380	75%	49,785	38,033	11,752
Vacants (3.38 FTE)	3.38 Positions/FTE	Mental Health Specialist	Y	D	47,821	14776.589	62,597	675%	422,532	322,790	99,742
Mutiple Staff (1.25 FTE)	1.25 Positions/FTE	Referral Coordinator	N	D	47,821	14776.589	62,597	250%	156,493	119,552	36,941
Mutiple Staff		Program Support (Tech Support, Quality)	N	D	94,940	29336.46	124,276	158%	195,767	149,555	46,212
Mutiple Staff	2.92 Positions/FTE	Program Support Team (Admin Associates, Fisc	N	D	51,169	15811.221	66,980	584%	391,400	299,007	92,393
Mutiple Staff		On Call Support	N	D	54,621	16877.927	71,499	10%	6,875	5,252	1,623
Dr Patel	MD	Psychiatrist	Y	C	214,833		214,833	0%	0	0	0
							0		0	0	0
							0		0	0	0
										4,155,951	1,284,184

TOTAL COST: 5,440,135

*Clinical Therapist are contracted employees that are part time but 65% their time is towards the MH services

Detail of Fringe Benefits: Employer FICA/Medicare, Workers Compensation,
Unemployment, Vacation Pay, Sick Pay, Pension and Health Benefits

[1] Input "D" to indicate a direct staffing position, "I" for an indirect staffing position, and "C" for Contract position

Note, administrative and clerical staff are normally treated as indirect cost. For any administrative or clerical staff that are identified as direct, please ensure the required documentation is maintained to fill CFR 200.413 (c)(1) – (4)

[2] Contracted positions need to be Clinical positions only. Any Non-clinical contracted position need to be included on the Operating Expense schedule only.

SCHEDULE B

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B

FY 2025-2026
July 1, 2025 to June 30, 2026

Contractor Name: Victor Community Support Services
Provider # East Valley Region RU# 36FSE
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Operating Expenses - Please list all operating costs charged to this program, including administrative support costs and management fees along with a detail explanation of the categories below.

July 1, 2025 to June 30, 2026

	ITEM	TOTAL COST TO ORGANIZATION	% CHARGED TO OTHER FUNDING SOURCE	TOTAL COST TO OTHER FUNDING SOURCE	PERCENT CHARGED TO PROGRAM	TOTAL COST TO PROGRAM
1	Professional Fees	$27,651	0%	$0	100%	$27,651
2	Software Maintenance	$76,801	0%	$0	100%	$76,801
3	Employment Expenses	$29,113	0%	$0	100%	$29,113
4	Office Supplies	$42,914	0%	$0	100%	$42,914
5	Program Supplies	$10,215	0%	$0	100%	$10,215
6	Rent	$197,308	0%	$0	100%	$197,308
7	Utilities	$105,286	0%	$0	100%	$105,286
8	Building Maintenance	$41,211	0%	$0	100%	$41,211
9	Equipment Expense	$119,234	0%	$0	100%	$119,234
10	Transportaton	$129,234	0%	$0	100%	$129,234
11	General & Administrative Costs	$12,958	0%	$0	100%	$12,958
12	Conference & Meetings	$64,769	0%	$0	100%	$64,769
13	Taxes & Insurance	$13,795	0%	$0	100%	$13,795
14	Indirect Expenses	$717,800	0%	$0	100%	$717,800
15	Contractors	$214,833	0%	$0	100%	$214,833
16			100%	$0		$0
17			100%	$0		$0
SUBTOTAL B:		$1,803,121		$0		$1,803,121
GROSS COSTS TOTAL STAFFING AND OPERATING EXPENSES:						$7,243,256

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
BUDGET NARRATIVE
FY 2025-2026

Contractor Name: Victor Community Support Services
Provider # East Valley Region RU# 36FSE
Contract/RFP# 22-149
Address: 1360 East Lassen Ave
Chico, CA 95973
Date Form Completed: 2/13/25

Prepared by: Matt Jafari
Title: Senior Financial Analyst

Budget Narrative for Operating Expenses. Explain each expense by line item. Provide an explanation for determination of all figures (rate, duration, quantity, Benefits, FTE's, etc.) for example explain how overhead or indirect cost were calculated.

July 1, 2025 to June 30, 2026

ITEM	Justification of Cost
1 Professional Fees	Budgeted for any professional service needs associated with program operations, interpreter services, staff training materials, and guest speakers for trainings.
2 Software Maintenance	Budgeted for technical support services as well as annual software licenses and maintenance costs. Software maintenance includes costs associated with VCSS's EHR, as well as correcting, updating and enhancing other agency software.
3 Employment Expenses	Budgeted for costs associated with recruiting, advertising, completion of a 3rd party physical, drug testing, fingerprinting, clinical license renewals, and continuing education.
4 Office Supplies	Budgeted for costs associated with general office supplies, such as paper, pens, pencils, envelopes, folders, tape, printed brochures, checks, business cards, kitchen supplies, toner for copier, fax machine, paper for fax machine, copier and computer printers, postage and shipping costs, and subscription expense.
5 Program Supplies	Budgeted for costs associated with general program support supplies. Which may include bilingual materials, orientation and treatment packets, therapeutic supplies, toys and materials, group snack packs, and instructional supplies. This also includes curriculums and required assessment measures such as: PCIT, PSC-35, Trauma focused CBT, Solution Focused Brief Therapy materials, Seeking Safety, Love and Logic, Incredible Years, Nurturing Parenting, Why Try, NCTI Crossroads, and Real Colors Curriculum.
6 Rent	Budgeted for the rental cost of a leased building and depreciation costs related to leasehold improvements.
7 Utilities	Budgeted for costs associated with general utility costs, such as telephone, water, natural gas, electricity, cable, internet, and garbage service.
8 Building Maintenance	Budgeted for costs associated with janitorial, maintenance, building and ground supplies, licenses and permits.
9 Equipment Expense	Budgeted for costs associated with equipment maintenance, office equipment, furnishings, computer equipment, and equipment lease expenses such as postage and copier machines.
10 Transportaton	Budgeted for costs associated with staff mileage reimbursements as well as agency vehicle operating, repair, maintenance, and licensing costs. This is budgeted to cover the cost of staff travel related to service delivery, training, and meetings. The mileage reimbursement rate is reviewed and set by management annually. The annual rate will not exceed the IRS mileage reimbursement rate.
11 General & Administrative Costs	Budgeted for all other operating expenses including bank fees, interest expense, dues and memberships.
12 Conference & Meetings	Budgeted for costs associated with meetings, staff events, and conferences, such as conference fees, airfare, food and lodging to attend conferences and trainings.
13 Taxes & Insurance	Budgeted for property taxes and insurance costs including liability, property and vehicle insurance.
14 Indirect Expenses	Budgeted for the indirect costs that supports VCSS administrative services which includes, but may not be limited to, the following: CEO, COO, CFO, Agency-wide Human Resource functions, Agency-wide Administrative and Executive support functions, Agency-wide Technology services, Agency-wide Fiscal and Accounting functions, along with the operating expenses associated with supporting these positions. This is calculated at an estimated rate of 12% of total direct costs. This estimated rate is trued-up to the Agency's actual indirect cost rate as part of our yearend closing procedure.
15 Contractors	Direct Costs associated with contractors providing direct service to clients. Includes: Psychiatrist (Dr Patel @$240 an hour not to exceed $214,633).
16	

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCHEDULE B
FY 2025-2026
Service Projections (Mode 15)

Prior fiscal year Rates (Completed by DBH)				
Old County Contract (CCR) Rates	$2.20	$2.99	$5.56	$4.20
Productivity Expectation: 60%	CM Rate per Min.	MHS Rate/Min	MSS Rate/Min	Crisis Rate/Min
Target Cost Per Unit of Service	$2.87	$7.04	$7.04	$4.88

NOTE: If no estabalished agency per minute rates, please input the CCR rates in the highlighed cells

Contractor Name:	Victor Community Support Services
Provider #	East Valley Region RU# 36FSE
Contract/RFP#	22-149
	Chico, CA 95973
Date Form Completed:	2/13/25
Date Form Revised:	

ALL YELLOW HIGHLIGHTED AREAS REQUIRE INPUT BY PROVIDER

MONTH	Estimated Units of Service (Minutes)	Planned Clinical FTE's	Projected Revenue Generated by Service Type: Case Management (01-06 & 08-09)	Intensive Care Coordination (07)	Mental Health Services (10-50)			Medication Support (60)	Crisis Intervention (70)	Clients Served — Starting Census: Admissions (Episodes Opened)	Discharges (Episodes Closed)	300 — Monthly Census
Jul-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	325
Aug-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	351
Sep-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	376
Oct-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	402
Nov-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	427
Dec-24	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	453
Jan-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	478
Feb-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	503
Mar-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	529
Apr-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	554
May-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	580
Jun-25	100,862	38.15	$23,855	$95,420	$476,742	$0	$0	$7,230	$358	65	40	605
TOTAL	1,210,339		$286,259	$1,145,041	$5,720,904			$86,758	$4,294	785	480	
			Total Revenue					$7,243,256	Unduplicated Clients Served			1,085
								Estimated Cost Per Client:		$6,676		

SCHEDULE B

	15-Outpatient	15-Outpatient	15-Outpatient	15-Outpatient	
	Case Management	Mental Health Services	Medication Support Services	Crisis Intervention	TOTAL
Total Minutes of Services	384,505	812,629	12,324	880	**1,210,339**
Total Monthly Minutes of Services (Average)	32042	67719	1027	73	**100862**
Dosage (minutes) per client per month	69	146	2	0	**217**
Dosage (hours) per client per month	1.15	2.43	0.04	0.00	**3.61**

Total Hours Per Unduplicated Client for Duration of the Program: 32.52

Avg Monthly Census	Expected Length of Program (months)
465	9

ADDENDUM I

Description of Program Services
STUDENT ASSISTANCE PROGRAM

Victor Community Support Services, Inc.
1360 East Lassen Avenue
Chico, CA 95973
530-893-0758

I. DEFINITION OF RECOVERY, WELLNESS, AND RESILIENCE AND REHABILITATIVE MENTAL HEALTH SERVICES

A. Mental Health Recovery, Wellness, and Resilience (RWR) is an approach to helping the individual to live a healthy, satisfying, and hopeful life despite limitations and/or continuing effects caused by his or her mental illness according to his or her own values and cultural framework. RWR focuses on client strengths, skills and possibilities, rather than on illness, deficits, and limitations, in order to encourage hope (in staff and clients) and progress toward the life the client desires. RWR involves collaboration with and encouragement of clients and their families, support systems and involved others to take control of major life decisions and client care; it encourages involvement or re-involvement of clients in family, social, and community roles that are consistent with their values, culture, and predominate language; it facilitates hope and empowerment with the goal of counteracting internal and external "stigma"; it improves self-esteem; it encourages client self-management of his/her life and the making of his/her own choices and decisions, it re-integrates the client back into his/her community as a contributing member; and it achieves a satisfying and fulfilling life for the individual. It is believed that all clients can recover, even if that recovery is not complete. This may at times involve risks as clients move to new levels of functioning. The individual is ultimately responsible for his or her own recovery choices.

For children, the goal of the RWR philosophy of care is to help children (hereinafter used to refer to both children and adolescents) to recover from mistreatment and trauma, to learn more adaptive methods of coping with environmental demands and with their own emotions, and to joyfully discover their potential and their place in the world. RWR focuses on a child's strengths, skills, and possibilities rather than on illness, deficits and limitations. RWR encourages children to take increasing responsibility for their choices and their behavior, since these choices can lead either in the direction of recovery and growth or in the direction of stagnation and unhappiness. RWR encourages children to assume and to regain family, social, and community roles in which they can learn and grow toward maturity and that are consistent with their values and culture. RWR promotes acceptance by parents and other caregivers and by the community of all children, regardless of developmental level, illness, or handicap, and it addresses issues of stigma and prejudice that are related to this. This may involve interacting with the community group's or cultural group's way of viewing mental and emotional problems and differences.

B. "Rehabilitation" is a strength-based approach to skills development that focuses on maximizing an individual's functioning. Services will support the individual, family, support

system, and/or involved others in accomplishing the desired results. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities.

C. Accordingly, program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community in which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. Programs may be designed to use both licensed and non-licensed personnel who are experienced in providing behavioral health services.

II. PROGRAM DEFINITIONS

All of the requirements and definitions noted **RFP DBH 22-149 Request for Proposals for Comprehensive Treatment Services: Student Assistance Program (SAP)** are incorporated into this Addendum by reference.

III. STUDENT ASSISTANCE PROGRAM (SAP) MISSION AND GOALS

A. Overivew

SAP focuses services to diverse students (grades (K-12) and their families who are at risk for school failure due to substance abuse, juvenile justice involvement, mental health, emotional and social issues. SAP connects behavioral health, educators, programs and services to create a network of support between schools and community based organizations supporting students and their families. The SAP program is intended to minimize barriers to learning, and support students in developing academic and personal successes and shortens the duration of untreated mental illness.

Additionally, SAP will implement the National Curriculum and Training Institute (NCTI) Crossroads® Education Program which is a curriculum-based education strategy delivered according to unique methods that foster positive, pro-social behavior in children and youth with emphasis on prior offenders. NCTI Crossroads® is targeted for children ages 10-15 and transitional age youth ages 16-25 with emphasis on those who are at risk of or involved in the juvenile justice system.

NCTI employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process. The curriculum focuses on the relationship between values, attitudes, and behaviors as they relate to the decision making process. Class topics include: anger management, life skills, parent education, substance abuse prevention, gang involvement, truancy intervention, and graffiti prevention. Parenting classes are offered to the families of the children and youth participating in the program. Implementation of the NCTI Crossroads Education® program requires staff be trained and certified for the delivery of the curricula.

All Student Assistance Program contract agencies are required to provide services under Title 9, Chapter 11, Section 1810.249, which superseded the rehabilitation option and targeted

case management guidelines of July 1, 1993, and more recent guidelines as may be incorporated or referenced herein by attachment.

B. Program Objectives

1. The overarching goal of SAP services is to strengthen student health and wellness by working to reduce risk factors, barriers and/or stressors; build protective factors and supports; and provide appropriate strategies, activities, and interventions. Schools and Community Based Organizations (CBOs) wishing to participate in the Student Assistance Program will coordinate with DBH for coordination of services. DBH will approve school sites with CBOs, based on capacity and geographic regions. Community Based organizations will provide prevention and early intervention services including relapse prevention to school-aged children, youth, transition age youth and their families. Services are to be provided at schools and after school programs with culturally and linguistically appropriate practices for the target population and area served. Services should be offered at times and at locations easily accessible to the children and their family members, taking into consideration the needs of families. Such activities are intended to address the PEI key community mental health needs, which are:

   a. Disparity in access to mental health services
   b. Psycho-social impact of trauma
   c. At-risk children and youth populations
   d. Stigma & discrimination
   e. Suicide risk

2. Contractor is required to utilize a variety of strategies to meet the SAP objectives, including the following:

   a. Improved educator knowledge in identifying early signs, symptoms, and risk factors, contributing to substance abuse, mental illness and co-occurring disorders and making appropriate referrals
   b. Increased access to PEI services for students at risk of school failure, in stressed families, exposed to trauma, at risk of or experiencing juvenile justice involvement, or experiencing early onset of serious mental illness
   c. Improved school/community bonding, resilience promotion, and access to PEI services for underserved populations
   d. Improved ability to provide PEI services to families of children and youth experiencing behavior problems, grief or loss, and/or in need of referral for evaluation (as related to a possible mental health condition)
   e. Improved school success factors, such as decreased absences, tardiness and disciplinary referrals.

IV. PERSONS TO BE SERVED (TARGET POPULATION)

Contract providers will work collaboratively with the schools to ensure delivery of prevention and early intervention services during each school year. **Contract providers serve various proportions of the**

required total of unduplicated clients, depending on the proposed area(s) and agency capacity, which will be determined and assigned by the Program Manager, designee.

A. The target population to be served includes children and youth (grades K-12) and their families, that have been exposed to trauma, are experiencing the first onset of serious psychiatric illness, are in stressed families, are at risk for school failure and/or at risk of, or are experiencing, juvenile justice involvement. These services are not intended for students qualified for or receiving special education services for behavioral health concerns. Priority target schools and school districts are those with:

  1. High number of children and youth from underserved ethnic/cultural groups
  2. High poverty
  3. Low academic achievement
  4. High rates of suspension, expulsion and drop out
  5. High number of children/youth in foster care
  6. High number of children/youth at risk of experiencing juvenile justice involvement
  7. High rates of violence in the community

B. Prevention and Early Intervention services will be offered to children, youth and transitional age youth, and their families, when appropriate, in the following PEI Priority populations:

  1. Trauma exposed individuals
  2. Individuals experiencing onset of serious psychiatric illness
  3. Children and youth in stressed families
  4. Children and youth at risk for school failure
  5. Children and youth at risk of or experiencing juvenile justice involvement.

C. It is further expected that the participant population will be reflective of the social, economic and ethnic characteristics of the communities served by the Contractor.

V. DESCRIPTION OF SPECIFIC SERVICES TO BE PROVIDED

SAP is a school-based approach to providing focused services to students needing interventions for substance abuse, mental health, academic, emotional, and/or social issues. It is a process that connects education, programs, and services within and across school and community systems to create a network of supports to help students. As a process, SAPs identify troubled students, assess students' needs, and provide support and referral to appropriate resources. Activities within SAP fall into the State Prevention Program reporting category. SAP activities will also include Early Intervention services along with the implementation of the State Strategies pursuant to the PEI Regulations effective October 6, 2015.

SAP services are an essential part of the continuum of care, as they provide interventions and preventative services, working closely with schools to address a variety of student issues. An essential aspect of SAP is close collaboration with other programs and provision of appropriate services.

SAP focuses services to diverse students (grades (K-12) and their families who are at risk for school failure due to substance abuse, juvenile justice involvement, mental health, emotional and social

issues. SAP connects behavioral health, educators, programs and services to create a network of support between schools and community based organizations supporting students and their families. The SAP program is intended to minimize barriers to learning, and support students in developing academic and personal successes and shortens the duration of untreated mental illness.

Additionally, SAP will implement the National Curriculum and Training Institute (NCTI) Crossroads® Education Program which is a curriculum-based education strategy delivered according to unique methods that foster positive, pro-social behavior in children and youth with emphasis on prior offenders. NCTI Crossroads® is targeted for children ages 10-15 and transitional age youth ages 16-25 with emphasis on those who are at risk of or involved in the juvenile justice system.

NCTI employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process. The curriculum focuses on the relationship between values, attitudes, and behaviors as they relate to the decision making process. Class topics include: anger management, life skills, parent education, substance abuse prevention, gang involvement, truancy intervention, and graffiti prevention. Parenting classes are offered to the families of the children and youth participating in the program. Implementation of the NCTI Crossroads Education® program requires staff be trained and certified for the delivery of the curricula.

All Student Assistance Program contract agencies are required to provide services under Title 9, Chapter 11, Section 1810.249, which superseded the rehabilitation option and targeted case management guidelines of July 1, 1993, and more recent guidelines as may be incorporated or referenced herein by attachment

A. The number of estimated participants to be served is based on a prescribed formula *as follows*: 20% of services will be allocated to mental health promotion and education to the general population, 70% of services will be allocated for individuals at a higher than average risk of developing a mental health condition and will consist of education/intervention and 10% of services will be allocated for students requiring early intervention treatment services. Providers will limit their mental health promotion and education services to 20%. All Providers are required to refer and link individuals with serious mental illness to the appropriate level of services.

B. Providers will work with San Bernardino County Superintendent of Schools and Local Education Area (LEAs) to provide prevention and early intervention services to children and youth (grades K-12) and their families. Required services include identification and referral of students requiring individual and/or small group counseling, education, parent participation, and/or short-term treatment for those first experiencing the onset of a mental health condition. SAP activities, services, and strategies are not intended for students who have been previously diagnosed with a mental health condition and services are not intended for students whose needs have been identified and should be met as part of an Individual Education Plan.

C. Overall Requirements

   1. Contract providers are required to work collaboratively with the school(s) to identify, collect, maintain data and statistical information on PEI activities and services to ensure outcomes can be measured and evaluated.

   2. A Contract provider is required to provide data reports to DBH on a monthly basis and a

qualitative narrative report on a quarterly basis.

3. Contract provider shall provide cognitive behavioral change curriculum classes utilizing the National Curriculum and Training Institute® (NCTI®) Crossroads curriculum and Real Colors® Personality Instrument.
4. NCTI® Crossroads Curriculum and Real Colors® Personality Instruments are designed to meet different learning styles in a highly interactive group setting. As such, curricula must be delivered according to unique methods that foster positive, pro-social behavior
5. Each class will consist of its own workbook, covering up to six weeks of curriculum relating to each individual topic. The workbooks cover different topics within a combination of the following subjects that include but are not limited to:
   a. Anger Management
   b. Cognitive Life Skills
   c. Curfew
   d. Drugs and Alcohol
   e. Gang involvement
   f. Shoplifting
   g. Truancy
6. NCTI® Crossroads Education classes are to be held at locations that are easily accessible to children/youth, TAY and their families such as school sites, provider offices or alternative sites in the community such as schools, clinics, Transitional Aged Youth (TAY) centers, community centers, and anywhere children/youth/TAY live and congregate.
7. The Contract provider should also offer the parenting component. Parenting sessions include:
   a. Session 1 – Introductions, Agreements, and Objectives
   b. Session 2 – Developing Values
   c. Session 3 – Getting to Know Your Children / Communication / What Motivates a Child?
   d. Session 4 – Family Rules / How Do You Discipline?
   e. Session 5 – Keys to Success / Stress Test
   f. Session 6 – Coping with Stress / Positive Self-Image / Goals
8. Classes are designed to be delivered over a three-week period; twice a week for two 1-2 hours for each session, for a total of six sessions or one a week for a 1-2 hours each for each session, for a total of six weeks. This format has demonstrated the best results for retention of students. Written permission to deviate from this structure is required by NCTI®. Written permission (via email is acceptable) to deviate from this structure is required from NCTI® and shall be submitted to the DBH Office of PEI when obtained.
9. Classes shall be delivered in groups ranging in size from 4-15 individuals per facilitator.
10. Classes are to be available outside of traditional school hours to ensure all individuals of

a community may attend.

11. All available NCTI® curriculums are available for use and the subject matters may be viewed at www.ncti.org.
12. The DBH Office of PEI will provide Real Colors® Instruments and curricula to Contract providers at no additional cost until the limited numbers of printing licenses are exhausted. When there are no longer any available licenses, the contract provider will be responsible for the costs associated with delivering NCTI® services.
13. Contract providers providing this service will be responsible for ensuring staff receive training through NCTI®.
14. Only NCTI® certified staff may teach NCTI® Crossroads curriculum and Real Colors®.
15. To ensure certified staff deliver NCTI® Crossroads curriculum with fidelity, the Contract provider shall be responsible for using the assessment tools provided by NCTI®.
16. Contract provider shall utilize the pre- and post-tests developed by NCTI®.
17. Contract provider shall either enter the pre- and post-tests electronically into the NCTI® database or they shall send the hard copies of pre- and post-tests to NCTI® to be entered by NCTI® staff.
18. Contract provider shall contact NCTI® to receive training on how to appropriately and effectively use the pre- and post-tests.
19. Sign-in sheets are to be utilized and retained for each class session and are to include, but are not limited to: date, class topic, instructor's name, class location, and student's name, signature, age, gender, and race/ethnicity. Each class session requires a new sign-in sheet (ex: Anger Management is six total class sessions, facilitator will have six sign-in sheets.)
20. Pre- and Post- test results and analysis are included in various stakeholder reports.
21. Pre- and Post-test result goal is to have at least an 80% completion rate.
22. Pre- and Post-tests are to be evaluated to ensure an appropriate number of individuals are being served per facilitator, the pre- and post-tests are being utilized and entered into the NCTI® database appropriately
23. Encourage parental and family participation as appropriate.
24. Provide appropriate short-term (usually less than eighteen months) therapeutic interventions intended to measurably improve a behavioral health problem or concern early in its manifestation. Early intervention services may be provided up to four (4) years if the individual is experiencing their first onset of a mental illness or emotional disturbance with psychotic features. These activities shall be provided, whenever appropriate, through the provision of EPSDT Medi-Cal Specialty Mental Health Services (SMHS).
25. Provide individual and small group counseling and/or education and parent participation. These activities shall be provided, whenever appropriate, through the provision of EPSDT Medi-Cal Specialty Mental Health Services (SMHS).
26. Provide support and education that increases protective factors at the school and/or in

the community via individual and small group counseling and a science-based program.

27. Provide culturally and linguistically competent services; at minimum, services must be offered in English *and* Spanish.
28. Provide support and follow-up for students and their families regarding, but not limited to:
    a. Alcohol and Drug Education and Interventions
    b. Anger Management
    c. Caregiver Support
    d. Case Management
    e. Childcare during Parent Component, if appropriate
    f. Curriculum Based Psychosocial Education (science or evidence based)
    g. Dating and Relationship Violence
    h. Multidisciplinary Assessments
    i. Relapse Prevention
    j. Social Skills Groups
    k. Substance Abuse/Misuse Education and Services
    l. Support Groups
    m. Teen Pregnancy
    n. Screening and Assessment
    o. Short-term Treatment for individuals first experiencing the onset of a mental illness.
    p. Maintain sign-in sheets that include, but are not limited to race, ethnicity, age and gender.
    q. Maintain DBH approved service activity sheets that provide an overview of the prevention service provided
    r. Input Prevention Service Information and data into a system identified by DBH no later than ten (10) days from the end of the service month.
    s. Input Early Intervention Services into the County transactional billing system (currently is called InSyst SIMON) no later than ten (10) days from the end of the service month. (The contractor will be responsible for purchasing the initial InSyst software required to operate SIMON; DBH will provide the access required to submit data.)

D. Mental health services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements of learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the individual's goals/desired results/personal milestones, and minimum guidelines for the provision of coordinated services under the rehabilitation and targeted case management options are set forth below. Not all the activities need to be

provided for a service to be billable. Mental health services will primarily be captured as EPSDT Medi-Cal Specialty Mental Health Services (SMHS): Contractor will provide EPSDT Medi-Cal SMHS to San Bernardino County school-aged children and youth who (i.e., up to 21 years of age) who are experiencing significant distress due to a mental health condition and meet medical necessity criteria. Additionally services listed below will be provided to children and youth who do not meet medical necessity criteria as funding permits. Specific EPSDT Medi-Cal SMHS shall include:

1) Assessment: A service activity designed to evaluate the current status of a child's/youth's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

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

3) Intensive Care Coordination: ICC is similar to the activities provided through Targeted Case Management (TCM). ICC must be delivered using a Child and Family Team (CFT) to develop and guide the planning and services delivery process. ICC may be utilized by more than one mental health provider; however, there must an identified mental health ICC coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the child/youth's needs and strengths in the context of the values and philosophy of the CPM.

   Activities coded as ICC may include interventions such as:

   a. Facilitation of the development and maintenance of a constructive and collaborative relationship among child/youth, his/her family or caregiver(s), other providers, and other involved child-serving systems to create a CFT.

   b. Facilitation of a care planning and monitoring process which ensures that the plan is aligned and coordinated across the mental health and child serving systems to allow the child/youth to be served in his/her community in the least restrictive setting possible.

   c. Ensuring services are provided that equip the parent/caregiver(s) to meet the child/youth's mental health treatment and care coordination needs, described in the child/youth's plan.

   d. Ensuring that medically necessary mental health services included in the child/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is

consistent with the full intent of the CPM.

e. Providing active participation in the CFT planning and monitoring process to assure that the plan addresses or is refined to meet the mental health needs of the child/youth.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members.

4) Plan Development: A service activity that consists of developing and approving client plans, and monitoring and recording an individual's progress.

5) Rehabilitation: A service activity that includes, but is not limited to, assistance in improving, maintaining, or restoring a child/youth or group of children/youth functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education. This service includes:

a. Assistance in restoring or maintaining an individual's functional skills, social skills, medication compliance, and support resources

b. Age-appropriate counseling of the individual and/or family, support systems and involved others

c. Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones

d. Medication education for family and other support systems

6) Targeted Case Management: Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. Targeted Case Management may be either face-to-face or by telephone with the child/youth or significant support persons and may be provided anywhere in the community.

7) Therapy: A service activity that is a therapeutic intervention, focusing primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to a child/youth or a group of children/youth, and may include family therapy.

E. Provider Adequacy

Contractor shall submit to DBH documentation verifying it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards developed by DHCS. Documentation shall be submitted no less frequently than the following:

1. At the time it enters into this Contract with the County;

2. On an annual basis; and

3. At any time there has been a significant change, as defined by DBH, in the Contractor's operations that would affect the adequacy capacity of services, including the following:

   a. A decrease of twenty-five percent (25%) or more in services or providers available to beneficiaries;

   b. Changes in benefits;

   c. Changes in geographic service area; and

   d. Details regarding the change and Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

F. DBH is emphasizing EPSDT mental health services to the unserved and underserved children Overall Service Requirements

1. Contractor will have primary responsibility to provide the full range of mental health services to children/youth that live within the Contractor's service area(s), including crisis and emergency services.

2. Accept referrals directly from DBH and other child serving agencies

3. Maintain a system/protocol to address crisis and emergency situation, 24 hours a day – seven days a week, to meet the needs of the child/youth/family.

4. Develop, coordinate and provide formal therapeutic treatment services based on assessments and treatment recommendations.

5. Develop a system to screen and prioritize clients awaiting treatment and those in treatment, to ensure availability of service to the most severely ill.

6. Provide services in a culturally competent manner by recruiting, hiring, training and maintaining staff that provide culturally appropriate services to diverse populations.

7. Maintain a clear audit trail between school-aged treatment services and the provision of other specialty mental health services.

8. Establish a plan to deal with a crisis involving the client, family members and treatment team.

9. Ensure there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.

10. Maintain ongoing communication with the DBH Program Manager and make all policies and procedures (administrative and service-related) available to the Program Manager on a regular basis.

11. Contractor's Director or designee must attend regional meetings as scheduled.

12. Contractor must make pamphlets available, identifying the clinic and its services in threshold languages (English and Spanish) for distribution to the community.

13. Contractor's Director or designee must attend regional meetings as scheduled.

G. Coordination of Care

Contractor shall deliver care to and coordinate services for all of its beneficiaries by doing the following [42 C.F.R. § 438.208(b)]:

1. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity [42 C.F.R. § 438.208(b)(1)].
2. Coordinate the services Contractor furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services Contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries [(42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, title 9 § 1810.415.]

H. Administrative Requirements

1. Identify and refer students requiring early intervention services or system of care services through activities and special programs directed at individuals exhibiting early signs of a mental health condition and other problem behaviors associated with mental illness.
2. Provide appropriate interventions intended to measurably improve a behavioral health problem or concern early in its manifestation. Please see items 6. and 9. below with list of specific mental health services which shall be provided.
3. Provide support and education that increases protective factors at the school and/or in the community via individual and small group counseling and a science-based program.
4. Provide culturally and linguistically competent services; at minimum, services must be offered in English *and* Spanish.
5. Encourage parental and family participation as appropriate.
6. Provide support and follow-up for students and their families regarding, but not limited to:
    1) Alcohol and Drug Prevention
    2) Anger management classes
    3) Case management
    4) Childcare during parent component, if appropriate
    5) Psychosocial education curriculum (i.e., science or research based curriculum)
    6) Dating education and relationship violence prevention
    7) Individual and small group counseling
    8) Multidisciplinary assessments
    9) Social skills groups
    10) Substance abuse/misuse education and services

11) Support groups
12) Teen pregnancy prevention
13) Screening and assessment
14) Short-term treatment for those first experiencing mental illness, including rehabilitation services

7. Contract providers will work collaboratively with the schools to ensure delivery of a universal prevention education to an estimated 85 schools each school year.
8. Evidence-based, community-based, and/or promising practices standards must be used for PEI services.

I. Oversight/Engagement Requirements

1. Implement and/or enhance a SAP collaboratively with the schools and community provider to:
   a. Identify and minimize barriers to learning
   b. Identify students stressed, at-risk, or displaying signs of high-risk substance use and/or mental health risks
   c. Support students in developing academic and personal success through the asset development process
2. Provide appropriate interventions at school(s) or through referrals
3. Provide mental health promotion at participating school sites to identify and engage underserved, unserved or inappropriately served children and transitional age youth in need of prevention and early intervention services. This includes reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.
4. Complete Work Plan and submit to DBH on an annual basis no later than May 30th. The Work Plan will consist of all planned activities such as collaborative efforts, mental health promotion, group activities, individual counseling, etc. The Work Plan should detail how the agency will implement the PEI Program effectively and will include how outcomes will be measured and evaluated. The Work Plan effective period is July 1 – June 30 of each fiscal year.
5. Complete quarterly and annual program reports in a format provided by DBH. The quarterly and annual reports are provided in a narrative format and summarize the activities, services, and outcomes of the PEI participants. Reports shall include attached copies of outcomes and evaluation results (ex: survey results, pre/post-tests, and assessment results). The annual report shall include a summary of the entire fiscal year's outcomes and evaluation.
6. Ensure delivery of services to students is based on approved effective methods which are evidence-based practices, promising practices, or community-based practices at targeted school sites, being certain to implement the program model and not compromise the fidelity and validity of the program in culturally and linguistically appropriate manner. (See http://www.nrepp.samhsa.gov for curricula examples.)

7. Evidence, science based or research based curriculum and/or promising practices must be used for prevention services. Examples of possible curriculums include but are not limited to:
   a. S.S. Grin
   b. Strengthening Families
   c. Guiding Good Choices
   d. Project ALERT
   e. Jellybean Jamboree
   f. Building Resiliency
   g. Creative Small Groups
   h. Choosing Not to Use
   i. Girl Empowerment
   j. Owning Up
   k. Grieving Sharing & Healing
   l. Children's Program KIT from SAMSHA
   m. Peace Builders
   n. Too Good for Drugs
   o. Parent Project
   p. Why Try
   q. Personal Power for Young Men
   r. Personal Power for Young Women
   s. Cognitive Life Skills in Behavioral Therapy
   t. Second Step
8. Build capacity in conjunction with LEA(s), by ensuring employees attend training and technical assistance classes and the annual The Wellness Conference
9. Participate in evaluation activities related to implementation and outcomes of the SAP.
10. Community based organizations will work collaboratively with the schools to ensure the SAP program as a whole delivers prevention activities to an estimated 19,490 students and 774 parents (e.g., support groups) countywide each school year. Additionally, an estimated 841 students will receive early intervention services including activities and special programs directed toward individuals who are exhibiting early signs of a behavioral health condition and other problem behaviors associated with mental illness.

J. Access and Linkage to Treatment Strategy within a Program

1. Access and Linkage to Treatment- as defined by the PEI Regulations effective October 6, 2015, means connecting children, transitional age youth, adults, and older adults with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care

and treatment, including but not limited to care provided by county mental health programs. Examples of Access and Linkage to Treatment Programs include but are not limited to, focus on mental health screening, assessment, referral, telephone help lines, and mobile response.

K. Non-Stigmatizing and Non-Discriminatory Strategy within a Program

1. Contractors shall promote, design, and implement Programs in ways that reduce and circumvent stigma, included self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

2. Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

L. Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations Strategy within a Program

1. Increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

2. Services shall be provided in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.

M. Evaluation/Plan Development

Early Intervention Program Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four (4) years.

1. For purpose of this section, "serious mental illness or emotional disturbance with psychotic features" means, schizophrenia spectrum and other psychotic disorders including schizophrenia, other psychotic disorders, disorders with psychotic features, and schizotypal (personality) disorder). These disorders include abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking

(speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

2. Early Intervention Program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

3. Prevention Program Services are a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

    a. "Risk factors for mental illness" means conditions or experiences that are associated with a greater than average risk of developing a potentially serious mental illness. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.

4. Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, traumatic loss (e.g. complicated, multiple, prolonged, severe), having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.

    a. Prevention Program services may include relapse prevention for individuals in recovery from a serious mental illness.

    b. Prevention Programs may include universal prevention if there is evidence to suggest that the universal prevention is an effective method for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average.

VI. BILLING UNIT

A. Reimbursement to Contractor shall be made monthly in arrears based on the actual cost of direct (face to face) services and/or activities provided during the service month, however not to exceed 1/12th of the maximum annual contract obligation for each fiscal year. Failure to meet performance requirements can result in a reduction or denial of payment.

B. EPSDT Medi-Cal Reimbursement:

The billing unit for mental health services is staff time, based on minutes of time.

The exact number of minutes used by staff providing a reimbursable service shall be reported and billed. In no case shall more than sixty units of time be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the units of time reported or claimed for any one staff member exceed the hours worked.

When a staff member provides service to or on behalf of more than one individual at the same time, the staff member's time must be pro-rated to each individual. When more than one staff person provides a service, the time utilized by involved staff members shall be added together to yield the total billable time. The total time claimed shall not exceed the actual staff time utilized for billable service.

The time required for documentation and travel shall be linked to the delivery of the reimbursable service and shall not be separately billed.

Plan development is reimbursable. Units of time may be billed when there is no unit of service (e.g., time spent in plan development activities may be billed regardless of whether there is a face-to-face or phone contact with the individual or significant other).

C. Reimbursement for services provided shall occur on a monthly basis for approved expenses incurred and claimed by Contractor. No later than ten (10) calendar days following the month of service, the Contractor shall submit a claim for payment for the reporting month, in a format acceptable by DBH. The monthly claim must be sent to:

Department of Behavioral Health
Fiscal Department-PEI
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026

VII. FACILITY LOCATION

Contractor's facility(ies) where SAP services are to be provided is/are located at:

Locations are subject to prior approval by DBH. Medi-Cal certification is required prior to the reimbursement of EPSDT Specialty Mental Health Services and no mental health services provided prior to the Medi-Cal Certification Date shall be reimbursed.

School Districts:

- ***That will be reviewed and approved by DBH Program Manager, or designee***

A. The Contractor shall obtain the prior written consent of the Director of DBH or the designee before terminating SAP services at the above location(s) or providing services at another office location.

B. The Contractor shall comply with all requirements of the State and obtain necessary fire clearances.

C. The Contractor shall provide adequate furnishings and supplies to operate a SAP based on requirements described herein.

D. The Contractor shall maintain the facility exterior and interior appearances in a safe, clean, and attractive manner.

E. The Contractor shall have adequate fire extinguishers and smoke alarms, as well as a fire safety plan.

F. The Contractor shall have an exterior sign clearly indicating the location, name of facility and hours of operation.

G. The Contractor shall have program pamphlets identifying the facility and its services, both in English and Spanish, for distribution in the community. All materials that are distributed to the public shall be approved by DBH prior to distribution.

H. Contractor shall have hours of operation posted at the facility and visible to consumers/customers that match the hours listed in the Contract. Contractor is responsible for notifying DBH of any changes in hours or availability. Notice of change in hours must be provided in writing to the DBH Access Unit at fax number 909-890-0353, as well as the DBH program contact overseeing the Contract.

VIII. STAFFING

All staff shall be employed by, or contracted for, by the Contractor. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations requirements. All clinical treatment staff providing services with DBH funding shall be licensed or waived by viable internship by the State.

A. Contract must meet school requirements for all staff members are met including, but not limited to:

1. **Background checks and Criminal Record Reviews any other required clearances, etc.-.**
2. **Department of Justice (DOJ) Clearance/Live Scan**
3. **Health and Safety** -The Contractor shall comply with all applicable local health and safety clearances, including fire clearances, for each site where program services are provided under the terms of the Contract.
4. **Professional Development and Staff Training Requirements**
5. **Tuberculosis (TB) Testing**

B. Ensure staff attend the five (5) day SAP training program offered by San Bernardino County Superintendent of Schools, as appropriate.

C. Ensure staff attend County provided orientation and/or training, including cultural competency training, to assure equal access and opportunity for services, and to improve service delivery.

D. All treatment staff shall work within their scope of practice as defined by DBH or their license type; psychotherapists must be licensed or waivered by the State. Treatment professionals should be primarily comprised of professionals trained in working with children/youth with mental health needs.

E. Personnel shall possess appropriate licenses and certificates, and be qualified in accordance with applicable statutes and regulations. Contractor will obtain, maintain and comply with all necessary government authorizations, permits and licenses required to conduct operations. In addition, the Contractor will comply with applicable Federal, State and local laws, rules, regulations and orders in its operations, including compliance with all applicable safety and health requirements concerning Contractors' employees.

F. Staff Training Plan – Contractor shall provide training for staff on an ongoing basis, including cultural competency training that addresses service delivery to diverse children and their

families as required in the Performance Article. A staff roster must be kept current and must be provided to DBH Program Manager or designee. Additionally, all copies of licenses and waivers will be provided to DBH Program Manager or designee on a regular basis.

G. Staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment and/or transition.

H. Contract provider shall comply with all applicable local health and safety clearances, including fire clearances, for each site where program services are provided.

I. Contract provider staff to attend SAP training and the annual The Wellness Conference as appropriate, as well as training requirements articulated in the Cultural Competency Plan.

J. Contract provider staff should have an appropriate background and training for working with the target population of children/youthand families.

K. Staffing should be comprised of personnel with the appropriate background and education to establish effective SAP programs in the proposed LEAs. Staff must also be culturally proficient to deliver services in a manner most appropriate to the target population. A SAP team should include, at minimum, the following positions, or equivalent to the following:

1. **Alcohol and Drug Counselor (registered or certified)** who plans and implements educational counseling for program participants, facilitates individual and group counseling & educational sessions.

2. **Clinic Supervisor** who will support all service strategies in the project. The clinic supervisor will also serve as a liaison to the collaborative with agencies working with target populations.

3. **Clinical Therapist** who is licensed, registered, or waivered by the State, as a clinical professional [Licensed Psychologist (LP), Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW) or Marriage and Family Therapist (MFT)]. This position will screen participants to determine appropriate activities, assist participants and families in understanding the nature and risk factors of behavioral disorders, assess participants for diagnosis, and develop early intervention treatment plans. Please note, early intervention (therapeutic) services should be conducted by registered pre-licensed/licensed staff. Therapists providing services described herein shall be licensed, registered or waivered by the State, according to DBH's policy.

4. **Prevention Specialist/Interventionist** who assists in the implementation of approved SAP strategies, including leading activities, trainings and supportive educational groups; develops and maintains school and community networks and educational programs; collaborates with school site staff and other agencies as needed; and performs other related duties as required.

5. **Program Manager/Coordinator** that organizes and monitors program activities, oversees the integrity of the SAP program, facilitates communication between school(s) and provider, ensures community stakeholder satisfaction and participates in capacity building and multi-agency collaborative activities.

6. **Social Worker II** who provides case management, develops and monitors prevention and/or early intervention plans, facilitates individual and group educational sessions, maintains case documentation and provides participants with linkages and referrals for services as needed.

7. **Support Staff** would provide administrative support as needed. Responsibilities may include collection, data entry, management of data, completing forms and/or reports, scheduling of meetings and trainings, and providing general administrative support, as appropriate, for the PEI SAP program. An appropriate amount of support staff will be required to complete the duties above as well as help support the evaluation and reporting requirements of the PEI SAP program.

L. **Additional Role Required of Staff** Contractor is responsible for ensuring all staff are provided sufficient support to maximize their utilization of various data systems. Currently, this includes utilization of Objective Arts, the CANS-SB tracking and reporting system and SIMON, the local billing system. Expectation is that Contractor will have a sufficient number of staff fully trained in these systems and functioning as subject matter experts so that they are able to support other staff as needed. This responsibility may be assigned to any appropriate staff in any position, but the Contractor must clarify how this requirement will be met and maintained for the duration of the contract

IX. STAFF CULTURAL COMPETENCY REQUIREMENTS

The State Department of Health Care Services (DHCS) mandates counties to develop and implement a Cultural Competency Plan for residents of San Bernardino County. Policies and procedures and array of services must be culturally and linguistically appropriate. Contractor will be included in the implementation process and shall adhere to cultural competency requirements.

A. Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations.

1. The Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health and substance use disorder services.

2. The DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing medically necessary specialty behavioral health and substance abuse services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost-effective

behavioral health and substance abuse services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

B. To assist the contractor's effort towards cultural and linguistic competency, the DBH shall provide the following:

1. Technical assistance to the Contractor regarding cultural competency implementation.
2. Demographic information to the Contractor on service area for services planning.
3. Cultural competency training for DBH and Contractor personnel per contract.
4. Interpreter training for DBH and Contractor personnel.
5. Technical assistance for the proposer in translating Behavioral Health and substance abuse services information to DBH's threshold language (Spanish)

C. Spanish has been identified as a threshold language for this county by the Department of Health Care Services. Staffing should adequately accommodate the Latino population in the region being serviced. The ratio of English speaking staff to Spanish speaking staff will be driven by the ethnicity levels in the region being served. The Contractor will be required to provide services in a culturally competent manner by recruiting, hiring and maintaining staff that can provide services to the diverse population. They must provide services in the appropriate language, in a culturally sensitive manner, and in a setting accessible to diverse communities. (Diversity in a community context includes features that bind a group of people together but set the group apart from other groups; these features include but are not limited to, ethnicity, age, sexual orientation, gender, race, culture, and physical challenges.) The Contractor will continue to develop and implement policies relating to cultural diversity and equity as provided by the County. The Contractor shall document efforts to provide services in a culturally competent manner. Documentation may include, but is not limited to:

1. Records in personnel files attesting to efforts made in recruitment and hiring practices;
2. Participation in County sponsored and other cultural competency training;
3. Availability of literature in multiple languages and formats as appropriate; and
4. Identification of measures taken to enhance accessibility for, and sensitivity to, physically challenged communities.

D. The Contractor shall utilize appropriate language translation and interpretation (with prior written approval from the County) as needed for services provided to children and families. In addition to language skills, a qualified interpreter must have the ability to accurately translate terms associated with mental health and cultural beliefs and practices; however, he/she need not be trained in mental health services. The Contractor will have materials translated into Spanish and any other languages identified by the County as necessary.

X. ADMINISTRATIVE AND OUTCOMES/EVALUATION REQUIREMENTS

A. The main facility will be available a minimum of forty (40) hours per week by appointment. The Contractor shall be available 24 hours per day through a recording/answering system.

B. The Contractor to state their hours of operations at the school site and outside traditional school hours.

C. Contractor shall have written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

D. The main clinic office will be available a minimum of forty (40) hours per week by appointment. Services will primarily be field-based in the natural settings of the child and parent and access will be available 24 hours per day through answering system and paging system.

E. Contractors are required to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the hours of operation must be comparable to the hours made available for Medi-Cal services that are not covered by Contractor or another Mental Health Plan (i.e., must be available during the times that services are accessible by consumers based on program requirements).

F. Contractor shall abide by the criteria and procedures set forth in the Uniform Method of Determining Ability to Pay (UMDAP) manual consistent with State regulations for mental health programs. The Contractor shall not charge mental health clients in excess of what UMDAP allows.

G. Contractor shall maintain client records in compliance with all regulations set forth by the State and provide access to clinical records by DBH staff.

H. Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and record keeping requirements. The Contractor will participate in on-going contract related Medi-Cal audits by the State. A copy of the plan of correction regarding deficiencies will be forwarded to DBH.

I. Contractor shall maintain high standards of quality of care for the units of service which it has committed to provide.

Contractor's staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment.

Contractor has the primary responsibility to provide the full range of mental health services, as specified within this addendum, to clients referred to Contractor.

The Contractor shall develop a system to screen and prioritize clients awaiting treatment and those in treatment to target the availability of service to the most severely ill clients. Contractor and the applicable DBH Program Manager or designee will have ongoing collaboration to assist Contractor in identifying the target population(s) as defined in this Addendum. Contractor will participate as needed in weekly staffing of children's cases to assist in identifying the target population.

Summary copies of internal peer review conducted must be forwarded to DBH upon request.

J. The Contractor shall participate in DBH's annual evaluation of the program and shall make required changes in areas of deficiency.

K. The Contractors are required to work collaboratively with the school(s) to identify, collect, maintain data and statistical information on PEI activities and services to ensure outcomes can be measured and evaluated

L. The Contractor shall ensure that there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.

M. The Contractor shall maintain a separate and clear audit trail reflecting expenditure of funds under this Agreement.

N. The Contractor shall make available to the DBH Regional Program Manager copies of all administrative policies and procedures utilized and developed for service location(s) and shall maintain ongoing communication with the Program Manager regarding those policies and procedures.

O. The program shall submit additional reports as required by DBH.

P. The Contractor's Director or designee must attend regional meetings as scheduled.

Q. Vacancies or changes in staffing plan shall be submitted to the appropriate DBH Program Manager within 48 hours of Contractor's knowledge of such occurrence. Such notice shall include a plan of action to address the vacancy or a justification for the staffing plan change.

R. The Contractor understands that compliance with all standards listed is required by the State and the County of San Bernardino. Failure to comply with any of the above requirements or special provisions below may result in reimbursement checks being withheld until the Contractor is in full compliance.

S. Contractor shall work collaboratively with LEAs to identify, collect, and maintain data and statistical information to ensure outcomes can be measured and evaluated. Expected outcomes are consistent with those described in the PEI component regulations.

T. The Contractor will strive to meet the following goals, objectives and outcomes;

Goal	Key Outcomes
Improve timely access to services for underserved populations	• Increase extent to which individual or family from underserved population who need MH services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable
Reduce prolonged suffering associated with untreated mental illness	• <u>Prevention</u> Reduce risk factors Reduce indicators Increase protective factors that may lead to improved mental, emotional, and relational functioning

	• Early Intervention Reduce Symptoms Improve Recovery, including mental emotional and relational functioning
Reduce stigma and discrimination associated with mental illness (Non-Stigmatizing/Non-Discriminatory)	• Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services. • Increase acceptance, dignity, inclusion and equity for individuals with mental illness and members of families.
Increase early access and linkage to medically necessary care and treatment	• Connect children, adults and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

U. The Contractor agrees to utilize approved data collection tools to collect, analyze, report, and distribute individual and family level outcomes. All data must be provided to DBH in an approved format.

V. The Contractor agrees to use the PEI Data Collection System, SIMON, or any other data tracking system developed by DBH to track data collection.

W. The Contractor agrees to submit participant data via the PEI Data Collection system, or any other data tracking system developed by DBH, by the 10th of each month.

X. The Contractor agrees to submit monthly reports containing relevant data (statistical and anecdotal) with their monthly invoices for payment. The invoices and supporting data are due to DBH no later than ten (10) days following the last day of the month of service.

Y. Quarterly Reports

1. The Contractor agrees to submit a qualitative report quarterly approved by DBH, outlining progress made toward the overall project goals and specific objectives, problems encountered in achieving objectives, methods employed to resolve stated problems and any program modifications that occurred as a result of program evaluation. Sign-in sheets will be required to document trainings and services rendered, as appropriate. Sign-in sheets to contain race/ethnicity, age and gender data as appropriate.

2. The Contractor agrees to attach and include, within the quarterly report, outcomes data such as survey results, pre/post-test, and assessment results used to evaluate the program each quarter.

3. The quarterly report shall be due to PEI program staff no later than thirty (30) days following the end of the quarter.

4. The quarterly reports shall be due on the following dates:
   - October 30th for period July 1st – September 30th,
   - January 30th for period October 1st – December 31st,
   - April 30th for period January 1st – March 30th, and
   - July 30th for period April 1st – June 30th

Z. Annual Report

The Contractor agrees to submit a written annual report covering services implemented, progress made toward goals, and summarizing outcome measures identified in evaluation tools in a format designed and approved by DBH.

1. Annual Reports are due by July 30thof each year.
2. Annual Reports will include summary data and analysis of the entire fiscal year (July1-June 30) on key outcomes using required assessment tools

AA. The Contractor agrees to meet with LEAs and DBH on a regular basis to measure effectiveness of the SAP program and take corrective measures when necessary.

BB. The Contractor agrees, in collaboration with LEAs, to evaluate and provide DBH with:

1. Pre/post "behavior" status as reported by teacher, parent and/or student in a format approved by DBH
2. Pre/post of development assets in a format approved by DBH
3. Change in participant school attendance in a format approved by DBH
4. Change in participant suspensions and referrals in a format approved by DBH
5. Utilize assessment tools and evaluation methods (such as the PEI Participant Survey Tool) as directed by DBH for all clients.

CC. Report outputs including, but not limited to:

1. Types of services provided and where services occurred
2. Demographics of service population
3. Number of individuals served
4. Number of sessions attended
5. Program completion rate
6. Changes in behavior, knowledge, and/or skills as determined by DBH
7. Any other data the County considers relevant, including but not limited to collection of data pursuant to the PEI Regulations effective 10/06/2015 and any subsequent amendments to said Regulations.

DD. PEI Regulations, Section 3560.020 requires the County to submit a three-year Program and Evaluation Report. The goal of the Evaluation Report is to answer questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

1. SAP Providers shall provide information on the outcomes and indicators selected as well as the approaches used to select the outcomes and indicators, and collection of data. SAP Providers shall also provide to DBH how often data was collected for the evaluation of the program.

EE. The County shall select, define, and measure appropriate indicators that are applicable to the Prevention Program. SAP Providers will provide consumer data which reports the reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning.

FF. For each Prevention Program and each Early Intervention Program list:

1. The Program name.
2. Unduplicated numbers of individuals served in the preceding fiscal year
    a. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
    b. If a Program served families the County shall report the number of individual family members served.

GG. For Access and Linkage to Treatment as a Strategy within a Program the County shall track:

1. Number of referrals for treatment, and kind of treatment to which person was referred
2. Number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred
3. Duration of untreated mental illness
    a. The time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment, defined as participating at least once in treatment to which the person was referred
    b. The interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred

HH. For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:

1. The program name
2. Identify the specific underserved populations for whom the County intended to increase timely access to services.

3. Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.

4. Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.

5. Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.

6. Description of ways the County encouraged access to services and follow-through on referrals

XI. COUNTY DEPARTMENT OF BEHAVIORAL HEALTH RESPONSIBILITIES

A. DBH shall provide technical assistance to the Contractor in regard to SAP requirements.

B. DBH shall participate in evaluating the progress of the overall program in regard to responding to the prevention and early intervention mental health needs of local communities.

C. DBH shall monitor the Contractor on a regular basis in regard to compliance with all requirements and ensure program is being implemented with fidelity and according to program description.

D. DBH shall provide technical assistance to Contractor in regard to Short-Doyle/EPSDT Medi-Cal requirements, as well as charting and Utilization Review requirements.

E. DBH shall provide linkages with the total Mental Health system to assist Contractor in meeting the needs of its clients.

XII. SPECIAL PROVISIONS

A. It is preferred that SAP services for family members are offered during non-traditional school hours and days. This will ensure/increase the possibility of parent/caregiver participation.

B. Contractor must start providing assessment and treatment services as soon as possible, but no later than one hundred twenty (120) days from the contract start date.

C. Contractor must obtain Medi-Cal certification in order to bill EPSDT Medi-Cal for services provided to Medi-Cal eligible children/youth. If Contractor is not Medi-Cal certified at the time that the contract is awarded, Contractor must submit Medi-Cal certification paperwork to the DBH Program Manager within thirty (30) days of the start date of the contract. Not obtaining Medi-Cal certification within one hundred twenty (120) days from the contract start date may result in contract termination.

D. Contractor(s) must be available to initiate services with new clients during all twelve (12) months of the fiscal year; waiting lists are <u>not</u> permitted. (This requirement takes effect immediately after Contractor is Medi-Cal certified to provide services within the 120 day requirement during beginning of contract term.) Notification to DBH that a Contractor is unable to initiate any more services during a fiscal year will result in monthly contract management meetings for the remainder of the fiscal year and the following fiscal year, until DBH Program

Manager is satisfied that fiscal resources are being allocated in such a way that the Contractor is able to initiate services to new clients during any of the remaining months of the applicable fiscal year.

E. County will only reimburse Contractor for services provided to out-of-county Medi-Cal beneficiaries if applicable through the Senate Bill (SB) 785 Out of County Placements process and/or the Assembly Bill (AB) 1299 Presumptive Transfer process. Both AB 1299 and SB785 procedures need to be followed by Contractor in order for reimbursement to occur. These procedures require contact with the DBH Access Unit prior to the onset of services being delivered.

F. A review of productivity of the Contractor shall be conducted after the end of each quarter of each fiscal year.

G. The Contractor and DBH will work jointly to monitor outcome measures.

H. Satisfaction Surveys will be provided to participants (including parents), if applicable, upon completion/termination of SAP services.

I. The Contractor and DBH will participate in evaluating the progress of the overall program in regard to responding to the mental health needs of local communities (i.e. Annual Program Review, quarterly site reviews, audits, etc.).

J. The Contractor must comply with California Vehicle Restraint Laws which states:

1. Children under two (2) years of age shall ride in a rear-facing care seat unless the child weights forty (40) or more pounds OR is forty (40) or more inches tall. The child shall be secured in a manner that complies with the height and weight limits specified by the manufacturer of the care seat.
2. Children under the age of eight (8) must be secured in a car seat or booster seat in the back seat.
3. Children who are eight (8) years of age OR have reached four feet and nine inches (4'9") in height must be secured by a safety belt.
4. Passengers who are sixteen (16) years of age and over are subject to California's Mandatory Seat Belt law.

XIII. OUTCOME MEASURES AND DATA REPORTING REQUIREMENTS

A. Outcomes/Evaluation – Process Measures

1. Median number of business days between the initial contact or referral and first attempted contact of family is two days or less.
2. Median number of calendar days between first contact and first service provision is 14 days or less.
3. Median number of days between first assessment appointment and provision of first treatment plan driven service is 30 days (1 month) or less.

B. Data Reporting Elements

a. Data Reporting Elements including when data is due, how it should be submitted, and

any other specifics

(1) Data is gathered through the billing systems, which will be completed by the seventh (7th) day of the month following the billing for the previous month's Medi-Cal based services.

(2) Exception is the "opening" and "closing" of clients within the County's current billing and transactional database system. This will be done within five (5) working days of admission and discharge from the facility.

(3) Data shall be entered, either directly or through batch upload processes, into Objective Arts at least every two weeks. This shall minimally include the CANS-SB and PSC-35 data.

(4) Maintain sign-in sheets that include, but are not limited to race, ethnicity, age and gender.

(5) Input prevention service information and data into a system identified by DBH no later than thirty (30) days from the date of service.

b. Child, Adolescent Needs and Strengths Assessment – San Bernardino: CANS-SB shall be completed:

a. Within thirty (30) days of admission,

b. Every six (6) months, and

c. Within thirty (30) days of discharge.

d. Clarifications:

1) A CANS-SB is not required at admission if the client does not meet the criteria for services **AND** there is deemed insufficient information to complete the CANS-SB accurately.

2) In no case shall a period of more than six (6) months pass without completing a CAN-SB.

3) A CANS-SB is not required at discharge if an Update CANS-SB was administered within the past thirty (30) days **AND** no significant change in the client's presentation has occurred.

c. Pediatric Symptom Checklist – 35: PSC-35 (parent/caregiver version) shall be requested/obtained from parent/guardians:

(1) For children and youth from three (3) years of age to eighteen (18) years of age receiving early intervention services,

(2) At the onset of services,

(3) Every six (6) months, and

(4) Upon discharge from services

d. Program Goals

a. Provide services appropriate to needs based on functioning and cultural background.

b. Provide effective services that are continually reviewed and revised as needed.

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

c. Increase early access and linkage to medically necessary care and treatment
d. Improve timely access to services (PEI, Early Intervention [IE], and System of Care [SOC]) for underserved populations
e. Promote, design, and implement Programs in ways that reduce and circumvent stigma
f. Reduce prolonged suffering associated with untreated mental illness

e. Key Outcomes:

a. Key Outcome related to service appropriateness:

1) Services match the individual consumer's needs and strengths in accordance with system-of-care values and scientifically derived standards of care.

b. Key Outcomes related to service effectiveness:

(a) Improved functioning
(b) Reduction in symptom distress.
(c) Improvement in work or school performance.

c. Key Outcomes related to increasing early access and linkage to medically necessary care and treatment:

1) Connect children, adults and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs

d. Key Outcomes related to improving timely access to services (PEI, EI, and SOC) for underserved populations:

1) Increase extent to which individual or family from underserved population who need MH services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable

e. Key Outcomes related to reduce prolonged suffering associated with untreated mental illness:

1) Prevention:

i. Reduce risk factors
ii. Reduce indicators
iii. Increase protective factors that may lead to improved mental, emotional, and relational functioning
iv. Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and record keeping requirements. The Contractor will participate in ongoing Medi-Cal audits by the State DHCS. A copy of the plans of correction regarding deficiencies must be forwarded to DBH.

f. Provide the DBH Research and Evaluation Section (R&E) with important outcome information throughout the term of any contract awarded. R&E will notify the Contractor(s) when its participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, client and staff interviews, chart reviews, and other methods of obtaining the information needed.

g. Participate and cooperate with DBH bi-annual and/or annual site reviews; such reviews may require follow-up and action/correction plans.

h. Collect, analyze, and report on evaluation elements and their outcomes as defined by DBH.

   (1) A Contract provider, in collaboration with the schools, will be required to provide DBH with:

      i. Pre/post of behavior as status as reported by teacher, parent and/or student in a format approved by DBH.

      ii. Pre/post development assets.

      iii. Change in participant's school attendance.

      iv. Change in participant's suspensions and referrals.

      v. Assessment tools for all participants (such as PEI Participant Survey), as directed by DBH.

   (2) A Contract provider is required to report outputs to DBH including but not limited to:

      i. Types of services provided

      ii. Demographics

      iii. Numbers served in each mode of service

      iv. Number of sessions attended

      v. Completion rate

i. Perform testing/evaluation services in accordance with the frequency required by the testing instrument(s). This will, at minimum, include the Child, Adolescent, Needs and Strengths: Comprehensive Multisystem Assessment (CANS) – San Bernardino (SB) and the Pediatric Symptom Checklist – 35 (PSC-35).

j. Contractor(s) will have access to CANS-SB trainings and documentation.

k. Submit monthly reports containing relevant data (statistical and anecdotal) with their monthly invoices for payment. The invoices and supporting data are due to DBH no later than thirty (30) days following the last day of the month of service. (Training for reporting will be provided by DBH upon contract award.)

l. Provide data reports to DBH on a monthly basis and a qualitative narrative report on a quarterly and annual basis, covering services implemented, in a format designed and approved by DBH Program Manager.

m. Meet with LEAs and DBH on a regular basis to measure effectiveness of the SAP

program and take corrective measures when necessary.

n. In collaboration with LEAs, evaluate and provide DBH with:

   a. Pre/post "behavior" status as reported by teacher, parent and/or student in a format approved by DBH

   b. Pre/post of 22 of the 40 development assets in a format approved by DBH

   c. Change in participant school attendance in a format approved by DBH

   d. Change in participant suspensions and referrals in a format approved by DBH

   e. Assessment tools for all participants, as directed by DBH

o. Report outputs including, but not limited to:

   a. Types of services provided and where services occurred

   b. Demographics of service population

   c. Number of individuals served

   d. Number of sessions attended

   e. Program completion rate

   Changes in behavior, knowledge, and/or skills as determined by DBH

ADDENDUM II

Description of Program Services
School-Aged Treatment Services (SATS)
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Medi-Cal Speciality Mental Helath Services

Victor Community Support Services, Inc.
1360 East Lassen Avenue
Chico, CA 95973
530-893-0758

I. DEFINITION OF RECOVERY, WELLNESS, AND RESILIENCE

A. Mental Health Recovery, Wellness, and Resilience (RWR) is an approach to helping the individual to live a healthy, satisfying, and hopeful life despite limitations and/or continuing effects caused by his or her mental illness according to his or her own values and cultural framework. RWR focuses on client strengths, skills and possibilities, rather than on illness, deficits, and limitations, in order to encourage hope (in staff and clients) and progress toward the life the client desires. RWR involves collaboration with and encouragement of clients and their families, support systems and involved others to take control of major life decisions and client care; it encourages involvement or re-involvement of clients in family, social, and community roles that are consistent with their values, culture, and predominate language; it facilitates hope and empowerment with the goal of counteracting internal and external "stigma"; it improves self-esteem; it encourages client self-management of his/her life and the making of his/her own choices and decisions, it re-integrates the client back into his/her community as a contributing member; and it achieves a satisfying and fulfilling life for the individual. It is believed that all clients can recover, even if that recovery is not complete. This may at times involve risks as clients move to new levels of functioning. The individual is ultimately responsible for his or her own recovery choices.

For children, the goal of the RWR philosophy of care is to help children (hereinafter used to refer to both children and adolescents) to recover from mistreatment and trauma, to learn more adaptive methods of coping with environmental demands and with their own emotions, and to joyfully discover their potential and their place in the world. RWR focuses on a child's strengths, skills, and possibilities rather than on illness, deficits and limitations. RWR encourages children to take increasing responsibility for their choices and their behavior, since these choices can lead either in the direction of recovery and growth or in the direction of stagnation and unhappiness. RWR encourages children to assume and to regain family, social, and community roles in which they can learn and grow toward maturity and that are consistent with their values and culture. RWR promotes acceptance by parents and other caregivers and by the community of all children, regardless of developmental level, illness, or handicap, and it addresses issues of stigma and prejudice that are related to this. This may involve interacting with the community group's or cultural group's way of viewing mental and emotional problems and differences.

B. "Rehabilitation" is a strength-based approach to skills development that focuses on maximizing an individual's functioning. Services will support the individual, family, support system, and/or involved others in accomplishing the desired results. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities.

C. Accordingly, program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community in which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. Programs may be designed to use both licensed and non-licensed personnel who are experienced in providing behavioral health services.

D. Accordingly, the Contractor shall develop admission policies and procedures regarding those persons who are eligible for EPSDT Medi-Cal services. Non-EPSDT eligible children and youth in need of treatment should be screened and referred to an appropriate behavioral health service provider or be treated under separate funding streams. DBH cannot reimburse Contractor for services provided to out-of-county Medi-Cal beneficiaries with Medi-Cal funds; however, it is the responsibility of the Contractor to monitor the availability of these funds

E. All outpatient contract agencies are required to provide services under Title 9, Chapter 11, Section 1810.249, which superseded the rehabilitation option and targeted case management guidelines of July 1, 1993, and more recent guidelines as may be incorporated or referenced herein by attachment. Minimum guidelines are detailed in "DESCRIPTION OF SPECIFIC SERVICES TO BE PROVIDED" of this Addendum.

II. DEFINITIONS

All of the requirements and definitions included **RFP DBH 22-149 Request for Proposals for Comprehensive Treatment Services: School-Aged Treatment Services (SATS**) are incorporated into this Addendum by reference.

1. Access and Linkage to Treatment Program or Strategy – A set of related activities to connect children, TAY, adults, and older adults with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to care provided by county mental health programs.
2. Accessibility – Ease of obtaining services, measured by addressing geographical, travel and other barriers.
3. Best Practice Principles – Underlying principles inherent in a "family centered model" that includes:
    - The provision of community-based services and supports.
    - Focusing on the family setting by partnering with families.
    - A dyadic approach to treatment with the parent and child.

• Consumer-driven services that ensure access, voice, and choice for parents and children in the design, delivery, and evaluation of services.

• Drawing attention to family and child strengths in developing individualized Child and Family Service Plans.

• Providing individualized services and support to the unique needs of each child and family.

• Flexibility in location, time, planning, service response, and funding.

• Establishing community-wide collaboration in service design and system evolution, including parents, mental health, juvenile justice, education, social welfare, and cultural stakeholders in the community.

• Measurable accountability and outcome-driven individualized service plans.

• The provision of culturally relevant/competent services by tailoring responses to family culture, values, norms, strengths, and preferences. The Contractor will provide DBH with fiscal year reports (Frequency and form to be provided by DBH on "Consumer Focus Groups" to improve accessibility to specialty mental health services by identifying and removing barriers to treatment.)

4. California Advancing and Innovating Medi-Cal (CalAIM) – A California Department of Health Care Services (DHCS) initiative to implement a broad range Medi-Cal Program service delivery and payment reforms. https://www.dhcs.ca.gov/pages/BH-CalAIM-webpage.aspx
5. Centralized Children's Intensive Case Management Services (CCICMS) –DBH unit that provides contract monitoring and assistance to specialty children's programs and contractors.
6. Child, Adolescent, Needs and Strengths: Comprehensive Multisystem Assessment – San Bernardino (CANS-SB) – A multi-purpose tool developed in collaboration with John Lyons, Ph.D. and is based upon the CANS-Comprehensive Multisystem Assessment, which allows for communication and assessment of a child's functioning in a broad array of categories, support decision making, improve level of care and service planning, facilitate quality improvement initiatives, and allow for the monitoring of outcomes of services. CANS-SB is a slight modification of the CANS-Comprehensive Multisystem Assessment. Contractors are required to utilize the CANS-SB and participate in ongoing review of implementation and data analysis.
7. Child-centered – A value of the Model of Care that demands all decisions are made in the best interest of the child.
8. Children/Youth – A term used to describe consumers 0-15 years old as defined by the Mental Health Services Act (MHSA). For this proposal, Children/Youth is defined as consumers 0-18.
9. Children and Family Services (CFS) – The San Bernardino County department that provides family-centered programs and services designed to ensure safe, permanent, nurturing families for San Bernardino County's children while strengthening and attempting to preserve the family unit. CFS assists in preventing further harm to, and protecting children from, intentional physical or mental injury, sexual abuse, exploitation, or neglect by a person

responsible for a child's health or welfare. CFS provides support for families and strives towards goals of reducing risks to children, improving parenting skills, and strengthening social support networks for families.

10. Child and Family Team (CFT) – A group that forms to meet the needs of an eligible child through whatever means possible. In order to ensure family voice, choice, and ownership of the Individualized Service Plan, every effort shall be made to ensure family members and family representatives constitute a minimum of fifty percent of the Child & Family Team. The team is comprised of the child welfare worker, the youth and family, service providers and any other members as necessary and appropriate. No single individual, agency, or service provider works independently but rather as part of the team for decision-making. For additional information, refer to the DHCS manual, Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) (Medi-Cal Manual Third Edition ADA).
11. Child and Family Team Meeting (CFTM) - The formal meeting of the CFT. Ideally, Intensive Home Based Services (IHBS) will be authorized at a CFTM; however, less formal teaming is also acceptable.
12. Children and Youth Collaborative Services (CYCS) – The primary centralized children's administration for DBH programs through which the Department of Behavioral Health collaborates with other County agencies and community-based providers to meet the mental health needs of children. CYCS is comprised of six (6) distinct coordinating service branches: CCICMS (Centralized Children's Intensive Case Management Services), Juvenile Court Behavioral Health Services (JCBHS), the Healthy Homes Program, the mental health staffing at the Children's Assessment Center (CAC), AB 1299 Unit, and Qualified Individual (QI) Unit.
13. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS).
14. Children/Youth at Risk for School Failure – Children / Youth at risk for school failure due to unaddressed emotional and behavioral problems.
15. Children/Youth in Stressed Families – Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
16. Children's Assessment Center (CAC) – A public/private partnership between San Bernardino County and Loma Linda University Children's Hospital which provides forensic interviews and evidentiary medical examinations to assist in the evaluation of child abuse allegations. Referrals from CAC are prioritized to ensure an assessment is started as soon as possible.
17. Children's Network – An organization that concerns itself with at-risk children who are defined as minors who, because of behavior, abuse, neglect, medical needs, educational assessment, and/or detrimental daily living situations, are eligible for services from one or more of the member agencies of the Children's Network. The overall goal of the Children's Network is to help at-risk children by improving communications, planning, coordination, cooperation, and integration among youth-serving agencies.

18. Community-Based – The concept of children and families receiving formal services, whenever possible, in the community where they live. This will enable them to live, learn, and grow safely, competently, and productively in their families, neighborhoods, and natural environment.
19. Community and/or Practice-Based Standard – A set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically.
20. Continuum of Care Reform (CCR) – The legislative modifications to the services available to Dependents under the authority of Child Welfare which includes modifications to authorization of guardians (e.g., Resource Family Authorization), expansion of required core services from Foster Family Agencies (FFAs), and transition from a Rate Classification Level (RCL) Group Home facilities to Short Term Residential Therapeutic Programs (STRTPs).
21. Coordination of Care – to deliver care to and coordinate services for all clients by doing the following [42 C.F.R. § 438.208(b)]:
    - Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity [42 C.F.R. § 438.208(b) (1)].
    - Coordinate the services Contractor furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services Contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries [(42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, title 9 § 1810.415.]
22. Cost Effectiveness – Achieving the desired goal with the minimum of expenditure.
23. County's billing and transactional database system – The centralized data entry system used by DBH for patient and billing information.
24. Cultural Relevance (Cultural Competency) – The acceptance and understanding of cultural mores, history, language, race, ethnicity and culture and their possible influence on the client's issues and/or behavior, that is, using the understanding of the differences between the prevailing social culture and that of the client's family to aid in developing individualized supports and services.
25. Department of Behavioral Health (DBH) – The entity, under state law, that provides mental health and substance use disorder services to County residents. In order to maintain a continuum of care, DBH operates or contracts for the provision of prevention and early intervention services, 24-hour care, day treatment, outpatient services, case management, and crisis and referral services. Community services are provided in all major county metropolitan areas and are readily accessible to most County residents. Additionally, DBH assists individuals utilizing a Wellness, Recovery and Resilience approach to help the individual to live a healthy, satisfying, and hopeful life despite limitation and/or continuing effects caused by his/her mental illness and/or substance use disorders in the least restrictive setting possible.

26. Department of Health Care Services (DHCS) – The California department that provides oversight of statewide public mental health services through the Mental Health Services Division. Its responsibilities include providing leadership for local county mental health departments; evaluation and monitoring of public mental health programs; administration of federal funds for mental health programs and services; care and treatment of people with mental illness; and oversight of Mental Health Services Act service implementation.
27. Dependents – A general term to refer to children who have an open child welfare case. This population was historically, but less accurately, referred to as foster children.
28. Developmental Disabilities – Delays in motor, language, and cognitive development that impede a child's ability to function fully.
29. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Medi-Cal – a federally mandated Medicaid option that requires states to provide screening, diagnostic and treatment services to persons under age 21 who have unrestricted Medi-Cal and also meet necessary medical criteria by having a qualifying mental health diagnosis and functional impairment that is not responsive to treatment by a healthcare-based provider. In addition, services are generally acceptable for the purpose of correcting or ameliorating the mental disorder. For the purposes of this proposal, EPSDT Medi-Cal Rehabilitative Mental Health Services activities may include:
    - Assessment
    - Plan Development
    - Collateral
    - Crisis Intervention
    - Medication Support Services
    - Case Management
    - Intensive Care Coordination (ICC)
    - Intensive Home Based Services (IHBS)
    - Rehabilitation
    - Therapy

    EPSDT services may not be billed while the child is in an acute hospital setting.is defined as a federally-mandated Medicaid option that requires states to provide.
30. Early Intervention Program – Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence.
31. Effective Methods – Service methods that are likely to bring about intended outcomes. Effective methods include:
    - Evidence-based practice standard
    - Promising practice standard
    - Community and/or Practice-based evidence standard.

32. Evaluation - An appraisal of the individual's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues may be addressed where appropriate.
33. Evidence-Based Practices Standard – Activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population including, but not limited to, scientific peer-reviewed research using randomized clinical trials.
34. Faith-Based Organization – Charitable or social service organizations that, literally, are based in faith of a particular religion or denomination. However, the consumer of these services is not required to adhere or participate in religious activities of the type of organization.
35. Family-Centered – The needs of children that are addressed in the context of their families. Parents or other persons who are the primary or natural caregivers for the children participate in all aspects of the development and implementation of the plan of support and services, to the degree they are able, and to the extent permitted by any outstanding orders of the court.
36. Family Setting/Types – Any family setting where there is a relative or caregiver interested in strength-based services and willing to work toward permanency. This may include parents, relative placements, guardianships, resource homes, and/or foster homes.
37. File Transfer Protocol (FTP) – A network protocol for transmitting files between computers over Transmission Control Protocol/Internet Protocol (TCP/IP) connections.
38. Formal/Professional Resources, Services, and Supports – Traditional social service options administered by professionals, (e.g., counseling, psychological evaluations, parenting classes, and anger management training).
39. Foster Care – A temporary placement, which assists children in preparing for return to their birth parents or for a more permanent placement such as adoption or guardianship. Social workers visit the home on a regular basis to provide services to support the children's needs. Foster parents and Resource Parents receive ongoing financial and medical assistance for the child.
40. Full-Time Equivalent (FTE) – The percentage of time a staff member works represented as a decimal. A full-time person is 1.00, a half-time person is 0.50 and a quarter-time person is 0.25.
41. Health Insurance Portability and Accountability Act (HIPAA) – The acronym for the Health Insurance Portability and Accountability Act of 1996. A federal law designed to provide privacy and information security standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care Vendors.
42. Integrated Core Practice Model (ICPM) – is defined as a set of concepts, values, principles, and standards of practice that outline an integrated approach to working with children/youth and families involved with multiple systems of care. ICPM is further defined in the DHCS manual, Pathways to Mental Health Services Core Practice Model Guide. (https://cdss.ca.gov/inforesources/the-integrated-core-practice-model).
    The Values and Principles of ICPM are:
    - Children are first and foremost protected from abuse and neglect and maintained safely in their own home.

• Services are needs-driven, strength-based, and family focused from the first conversation with or about the family.

• Services are individualized and tailored to the strengths and needs of each child and family.

• Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.

• Parent/Family voice, choice, and preference are assured throughout the process.

• Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.

• Services are culturally competent and respectful of the culture of children and their families.

• Services and supports are provided in the child and family's community.

• Children have permanency and stability in their living situation.

43. Intensive Care Coordination (ICC) Coordinator – An identified coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the child/youth's needs and strengths in the context of the values and philosophy of the ICPM. Refer to the DHCS manual, Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) (Medi-Cal Manual Third Edition ADA).
44. Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations Strategy – To increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation family focus, hours available, and cost of services.
45. Individuals Experiencing Onset of Serious Mental Illness – Consumers identified as presenting signs of a serious mental illness for the first time.
46. Individualized Service Plan (ISP) – A flexible, creative approach to a plan of care/treatment for clients based on assessment of needs, resources, and family strengths with the ultimate goal of promoting the self-sufficiency of the family in dealing with their unique challenges. The plan reflects the best possible fit with the culture, values, and beliefs of the client and family/caregiver(s) and the referring agency's safety concerns.
47. Inland Regional Center (IRC) – An agency, contracted through the California Department of Developmental Services, which provides services to qualifying children and adults diagnosed with autism, an intellectual disability, and/or cerebral palsy.
48. Katie A. – Katie A. et al. v. Bonta et al. - Refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children/youth in California who are either in foster care or at imminent risk of coming into care. A settlement

agreement was reached in the case in December 2011, which is implemented through the Integrated Core Practice Model.

49. Specialty Mental Health Services – Individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, collateral, medication support, therapy, rehabilitation, and plan development. [Note: Please note which of the following services are required for each program. SATS will only provide these services if a participant is a EPSDT Medi-Cal beneficiary eligible for Medi-Cal funded services (meets medical necessity criteria and is under the age of 21).
    a. Assessment – A service activity designed to evaluate the current status of a child's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the child's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
    b. Collateral – A service activity to a Significant Support Person in a child's life for the purpose of meeting the needs of the child in terms of achieving the goals of the child's/youth's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the child, consultation and training of the significant support person(s) to assist in better understanding of the child's/youth's serious emotional disturbance; and family counseling with significant support person(s) in achieving the goals of the child's/youth's client plan. The child/youth may or may not be present for this service activity. NOTE: Per CalAIM payment reform there is no longer a specific code to capture collateral activities, but this activity is included within other billable service codes. For example, activities historically billed under collateral may be billable under Intensive Case Coordination for youth 21 and younger.
    c. Crisis Intervention – A quick emergency response service enabling the individual and/or family, support system and/or involved others to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible, and in the least restrictive care as applicable. A crisis is an unplanned event that results in the individual's need for immediate service intervention. Crisis intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program. Service activities include but are not limited to assessment, evaluation, collateral and therapy (all billed as crisis intervention).
    d. Intensive Care Coordination (ICC) – Targeted case management services designed to capture the time spent working with children being served by multiple agencies. This includes assessment of strengths and needs, care planning, and coordination of services, including urgent services for children and youth who meet the Katie A. Subclass criteria. Refer to the DHCS manual, Medi-Cal Manual for Intensive Care Coordination (ICC),

Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members (Medi-Cal Manual Third Edition ADA) for additional information.

e. Intensive Home Based Services (IHBS) (optional) – Services that includes intensive, individualized, strength-based, and needs-driven intervention activities that support the engagement and participation of the child/youth and significant others and help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS (EPSDT Medi-Cal) may only be provided to children and youth who meet the Katie A. Subclass criteria. IHBS (EPSDT Medi-Cal) must be authorized within a CFTM. Refer to the DHCS manual, Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) (Medi-Cal Manual Third Edition ADA) for additional information.

f. Medication Support Services – Services that include staff persons practicing within the scope of their professions by prescribing, administering, dispensing and/or monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. This service includes:
   1) Evaluation of the need for medication.
   2) Evaluation of clinical effectiveness and side effects of medication.
   3) Obtaining informed consent.
   4) Medication education (including discussing risks, benefits and alternatives with the individual, family or significant support persons).
   5) Plan development related to the delivery of this service.

g. Plan Development – A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a child's/youth's progress.

h. Rehabilitation – A service activity that includes, but is not limited to, assistance in improving, maintaining, or restoring a child's/youth's or group of children's/youth's functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
   1) Assistance in restoring or maintaining an individual's functional skills, social skills, medication compliance, and support resources.
   2) Age-appropriate counseling of the individual and/or family, support systems and involved others.
   3) Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones.
   4) Medication education for family, support systems and involved others.

i. Targeted Case Management (TCM) – Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. TCM may be either face-to-face or by telephone with the child/youth or significant support persons and may be provided anywhere in the community.

j. Therapeutic Behavioral Services (TBS) – One-to-one behavioral mental health services available to children/youth with serious emotional challenges who are under age 21 and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). Prior authorization from the Mental Health Plan is required. For SAP and SATS these services will be accessed, if needed, by working with another DBH vendor who holds a TBS Program contract.

k. Therapy – A service activity that may be delivered to an individual or group of individuals and may include family therapy (when the individual is present). Therapeutic interventions are consistent with the individual's goals, desired results, and personal milestones and focus primarily on symptom reduction as the means to improve functional impairments.

50. Mental Health Services Act (MHSA) – The passage of Proposition 63 in November 2004, provided the first opportunity in many years for the Department of Health Care Services to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

51. Mental illness/mental disorder (as used in the PEI Regulations) – A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological or biological processes underlying mental functioning. Mental illness is usually associated with significant distress or disability in social, occupational, or other important activities.

52. Medical Necessity –

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) or Title 42 of the United States Code. This section requires provision of Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Federal guidance from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are this medically necessary and covered as EPSDT services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition (42 C.F.R. §§ 456.5 and 440.230(b).

DHCS Behavioral Health Information Notice No. 21-073 provides additional specifics about beneficiaries under 21 years of age needing to meet either of the following criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the

following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involved, or experiencing homelessness as defined in BHIN 21-073.

OR

(2) The beneficiary meets both of the following requirements in (a) and (b), below:

a. The beneficiary has at lease one of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

b. The beneficiary's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

53. Memorandum of Understanding (MOU) – An official agreement outlining a mutual understanding between parties as to their working relationship.
54. Multidisciplinary Team (MDT) – The team that brings representatives from County agencies together to work collaboratively.
    - Members of an MDT are united by the realization that child/youth and family issues have complex causes and a serious impact on society.
    - Each member has a designated role and continues to do his or her traditional job, but with the additional insight and assistance provided by others on the team.

- Formal written agreements, protocols, and/or guidelines signed by authorized representatives of all team components allow for routine sharing of information among team members.

55. Needs Driven Services – A treatment determined through the formal assessment of child/youth and family needs. Family expression of needs is a valuable component in this process.
56. Non-Stigmatizing and Non-Discriminatory – Promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.
57. Outcome-Based - A County-approved system that measures the effectiveness and efficiency of services and supports being provided. Measurable change in outcomes is used as a mechanism for continuous quality monitoring, reporting and improvement.
58. Objective Arts - The web-based data system used by the San Bernardino County Department of Behavioral Health and required by DHCS to provide structure to the utilization of TCOM tools (e.g., CANS & ANSA). This training is a hands-on course intended to provide staff with the knowledge needed to utilize the Objective Arts system in the field.
59. Parent Partner - A staff who is a parent or family member of a child with serious emotional disturbance, hired to work closely with DBH Parent Partners. The duties and responsibilities of Parent Partners are either administrative or claimable as an allowable billable service, but not both.
60. Pediatric Symptom Checklist – 35 (PSC-35) – A psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible. Parents/caregivers will complete PSC-35 (parent/caregiver version) for children and youth from four (4) years of age to eighteen (18) years of age.
61. Prevention – Activities and services occurring prior to a diagnosis for a mental illness. Includes services that reduce risk factors for developing a potentially serious mental illness and stressors, build protective factors and skills and increase support. Promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.
62. Presumptive Transfer of Medi-Cal (AB 1299) – An Assembly Bill included in Welfare & Institutions Codes 14714 and 14717.1. Presumptive transfer of Medi-Cal occurs when a child or youth with an open child welfare case is placed outside of their County of Jurisdiction unless there has been a waiver of presumptive transfer completed. Vendors are expected to comply with the requirements of AB 1299 and work collaboratively with child welfare agencies from other counties as needed.
63. Promising Practices Standard – Activities for which there is research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.

64. Request for Proposal (RFP) – The document used to solicit a solution or solutions from potential Vendors to a specific problem or need. Although price is important, originality and effectiveness of the proposal and the background and experience of the Proposer are evaluated in addition to the proposed price.
65. Resource Family/Parent – In accordance with the Continuum of Care Reform, families taking on the responsibility of caring for Dependents shall be approved through the Resource Family Approval process, which includes a specific amount of training and orientation. Resource Families will be replacing foster families as CCR is implemented.
66. Risk Factors – Conditions or experiences that are associated with a greater than average risk of developing a potentially serious mental illness. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.
67. Serious mental illness / serious mental disorder / severe mental illness (as used in the PEI Regulations) – A mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.
68. Satisfaction Survey – A survey designed to measure the child's/youth's, the family's, and/or the referring Department's overall satisfaction with the service rendered. Satisfaction Surveys address specific aspects of service provision in order to identify problems and opportunities for improvement.
69. Seriously Emotionally Disturbed (SED) – refers to minors under 21 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:
    a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas:
        i. self-care, school functioning, family relationships, or ability to function in the community; and either of the following occurs:

           1) The child is at risk of removal from home or has already been removed from the home; or

           2) The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment.

           3) The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.

           4) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in

paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

70. State Bill (SB) 785 – Legislation intended to facilitate the receipt of medically necessary specialty mental health services by a Dependent who is placed outside of their county of jurisdiction. The bill clarifies responsibility for treatment authorizations and transfers the responsibility for the provision of services to the host county while keeping the financial responsibility to authorize and pay for services with the county of jurisdiction.
71. Strategy – A planned and specified method within a Program intended to achieve a defined goal.
72. Strength-based – The process of developing an Individualized Service Plan beginning with an assessment of the strengths of all the family members and other individuals involved with the family team. The Plan emphasizes the strengths of the family rather than their problems and deficits. It evaluates and utilizes family strengths in the individualized planning process. This is a departure from the professional-driven service delivery system that traditionally focuses on family deficits and generally fails to identify strengths.
73. Subject Matter Experts (SMEs) – The technical experts in Objective Arts program for their agency or program. Only users designated as agency SMEs can access the Objective Arts program.
74. Transformational Collaborative Outcomes Management (TCOM) - A framework into the daily care of mental health consumers within San Bernardino County. The TCOM system was developed by the Praed Foundation in 1998 and specific tools have been modified by DBH and Praed in an effort to ensure that the needs of the County's specific population are addressed. These tools are the Adult Needs and Strengths – San Bernardino and the Child and Adolescent Needs and Strengths – San Bernardino. TCOM:
    a. Focuses on change and impact to all levels of activities
    b. Information is integrated into all activities with the consumer, family, and staff as full partner
    c. Measures are relevant to decisions about and evaluation of interventions
    d. Information is used to manage services, from an individual consumer level to supervision to individual programs to the entire system of care
75. Transitional Age Youth (TAY) – A term used to describe consumers who are 16-25 years old.
76. Trauma Exposed – Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation.
77. Trauma-Informed Care (TIC)- Understands and considers the pervasive nature of trauma and promotes healing and recovery environments rather than practices and services that may inadvertently re-traumatize.
78. Treatment Progress Report – A structured report indicating current status, progress in treatment, and expectation of future services.
79. Unduplicated – When reporting the number of unduplicated clients, an individual client is to be included in the number reported; that individual client shall only be included once for the year, no matter how many times the individual client returns for assistance during the year.

80. Underserved or inappropriately served – Those individuals who may be receiving some services but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals.
81. Unserved – Those individuals who are not receiving mental health services, particularly those who are a part of racial ethnic populations that have not had access to mental health services.
82. Ward – A child or youth who is under the jurisdiction of the San Bernardino County Juvenile Court pursuant to WIC Section 602 and is under the supervision of Probation.
83. Welfare and Institutions Code (W&I Code) – A series of statutes in California that includes programs and services designed to provide protection, support, or care of individuals. The purpose of these statutes is to provide protective services to the fullest extent deemed necessary by the juvenile court, probation department, or other public agencies designated by the Board of Supervisors to perform the duties prescribed to ensure that the rights or physical, mental, or moral welfare of children are not violated or threatened by their present circumstances or environment.

III. <u>SATS MISSION AND GOALS</u>

A. <u>Overview</u>

SATS is intended to provide access to mental health care to school-age children, making it extremely important for providers to cultivate strong working relationships with Local Education Areas (LEAs). Cooperation and collaboration with schools in respective service region(s) is crucial in order to provide services on local campuses (as permitted by LEAs) and for identifying additional school-based services for linkages within San Bernardino County. The target population for SATS is children and youth initially dealing with mental health issues (i.e., mild to moderate within spectrum of medical necessity) and those with established long term difficulties (i.e., severely emotionally disturbed). Target population is limited to full scope Medi-Cal Beneficiaries who are enrolled, or recently were enrolled, in the school district.

Additionally, it is expected that in the provision of services to Dependents (aka, Foster Children) providers will adhere to the Core Practice Model; working in a highly collaborative manner and providing Intensive Care Coordination (ICC) as needed.

SATS is to provide EPSDT Medi-Cal Specialty Mental Health services for school-age children and youth (i.e., up to 21 years of age) who are experiencing significant distress due to a mental health condition and who meet medical necessity criteria. The target population for SATS is children and youth initially dealing with mental health issues (i.e., mild to moderate within spectrum of medical necessity) and those with established long-term difficulties (i.e., severely emotionally disturbed). Services will minimally include the following: Assessment, Plan Development, Targeted Case Management, Intensive Care Coordination, Rehabilitation, and Therapy. Provision of these services should be done within an easily accessible location for school aged clients and must be available for all twelve months of the fiscal year.

The Contractor will serve children, youth and their families during the term of the Contract with a primary focus in the areas and regions of San Bernardino County more commonly known as East Valley, West Valley, High Desert, Mountain, and Eastern Desert. The Contractor shall screen clients generated and referred by DBH outpatient contract agencies, acute inpatient psychiatric hospitals, agencies and local schools; in conjunction with the DBH, shall develop

admission policies and procedures regarding those persons who are eligible for services; and shall provide a discharge plan for all cases that aids in the maintenance of a stable level of functioning. (Cases will be discharged following completion of services, an acceptable level of stability and linkage with supportive resources.)

B. Program Objective

1. The overall objective of School-Aged Treatment Services (SATS) is to restore or maintain functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency in school-age children who are Medi-Cal beneficiaries and have experienced significant impairment from mental health difficulties. Service priority should be given to unserved/underserved populations and children/youth that are dually diagnosed with co-occurring disorders. Additional service priorities are as follows:
   - a. Children who are emotionally disturbed in the target populations.
   - b. Children in foster homes referred for assessments by the regional DBH liaison to the Department of Children's Services.
   - c. Children referred from DBH
2. The intent of this program is to provide access to mental health care to school-age children, making it extremely important for providers to cultivate strong working relationships with Local Education Areas (LEAs). Cooperation and collaboration with schools in respective service region(s) is crucial in order to provide services on local campuses (as permitted by LEAs) and for identifying additional school-based services for linkages within San Bernardino County.
3. The program objective is to:
   - a. Provide services appropriate to needs based on functioning and cultural background.
   - b. Provide effective services that are continually reviewed and revised as needed.

C. Values, Principles, Basic Tenets, and Philosophies of the Core Practice Model:

1. Children are first and foremost protected from abuse and neglect, and maintained safely in their own homes.
2. Services are needs driven, strength-based, and family focused from the first conversation with or about the family.
3. Services are individualized and tailored to the strengths and needs of each child and family.
4. SATS is a community-based effort.
5. Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.
6. Parent/Family voice, choice, and preference are assured throughout the process.
7. Services incorporate a blend of formal and informal resources designed to assist families with successful transition that ensure long-term success.

8. Services are culturally competent and respectful of the culture of children and their families.
9. Services and supports are provided in the child and family's community.
10. Children have permanency and stability in their living situation.
11. It is further expected that the client population will be reflective of the social, economic and ethnic characteristics of the communities served by the Contractor.

IV. PERSONS TO BE SERVED (TARGET POPULATION)

A. School-age children and youth (i.e., up to 21 years of age) who are experiencing significant distress due to a mental health condition and who meet medical necessity criteria. This includes children and youth who, while receiving mental health services, move outside the local area. Services should be continued as appropriate. The target population for SATS is children and youth initially dealing with mental health issues (i.e., mild to moderate within spectrum of medical necessity) and those with established long term difficulties (i.e., severely emotionally disturbed). Target population is limited to full scope Medi-Cal Beneficiaries.

B. Service priority should be given to unserved/underserved populations and children/youth that are dually-diagnosed with co-occurring disorders.

C. Additionally, it is expected that in the provision of services to Dependents (aka, Foster Children) providers will adhere to the Integrated Core Practice Model (ICPM); working in a highly collaborative manner and providing Intensive Care Coordination (ICC) as needed.

V. PROGRAM DESCRIPTION

SATS programs are an essential part of the continuum of care, as they provide a link between school-age children/youth and appropriate mental health services. An essential aspect of SATS is close collaboration with other programs for provision of appropriate services.

EPSDT is a federally mandated Medi-Cal plan requiring states to provide screening, diagnostic and treatment services to eligible Medi-Cal recipients under the age of twenty-one (21). The intent of the program is to extend Medi-Cal coverage to children and youth to "ascertain physical and mental defects" and "to provide treatment to correct or ameliorate defects and chronic conditions found." Thus, the Contractor will be expected to provide a full-range of services that are tailored to meet the respective target population in each geographic area to be served by the Contractor.

A. Mental Health Services

1. Assessment
2. Case Management
3. Crisis Intervention
4. Medication Support Services (Optional)
5. Plan Development
6. Rehabilitation
7. Therapy

B. Overall Service Requirements

ADDENDUM II

1. Contractor will have primary responsibility to provide the full range of mental health services to children/youth that live within the Contractor's service area(s), including crisis and emergency services.
2. Accept referrals directly from DBH and other child serving agencies
3. Maintain a system/protocol to address crisis and emergency situation, 24 hours a day – seven days a week, to meet the needs of the child/youth/family.
4. Develop, coordinate and provide formal therapeutic treatment services based on assessments and treatment recommendations.
5. Develop a system to screen and prioritize clients awaiting treatment and those in treatment, to ensure availability of service to the most severely ill.
6. Provide services in a culturally competent manner by recruiting, hiring, training and maintaining staff that provide culturally appropriate services to diverse populations.
7. Ensure clinical staff are trained in identification, treatment, and management of eating disorders.
8. Review and maintain information in Objective Arts on a weekly basis.
9. Median number of business days between a complete referral received and first attempted contact of family is two (2) days or less.
10. Median number of days between first contact and intake meeting is fourteen (14) calendar days or less.
11. Median number of days between first assessment appointment and provision of first treatment plan driven service is thirty (30) calendar days or less.
12. Median number of days between treatment services will be less than twenty-one (21).
13. Services provided will be within a range of intensities (e.g., 3x per week to 2x per month). Within this range it is expected that at least 20% of the children and youth served receive low-intensity services (i.e., 2x per month or less). It is also expected that SATS will provide more intensive services for a short period of time (e.g., 2x per week for 5 weeks) if needed; however, a referral to a more intensive program must be considered if this higher intensity is needed.
14. Median number of EPSDT Specialty Mental Health hours provided to a client who meets Medi-Cal Necessity will be at least 1 hour per week during the first 3 months of service.
15. Provide structure and support to children/youth enrolled in the program, including assisting the child/youth in engaging in appropriate activities.
16. Work towards reducing impulsivity in children/youth enrolled in the program.
17. Increase social and community competencies by building or reinstating those daily living skills that will assist the child/youth to live successfully in the community.
18. Maintain a clear audit trail between school-aged treatment services and the provision of other specialty mental health services.

19. Establish a plan to deal with a crisis involving the client, family members and treatment team.
20. Ensure there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.
21. Maintain ongoing communication with the DBH Program Manager and make all policies and procedures (administrative and service-related) available to the Program Manager on a regular basis.`
22. Contractor's Director or designee must attend regional meetings as scheduled.
23. Contractor must make pamphlets available, identifying the clinic and its services in threshold languages (English and Spanish) for distribution to the community.

VI. DESCRIPTION OF SPECIFIC SERVICES TO BE PROVIDED

The following list of mental health service activities includes both required and optional services to be provided:

A. Assessment (required): A service activity designed to evaluate the current status of a child's/youth's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

B. Collateral (required): A service activity to a Significant Support Person in a child's life for the purpose of meeting the needs of the child in terms of achieving the goals of the child's/youth's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the child, consultation and training of the significant support person(s) to assist in better understanding of the child's/youth's serious emotional disturbance; and family counseling with significant support person(s) in achieving the goals of the child's/youth's client plan. The child/youth may or may not be present for this service activity. Note: Per CalAIM payment reform, there is no longer a specific service code to bill for collateral activities. Clinical activities historically billed under collateral may be billable under Intensive Case Coordination for youth 21 and younger or other service codes that allow for these activities.

C. Crisis Intervention (required): A quick emergency response service enabling the individual, his or her family, support system, and/or involved others to cope with a crisis, while maintaining the child's status as a functioning family and/or "immediate community" member to the greatest extent possible, and in the least restrictive care as applicable. A crisis is an unplanned event that results in the individual's need for immediate service intervention. Crisis intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program. Service activities include but are not limited to assessment, evaluation, collateral, and therapy (all billed as crisis intervention).

D. Intensive Care Coordination (required): Within the Integrated Core Practices Model (ICPM) there is a need for thorough collaboration between all Child and Family Team (CFT) members. Planning within the ICPM is a dynamic and interactive process that addresses the goals and objective necessary to accomplish goals. The ICC Coordinator is responsible for working within the CFT to ensure that plans form any of the multi system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with the service to the child/youth and/or family, are coordinated to support an ensure successful and enduring change.

ICC is similar to the activities provided through Targeted Case Management (TCM). ICC must be delivered using a Child and Family Team (CFT) to develop and guide the planning and services delivery process. ICC may be utilized by more than one mental health provider; however, there must an identified mental health ICC Coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the child/youth's needs and strengths in the context of the values and philosophy of the Integrated Core Practice Model (ICPM).

ICC must be provided at the frequency needed to address the needs effectively. For many children this is monthly, but it should be provided more frequently if the situation warrants.

Activities coded as ICC may include interventions such as:

1) Facilitation of the development and maintenance of a constructive and collaborative relationship among child/youth, his/her family or caregiver(s), other providers, and other involved child-serving systems to create a CFT;

2) Facilitation of a care planning and monitoring process which ensures that the plan is aligned and coordinated across the mental health and child serving systems to allow the child/youth to be served in his/her community in the least restrictive setting possible;

3) Ensure services are provided that equip the parent/caregiver(s) to meet the child/youth's mental health treatment and care coordination needs, described in the child/youth's plan;

4) Ensure that medically necessary mental health services included in the child/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is consistent with the full intent of the Integrated Core Practice Model (ICPM).

5) Provide active participation in the CFT planning and monitoring process to assure that the plan addresses or is refined to meet the mental health needs of the child/youth.

NOTE: ICC was initially developed solely for the use with children with an open child welfare case who meet the 'Subclass" criteria of a class action lawsuit; however, ICC is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

Contractor must provide ICC for all children with an open child welfare case who meet the criteria for the 'Subclass' as least once every thirty (30) days, as this is the least frequent level of coordination needed for this population.

ICC may be provided in any setting; however, when provided in a hospital, psychiatric health facility, community treatment facility, STRTP or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/youth on discharge from those facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

Additional information on ICC may be obtained from the DHCS publication "Medical Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries".

E. Intensive Home Based Services (IHBS) (Optional) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not therapeutic services. Activities coded as IHBS may include interventions such as:

   1) Medically necessary skill-based interventions for remediation of behaviors or improvement of symptoms, including but not limited to the implementation of positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant other to assist them in implementing the strategies;

   2) Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;

   3) Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare services plan;

   4) Improvement of self-management of symptoms, including self-administration of medications as appropriate;

   5) Education of the child/youth and/or their family or caregiver(s) about, and about to manage the child/youth's mental health disorder or symptoms:

   6) Support of the development, maintenance and use of social networks including the use of natural and community resources;

   7) Support to address behaviors that interfere with the achievement of a stable and permanent family life;

   8) Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community; and

   9) Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintain housing and living independently.

NOTE: IHBS was initially developed solely for use with children with an open child welfare case who meet the 'Subclass' Criteria of a class action lawsuit. However, IHBS is a service available to all EPSDT Medi-Cal beneficiaries in need of this service.

• IHBS was developed to be provided within the context of the Integrated Core Practice Model and requires the provision of ICC to ensure a participatory CFT. IHBS may be provided to all EPSDT Medi-Cal Beneficiaries in need of this service; however, IHBS still requires the provision of ICC to ensure a participatory coordination of services.

• According to Information Notice No.: 19-026, IHBS may not be provided unless prior authorization from the Mental Health Plan is granted. To request authorization, providers will follow DBH's Prior Authorization for IHBS Procedure.

• DBH will notify the requesting provider in writing within 5 business days of a decision. DBH will also notify the client in writing of any decision to deny a service authorization or request, or to authorize a service in an amount, duration, or scope that is less than required. IHBS Services will be authorized for up to 125 hours for 6 months. Requests for more Authorization of services may be submitted according to the DBH Prior Authorization for IHBS Procedure.

• IHBS, as it is currently documented in the DHCS publication, has multiple requirements for authorization [e.g., should be authorized within a CFT Meeting with authorizations no longer than ninety (90) days]. The requirements provided by DHCS shall be followed and if new requirements are published, the new requirements shall be followed.

• IHBS is typically, but not only, provided by paraprofessionals under clinical supervision. IHBS can be provided in any setting and is expected to be provided primarily in the home, school, or other community setting.

• Additional information on IHBS may be obtained from the DHCS publication "Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) & Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, Third Edition, January 2018."

F. Medication Support Services (optional): Medication support services include staff persons practicing within the scope of their professions by prescribing, administering, dispensing and/or monitoring of psychiatric medications or biological factors necessary to alleviate the symptoms of mental illness. This service includes:

1) Evaluation of the need for medication

2) Evaluation of clinical effectiveness and side effects of medication

3) Obtaining informed consent

4) Medication education (including discussing risks, benefits and alternatives with the individual, family or significant support persons)

5) Plan development related to the delivery of this service

Note: It is recognized that many of the children/youth served through SATS will not require medication services, and many of those requiring medication services are best served through collaboration with their pediatrician; however, psychiatric care is a critical element to services and may be included in the SATS program. If medication support services are not included in

the SATS proposal, Proposer must explain how medication support will be attained for clients in need of this service.

G. Plan Development (required): A service activity that consists of developing and approving client plans, and monitoring and recording an individual's progress.

H. Rehabilitation (required): A service activity that includes, but is not limited to, assistance in improving, maintaining, or restoring a child/youth or group of children/youth functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education. This service includes:

1) Assistance in restoring or maintaining an individual's functional skills, social skills, medication compliance, and support resources

2) Age-appropriate counseling of the individual and/or family, support systems and involved others

3) Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones

4) Medication education for family and other support systems

I. Targeted Case Management (required): Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. Targeted Case Management may be either face-to-face or by telephone with the child/youth or significant support persons and may be provided anywhere in the community.

J. Therapy (required): A service activity that is a therapeutic intervention, focusing primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to a child/youth or a group of children/youth, and may include family therapy.

VII. BILLING UNIT

Generally, the Contractor shall collect revenues for the provision of the services described in the RFP. Such revenues may include, but are not limited to, fees for services, private contributions, grants or other funds. All revenues collected shall be used to offset the cost of services and should, therefore, be considered in computing the proposed schedules to this RFP and any existing contracts arising from this RFP.

a. Billing Unit (EPSDT Medi-Cal)

The billing unit for EPSDT Medi-Cal mental health services, medication support services, rehabilitation support services, crisis intervention and case management/brokerage is staff time, based on minutes of time. The exact

number of minutes used by staff providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the units of time reported or claimed for any one staff member exceed the hours worked.

When a staff member provides service to or on behalf of more than one individual at the same time, the staff member's time must be pro-rated to each individual. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable time. The total time claimed shall not exceed the actual staff time utilized for billable service. The time required for documentation and travel shall be linked to the delivery of the reimbursable service.

Plan development is reimbursable. Units of time may be billed for time spent in plan development activities, regardless of whether there is a face-to-face or phone contact with the individual or significant other. All treatment plans shall be developed in collaboration with individual and/or significant other.

b. UMDAP

The Contractor shall abide by the criteria and procedures set forth in the Uniform Method of Determining Ability to Pay (UMDAP) manual consistent with State regulations for mental health programs. The Contractor shall not charge behavioral health/ mental health patients in excess of what UMDAP allows.

VIII. FACILITY LOCATION

Contractor's facility(ies) where outpatient services are to be provided is/are located at:

Locations are subject to prior approval by DBH. Medi-Cal certification is required prior to the reimbursement of EPSDT Specialty Mental Health Services and no mental health services provided prior to the Medi-Cal Certification Date shall be reimbursed.

School Districts:

- ***That will be reviewed and approved by DBH Program Manager, or designee***

A. The Contractor shall comply with all requirements of DHCS to maintain Medi-Cal Certification and obtain necessary fire clearances. Short-Doyle/Medi-Cal Contractors must notify the DBH at least sixty (60) days prior to a change of ownership or a change of address. The DBH will request a new Contractor number from the State.

B. The selected Contractor(s) will maintain facilities and equipment and operate continuously with at least the number and classification of staff required for the provision of services.

C. The Contractor shall obtain the prior written consent of the Director of DBH or the designee before terminating outpatient services at the above location or providing services at another location.

D. Selected Contractor(s) must have a location that is accessible by public transportation and approved by DBH.

E. The Contractor shall provide adequate furnishings and clinical supplies to do outpatient therapy in a clinically effective manner.

F. The Contractor shall maintain the facility exterior and interior appearances in a safe, clean, and attractive manner.

G. The Contractor shall maintain a current fire clearance (i.e., every two years) and have adequate fire extinguishers and smoke alarms, as well as a fire safety plan.

H. The Contractor shall have an exterior sign clearly indicating the location and name of the clinic.

I. The Contractor shall have clinic pamphlets identifying the clinic and its services, in threshold languages, for distribution in the community.

IX. STAFFING

All staff shall be employed by, or contracted for, by the Contractor. The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified and shall meet the California Code of Regulations requirements. All clinical treatment staff providing services with DBH funding shall be licensed or waived by viable internship by the State.

A. Contract must ensure requirements for all staff members are met including, but not limited to:

1. **Background checks and Criminal Record Reviews any other required clearances, etc.**-The Contractor will ensure that it has all necessary licenses and permits required by the laws of the United States, State of California, County and all other appropriate governmental agencies, and agrees to maintain these licenses and permits in effect for the duration of this Contract. The Contractor will notify the County immediately of loss or suspension of any such licenses and permit.
2. **Department of Justice (DOJ) Clearance/Live Scan**-The Contractor shall obtain from the Department of Justice (DOJ) records of all convictions involving any sex crimes, drug crimes, or crimes of violence of a person who is offered employment or volunteers for all positions in which he or she would have contact with a minor, the aged, the blind, the disabled or a domestic violence client, as provided for in Penal Code 11105.3. This includes licensed personnel who are not able to provide documentation of prior Department of Justice clearance. A copy of a license from the State of California is sufficient proof.
3. **Health and Safety**-The Contractor shall comply with all applicable local health and safety clearances, including fire clearances, for each site where program services are provided under the terms of the Contract.
4. **Licensure and Certification Requirements**-Pre-licensed, licensed, pre-certified, and certified staff should have appropriate educational background and experience to work

with target population. Early intervention services must be provided by registered pre-licensed, or licensed staff.

5. **Professional Development and Staff Training Requirements**-Staff should have an appropriate background and training for working with the target population of children and families. Ensure staff attend County provided orientation and/or training including cultural competency training to assure equal access and opportunity for services, and to improve service delivery. Staff to attend SAP training and annual Southern Region Student Wellness Conference as appropriate, as well as training requirements articulated in the Cultural Competency Plan.

6. **Tuberculosis (TB) Testing-** The Contractor will ensure that staff employed under this contract be screened for Tuberculosis via a skin or blood test.

B. All treatment staff shall work within their scope of practice as defined by DBH or their license type; psychotherapists must be licensed or waivered by the State. Treatment professionals should be primarily comprised of professionals trained in working with children/youth with mental health needs.

C. Personnel shall possess appropriate licenses and certificates, and be qualified in accordance with applicable statutes and regulations. Contractor will obtain, maintain and comply with all necessary government authorizations, permits and licenses required to conduct operations. In addition, the Contractor will comply with applicable Federal, State and local laws, rules, regulations and orders in its operations, including compliance with all applicable safety and health requirements concerning Contractors' employees.

D. Ensure staff is given a training plan, to include attending County trainings, such as cultural competency training, to assure equal access and opportunity for services, and to improve service delivery practices.

E. A staff roster must be kept current and must be provided to DBH Program Manager or designee. Additionally, all copies of licenses and waivers will be provided to DBH Program Manager or designee on a regular basis. A staff organizational chart must be kept current and must be provided to the DBH Program Manager or designee within 72 hours of staff changes.

F. Resources must be sought to continuously obtain the necessary linguistic and/or translation capabilities necessary to serve the applicable population.

G. Staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment and/or transition.

H. Provide continual services with at least the number and classification of staff required for the provision of services.

I. Serve as a positive role model and assist the children/youth in developing the ability to sustain self-directed appropriate behaviors, internalize a sense of social responsibility, and/or enable appropriate participation in community activities.

J. Participate in weekly/monthly treatment plan meetings and conference calls requiring input and feedback regarding the progress of the intervention and continued client needs.

K. Program must include bilingual staff, English and Spanish speaking, as the community and/or client/family population needs warrant.

L. Contractor is responsible for ensuring all staff are provided sufficient support to maximize their utilization of various data systems. Currently, this includes utilization of Objective Arts, the CANS-SB tracking and reporting system and myAvatar, the local billing system. Expectation is that Contractor will have a sufficient number of staff fully trained in these systems and function as subject matter experts so that they are able to support other staff as needed. This responsibility may be assigned to any appropriate staff in any position, but the Contractor must clarify how this requirement will be met and maintained for the duration of the contract.

M. Staffing should be comprised of personnel with the appropriate background and education to establish and maintain effective treatment services. Personnel must also be culturally proficient to deliver services in a manner most appropriate to the target population. Staff should include the following positions, or equivalent to the following:

1. **Program Manager:** The FTE for this position will be allocated program according to the Schedule A/B as accepted by DBH. The Program Manager must include a clinical background, but is not required to be actively licensed in their clinical profession. Primary responsibilities of the manager include: ensuring compliance of all contract provisions, overseeing the allocation of program resources, and effectively engaging/collaborating with all involved agencies (e.g., CFS, DBH, First 5, Preschool Services, etc.).
2. **Clinic Supervisor:** The FTE for this position be allocated program according to the Schedule A/B as accepted by DBH. The Clinic Supervisor must be a licensed clinician with experience with the target population. Clinic Supervisors may be a Licensed Marriage and Family Therapist (MFT), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), or Licensed Clinical Psychologist (Ph.D. or Psy.D.). The supervisor must possess experience developing behavioral treatment plans and working with emotionally and behaviorally disturbed children/youth and their families/care givers. Mental Health Services may include a variety of activities which support the child's/youth's residential placement or transition to the least restrictive level of community care and may also be provided by pre-licensed psychologist, clinical social worker and/or marriage and family therapist under the supervision of the Clinic Supervisor.
3. **Clinical Therapist:** Who is a licensed, registered, or waivered by the State, clinical professional (Clinical Psychologist, LCSW, LMFT, LPCC, MSW Intern and MSW). Within the scope of licensure, this position will provide psychotherapy, psychotherapeutic treatment and counseling for clients exhibiting a variety of mental health and related disorders.
4. **Behavioral Health Specialist:** Who assists in the development and implementation of treatment plans including leading activity groups and providing rehabilitation/supportive counseling; develops and maintains community networks and educational programs; provides social services such as client advocacy and placement for both prospective and current client; and performs other related work as required.

5. **Peer and Family Advocates:** Mental health consumers and/or their family members who serve as advocates for consumers to help them access DBH and community resources such as TAY Centers, clubhouses, social events, wellness and recovery activities, self-help groups, and mental health and drug and alcohol services.
   a. Conduct various types of support groups, classes, wellness and recovery activities, and recreational activities through the department and contract agencies and promote the Mental Health Service Plan.
   b. Access and distribute educational information to the public and various internet resources related to education; utilize the computer to maintain files, records, and basic statistics on program activities, participation, and attendance.
6. **Volunteer**: This position is not required for the program; however, it may be included. Volunteers are unpaid, unlicensed staff that provides informal supports. Volunteers must still comply with the County's trainings as appropriate, including HIPAA training, before rendering any service.

X. ADMINISTRATIVE AND OUTCOMES/EVALUATION REQUIREMENTS

A. Contractor shall have written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

B. The main clinic office will be available a minimum of forty (40) hours per week by appointment. Services will primarily be field-based in the natural settings of the child and parent and access will be available 24 hours per day through answering system and paging system.

C. Contractors are required to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the hours of operation must be comparable to the hours made available for Medi-Cal services that are not covered by the Contractor or another Mental Health Plan; i.e., must be available during the times that services are accessible by consumers based on program requirements.

D. The Contractor shall abide by the criteria and procedures set forth in the Uniform Method of Determining Ability to Pay (UMDAP) manual consistent with State regulations for mental health programs. The Contractor shall not charge mental health clients in excess of what UMDAP allows.

E. The Contractor shall maintain client records in compliance with all regulations set forth by the State and provide access to clinical records by DBH staff.

F. The Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and record keeping requirements. The Contractor will participate in on-going contract related Medi-Cal audits by the State. A copy of the plan of correction regarding deficiencies will be forwarded to DBH.

G. The Contractor shall maintain high standards of quality of care for the units of service which it has committed to provide.

1. The Contractor's staff shall hold regular case conferences to evaluate the effects of treatment and the need for continued treatment.
2. The Contractor has the primary responsibility to provide the full range of mental health services to clients referred to Contractor.

   The Contractor shall develop a system to screen and prioritize clients awaiting treatment and those in treatment to target the availability of service to the most severely ill clients. Contractor and the applicable DBH Program Manager or designee will have ongoing collaboration to assist Contractor in identifying the target population(s) as defined in this Addendum. Contractor will participate as needed in weekly staffing of children's cases to assist in identifying the target population.
3. Summary copies of internal peer review conducted must be forwarded to DBH.

H. The Contractor shall participate in DBH's annual evaluation of the program and shall make required changes in areas of deficiency.

I. The Contractor shall ensure that there are adequate budgeted funds to pay for all necessary treatment staff, supplies and tools.

J. The Contractor shall maintain a separate and clear audit trail reflecting expenditure of funds under this Agreement.

K. The Contractor shall make available to the DBH Regional Program Manager copies of all administrative policies and procedures utilized and developed for service location(s) and shall maintain ongoing communication with the Program Manager regarding those policies and procedures.

L. Contractor must submit a report to the DBH Regional Program Manager by the fifth of each month. As a minimum, the monthly report must include an overview of the total caseload, number of Medi-Cal cases and non-Medi-Cal cases. The report is to cover changes and status of staffing, program and services that impact service delivery under the Contract. A copy of staff or team and peer review meetings minutes will be forwarded to DBH.

M. The program shall submit additional reports as required by DBH.

N. The Contractor's Director or designee must attend regional meetings as scheduled.

O. The Contractor shall make clients aware of their responsibility to pay for their own medications. However, if the client experiences a financial hardship, and the client cannot function without the prescribed medication, the Contractor shall cover the cost of those medications listed on the current Medi-Cal Formulary.

P. Vacancies or changes in staffing plan shall be submitted to the appropriate DBH Program Manager within 48 hours of Contractor's knowledge of such occurrence. Such notice shall include a plan of action to address the vacancy or a justification for the staffing plan change.

Q. The Contractor understands that compliance with all standards listed is required by the State and the County of San Bernardino. Failure to comply with any of the above requirements or special provisions below may result in reimbursement checks being withheld until the Contractor is in full compliance.

R. Contractor shall maintain ongoing compliance with Medi-Cal Utilization Review requirements and Medicare record keeping requirements. The Contractor will participate in ongoing Medi-Cal audits by the State DHCS. A copy of the plans of correction regarding deficiencies must be forwarded to DBH.

S. Participate and cooperate with DBH bi-annual and/or annual site reviews; such reviews may require follow-up and action/correction plans.

T. Collect, analyze, and report on evaluation elements and their outcomes as defined by DBH.

U. Perform testing/evaluation services in accordance with the frequency required by the testing instrument(s). This will – at minimum – include the Child, Adolescent, Needs and Strengths: Comprehensive Multisystem Assessment (CANS) – San Bernardino.

V. Process Measures:

1. Average number of EPSDT Specialty Mental Health Hours Provided to a client who meets Medi-Cal necessity will be at least one (1) hour per week during the first three (3) months of service.
2. Average number of days from First Assessment to First Treatment Services will be less than thirty (30) days.
3. Average number of days between treatment services will be less than twenty-one (21).

W. Data Reporting Elements including when data is due, how it should be submitted, and any other specifics:

1. Primary data is gathered through the billing systems, which will be completed by the tenth (10th) day of the month following the billing for the previous month's Medi-Cal based services.
2. Exception is the "opening" and "closing" of clients within the billing system. This will be done within five (5) working days of admission and discharge from the facility.
3. Data shall be entered, either directly or through approved batch upload processes, into Objective Arts at least every two weeks.
4. ICC Coordinator information will be entered and maintained in Objecitve Arts.
5. The Objective Arts Subject Matter Expert will supprt Objective Arts users, assist in problem solving data staff questions and rectifying errors prior to contacting DBH.
6. Data shall be entered into the Network Adequacey Certification Tool (NACT) as required by DHCS and per DBH insturctions.
7. Complete and submit weekly and monthly status reports to DBH Program Manager or designee as requeted.

X. Child, Adolescent Needs and Strengths Assessment – San Bernardino: (CANS-SB) shall be completed by clinical staff. The CANS-SB shall be completed:

1. Within thirty (30) days of admission,
2. Every six (6) months, and
3. Within thirty (30) days of discharge.
4. Clarifications:

- A CANS-SB is not required at admission if the client does not meet the criteria for services **AND** there is deemed insufficient information to complete the CANS-SB accurately.
- In no case shall a period of more than six (6) months pass without completing a CAN-SB.
- A CANS-SB is not required at discharge if a six (6) month (i.e., Update) CANS-SB, was administered within the past thirty (30) days **AND** no significant change in the client's presentation has occurred.

XI. DEPARTMENT OF BEHAVIORAL HEALTH RESPONSIBILITIES

A. DBH shall provide technical assistance to the Contractor in regard to EPSDT/Medi-Cal requirements, as well as charting and Utilization Review requirements.

B. DBH shall participate in evaluating the progress of the overall program in regard to responding to the mental health needs of local communities.

C. DBH shall monitor the Contractor on a regular basis in regard to compliance with all requirements.

D. DBH shall provide linkages with the total Mental Health system to assist Contractor in meeting the needs of its clients.

E. DBH shall provide CANS-SB training and documentation.

XII. OUTCOME MEASURES AND DATA REPORTING

A. The Contractor will strive to meet the following goals and outcomes

Goal	Key Outcomes
• Provide services appropriate to needs based on functioning and cultural background.	• Service Appropriateness: ➢ Services match the individual consumer's needs and strengths in accordance with system-of-care values and scientifically derived standards of care
• Provide effective services that are continually reviewed and revised as needed.	• Service Effectiveness: ➢ Improved Functioning ➢ Reduction in symptom distress ➢ Well-being and positive health.

B. The contractor will evaluate the progress of the overall program, specifically regarding responses to the mental health needs of local communities (e.g., audits, annual program reviews, contract monitor site reviews, and/or revieing of special incidents), and provide outcomes updates to the Program Manager or designee upon request.

XIII. SPECIAL PROVISIONS

A. A review of productivity of the Contractor shall be conducted after the end of each quarter of each fiscal year.

B. The Contractor and DBH will work jointly to monitor outcome measures.

C. Satisfaction Surveys will be provided to beneficiaries and parent/caregivers upon completion/termination of SATs.

D. The Contractor and DBH will participate in evaluating the progress of the overall program in regard to responding to the mental health needs of local communities (i.e. Annual Program Review, quarterly site reviews, audits, etc.).

E. The Contractor must comply with California Vehicle Restraint Laws which states:

- Children under two (2) years of age shall ride in a rear-facing care seat unless the child weights forty (40) or more pounds OR is forty (40) or more inches tall. The child shall be secured in a manner that complies with the height and weight limits specified by the manufacturer of the care seat.
- Children under the age of eight (8) must be secured in a car seat or booster seat in the back seat.
- Children who are eight (8) years of age OR have reached four feet and nine inches (4'9") in height must be secured by a safety belt.
- Passengers who are sixteen (16) years of age and over are subject to California's Mandatory Seat Belt law.

F. Contractor must start providing assessment and treatment services as soon as possible, but no later than one hundred twenty (120) days from the contract start date.

G. Contractor must obtain Medi-Cal certification in order to bill EPSDT Medi-Cal for services provided to Medi-Cal eligible children/youth. If Contractor is not Medi-Cal certified at the time that the contract is awarded, Contractor must submit Medi-Cal certification paperwork to the DBH Program Manager within thirty (30) days of the start date of the contract. Not obtaining Medi-Cal certification within one hundred twenty (120) days from the contract start date may result in contract termination.

H. Contractor must pay a one time-annual charge to support utilization of an outside database (Objective Arts) for the purpose of gathering outcome information. This service will be a subscription with cost reflecting the combination of the anticipated number of unduplicated clients served by a Contractor and the duration of treatment per episode. The annual fee will be a percentage of the total contract and will be due to DBH by the end of the fifth (5th) month of each fiscal year (November). Maximum cost for this service is .875% of the awarded contract amount of SATS amount.

I. Contractor(s) must be available to initiate services with new clients during all twelve (12) months of the fiscal year; waiting lists are <u>not</u> permitted. (This requirement takes effect immediately after Contractor is Medi-Cal certified to provide services and must fall within the 120 day requirement from the start of the contract term.) Notification to DBH that a Contractor

is unable to initiate any more services during a fiscal year will result in monthly contract management meetings for the remainder of the fiscal year and the following fiscal year, until DBH Program Manager is satisfied that fiscal resources are being allocated in such a way that the Contractor is able to initiate services to new clients during any of the remaining months of the applicable fiscal year.

J. County will only reimburse Contractor for services provided to out-of-county Medi-Cal beneficiaries if applicable through the Senate Bill (SB) 785 Out of County Placements process and if the SB785 procedures are followed by Contractor. These procedures require contact with the DBH Access Unit prior to the onset of services being delivered.

K. Contractor(s) will comply with Assembly Bill (AB) 1299 Presumptive Transfer of Medi-Cal as it relates to Dependents and Wards. This applies to children and youth placed into San Bernardino County from other counties as well as children and youth placed by San Bernardino County agencies (i.e., CFS and Probation) into other counties.

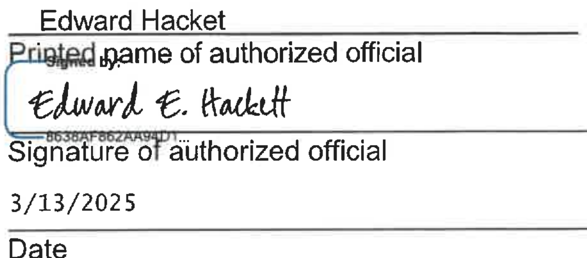
ATTACHMENT I

ATTESTATION REGARDING INELIGIBLE/EXCLUDED PERSONS

Contractor Victory Community Support Services, Inc. shall:
To the extent consistent with the provisions of this Agreement, comply with regulations as set forth in Executive Order 12549; Social Security Act, 42 U.S. Code, Section 1128 and 1320 a-7; Title 42 Code of Federal Regulations (CFR), Parts 1001 and 1002, et al; and Welfare and Institutions Code, Section 14043.6 and 14123 regarding exclusion from participation in federal and state funded programs, which provide in pertinent part:

1. Contractor certifies to the following:
   a. it is not presently excluded from participation in federal and state funded health care programs,
   b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency which is likely to result in exclusion from any federal or state funded health care program, and/or
   c. unlikely to be found by a federal and state agency to be ineligible to provide goods or services.
2. As the official responsible for the administration of Contractor, the signatory certifies the following:
   a. all of its officers, employees, agents, and/or sub-contractors are not presently excluded from participation in any federal or state funded health care programs,
   b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federal and state funded health care program, and/or
   c. its officers, employees, agents and/or sub-contractors are otherwise unlikely to be found by a federal or state agency to be ineligible to provide goods or services.
3. Contractor certifies it has reviewed, at minimum prior to hire or contract start date and monthly thereafter, the following lists in determining the organization nor its officers, employees, agents, and/or sub-contractors are not presently excluded from participation in any federal or state funded health care programs:
   a. OIG's List of Excluded Individuals/Entities (LEIE).
   b. United States General Services Administration's System for Award Management (SAM).
   c. California Department of Health Care Services Suspended and Ineligible Provider (S&I) List, if receives Medi-Cal reimbursement.
4. Contractor certifies that it shall notify DBH SUDRS Administration immediately (within 24 hours) by phone and in writing within ten (10) business days of being notified of:
   a. Any event, including an investigation, that would require Contractor or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federal or state funded health care programs, or
   b. Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federal or state funded healthcare program payment may be made.

Edward Hacket
Printed name of authorized official



Signature of authorized official

3/13/2025
Date

ATTACHMENT II

DATA SECURITY REQUIREMENTS

Pursuant to its contract with the State Department of Health Care Services, the Department of Behavioral Health (DBH) requires Contractor adhere to the following data security requirements:

A. Personnel Controls

1. Formal Policies and Procedures. Policies and procedures must be in place to reasonably protect against unauthorized uses and disclosures of patient identifying information and protect against reasonably anticipated threats or hazards to the security of patient identifying information. Formal policies and procedures must address 1) paper records and 2) electronic records, as specified in 42 CFR §2.16.
2. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of DBH, or access or disclose DBH Protected Health Information (PHI) or Personal Information (PI) must complete information privacy and security training, at least annually, at Contractor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.
3. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.
4. Confidentiality Statement. All persons that will be working with DBH PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The Statement must be signed by the workforce member prior to accessing DBH PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DBH inspection for a period of six (6) years following termination of the Agreement.
5. Background Check. Before a member of the workforce may access DBH PHI or PI, a background screening of that worker must be conducted. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years.

B. Technical Security Controls

1. Workstation/Laptop Encryption. All workstations and laptops that store DBH PHI or PI either directly or temporarily must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by DBH's Office of Information Technology.
2. Server Security. Servers containing unencrypted DBH PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.
3. Minimum Necessary. Only the minimum necessary amount of DBH PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

4. Removable Media Devices. All electronic files that contain DBH PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes, etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

5. Antivirus / Malware Software. All workstations, laptops and other systems that process and/or store DBH PHI or PI must install and actively use comprehensive anti-virus software / Antimalware software solution with automatic updates scheduled at least daily.

6. Patch Management. All workstations, laptops and other systems that process and/or store DBH PHI or PI must have all critical security patches applied with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release. Applications and systems that cannot be patched within this time frame due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Application and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.

7. User IDs and Password Controls. All users must be issued a unique user name for accessing DBH PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed at least every ninety (90) days, preferably every sixty (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

   a. Upper case letters (A-Z)

   b. Lower case letters (a-z)

   c. Arabic numerals (0-9)

   d. Non-alphanumeric characters (special characters)

8. Data Destruction. When no longer needed, all DBH PHI or PI must be wiped using the Gutmann or U.S. Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing and in accordance with 42 C.F.R. § 2.16 Security for Records. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of DBH's Office of Information Technology.

9. System Timeout. The system providing access to DBH PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than twenty (20) minutes of inactivity.

10. Warning Banners. All systems providing access to DBH PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

11. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DBH PHI or PI, or which alters DBH PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If

DBH PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three (3) years after occurrence.

12. Access Controls. The system providing access to DBH PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.
13. Transmission Encryption. All data transmissions of DBH PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing DBH PHI can be encrypted. This requirement pertains to any type of DBH PHI or PI in motion such as website access, file transfer, and E-Mail.
14. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DBH PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

C. Audit Controls

1. System Security Review. Contractor must ensure audit control mechanisms that record and examine system activity are in place. All systems processing and/or storing DBH PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.
2. Log Review. All systems processing and/or storing DBH PHI or PI must have a routine procedure in place to review system logs for unauthorized access.
3. Change Control. All systems processing and/or storing DBH PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

D. Business Continuity/Disaster Recovery Controls

1. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of DBH PHI or PI held in an electronic format in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.
2. Data Backup Plan. Contractor must have established documented procedures to backup DBH PHI to maintain retrievable exact copies of DBH PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DBH PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DBH data.

E. Paper Document Controls

1. Supervision of Data. DBH PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DBH PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

2. Escorting Visitors. Visitors to areas where DBH PHI or PI is contained shall be escorted and DBH PHI or PI shall be kept out of sight while visitors are in the area.
3. Confidential Destruction. DBH PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing and in accordance with 42 C.F.R. § 2.16 Security for Records.
4. Removal of Data. Removal of DBH PHI or PI may not be removed from the premises of Contractor unless authorized under 42 CFR Part 2.
5. Faxing. Faxes containing DBH PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.
6. Mailing. Mailings containing DBH PHI or PI shall be sealed and secured from damage or inappropriate viewing of such PHI or PI to the extent possible.

   Mailings which include 500 or more individually identifiable records of DBH PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DBH to use another method is obtained.

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

REQUIREMENTS FOR DAY TREATMENT INTENSIVE AND DAY REHABILITATION

A. Contractor shall request from the County Department of Behavioral Health (DBH) payment authorization for day treatment intensive and day rehabilitation services:

   1. In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.

   2. At least every three months for continuation of day treatment intensive.

   3. At least every six months for continuation of day rehabilitation.

   4. For mental health services, as defined in California Code of Regulations (CCR), Title. 9, § 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in CCR, Title 9, § 1810.216 and § 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.

B. Contractor shall meet the requirements of CCR, Title 9, §§ 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352 in providing day treatment intensive and day rehabilitation.

C. Contractor shall include, at a minimum, the following day treatment intensive and day rehabilitation service components:

   1. Community Meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and clients. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that clients or staff wishes to discuss to elicit support of the group and conflict resolution. Community meetings shall:

      a. For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.

      b. For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; and a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.

   2. Therapeutic Milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving clients in the overall program. For example, clients are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes 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 well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

   3. Process Groups. These groups, facilitated by staff, shall assist each client to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

4. Skill-Building Groups. In these groups, staff shall help clients identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients identify skills that address symptoms and increase adaptive behaviors.

5. Adjunctive Therapies. These are therapies in which both staff and clients participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed toward achieving client plan goals. Adjunctive therapies assist the client in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the client's needs identified in the client plan.

D. Day treatment intensive shall additionally include:

1. Psychotherapy. Psychotherapy means the use of psychological methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

2. Mental Health Crisis Procedure. Contractor shall develop and adhere to its established procedure for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified 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 (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the client is linked to an outside crisis service.

3. Written Weekly Schedule. Contractor shall ensure that a weekly detailed schedule is available to clients and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

E. Staffing Requirements. Staffing ratios shall be consistent with the requirements in CCR, Title 9, § 1840.350, for day treatment intensive, and CCR, 9, § 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

1. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).
2. Contractor shall ensure that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.
3. Contractor shall maintain documentation that enables DBH and the Department of Health Care Services to audit the day treatment intensive and day rehabilitation program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). Contractor shall ensure that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

F. If a client is unavoidably absent and does not attend all of the scheduled hours of the day rehabilitation or day treatment intensive program, Contractor shall receive Medi-Cal reimbursement only if the client is present for at least 50 percent of scheduled hours of operation for that day. Contractor shall enter a separate entry in the client record documenting the reason for the unavoidable absence and the total time (number of hours and minutes) the client actually attended the program that day. In cases where absences are frequent, it is the responsibility of Contractor to ensure that it re-evaluates the client's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

G. <u>Documentation Standards.</u> Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in this Contract and Attachment. The documentation shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the client actually attended the program. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist, or a registered nurse who is either staff to the day treatment intensive program or the person directing the services.

H. Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult clients may decline this service component. The contacts should focus on the role of the support person in supporting the client's community reintegration. Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

I. <u>Written Program Description.</u> Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. DBH shall review the written program description for compliance with this section <u>prior to</u> the date the Contractor begins delivering day treatment intensive or day rehabilitation.

Docusign Envelope ID: DCB07BE2-0088-4CD5-AB3B-B40245015FD1

J. Additional higher or more specific standards. DBH retains the authority to set additional higher or more specific standards than those set forth in this Contract, provided DBH's standards are consistent with applicable State and Federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.

K. Continuous Hours of Operation. Contractor shall apply the following when claiming for day treatment intensive and day rehabilitation services.

1. A half day shall be billed for each day in which the client receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

2. A full-day shall be billed for each day in which the client receives face-to- face services in a program with services available more than four hours per day.

3. Although the client must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the client.

4. The requirement for continuous hours or operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.