FIRST AMENDMENT TO STANDARD CONTRACT
BETWEEN COUNTY OF SOLANO AND CAMINAR, INC.

This First Amendment is made on April 7, 2020, between the COUNTY OF SOLANO, a political subdivision of the State of California ("County") and Caminar, Inc. ("Contractor").

1. Recitals

A. The parties entered into a contract dated July 1, 2019 (the "Contract"), in which Contractor agreed to provide Full Service Partnership services to Solano County adults with severe mental illness.

B. The County now needs to modify the Scope of Work and Budget of the Contract.

C. This First Amendment represents an increase of $205,839 of the Contract.

D. The parties agree to amend the Contract as set forth below.

2. Agreement

A. Term of the Contract
July 1, 2019 up to June 30, 2020

B. Amount of Contract
Section 3 is deleted in its entirety and replaced with: "The maximum amount of this Contract is $1,442,675."

C. Scope of Work
Exhibit A is deleted in its entirety and replaced with Exhibit A, attached to and incorporated by this reference.

D. Budget
(1) Exhibit B is deleted in its entirety and replaced with Exhibit B, attached to and incorporated by this reference.

(2) Exhibit B-1 is deleted in its entirety and replaced with the Budget attached to and incorporated by this reference as Exhibit B-1-1.

(3) Should the novation clause be invoked, the total amount of this Contract may be increased by up to $360,669.

3. Effectiveness of Contract

Except as set forth in this First Amendment, all other terms and conditions specified in the Contract remain in full force and effect.

COUNTY OF SOLANO, a Political Subdivision of the State of California

By_____
Birgitta E. Corsello
County Administrator

APPROVED AS TO FORM

By Daniel Wolk
County Counsel

CONTRACTOR

By Mark Cloutier
Mark Cloutier, CEO

APPROVED AS TO CONTENT

By Gerald Huber
Gerald R. Huber, Director
Health and Social Services Department

EXHIBIT A
SCOPE OF WORK

I. PROGRAM DESCRIPTION

Contractor will provide Full Service Partnership (FSP) services for the County. The FSP program is designed for adults 18 years and older who have been diagnosed with a severe mental illness and who are currently at risk of, or have recently been at risk of the following: hospitalization, homelessness, involvement with the criminal justice system, incarceration or are part of an unserved/underserved population. FSP services are intensive in nature and delivered by a multidisciplinary team to support consumers in becoming more independent and integrated within the community.

The FSP program is outlined in the Solano County Mental Health Services Act (MHSA) Integrated Three-Year Plan for Fiscal Year 2017/18.

II. CONTRACTOR SHALL BE RESPONSIBLE FOR THE FOLLOWING:

1. PROGRAM SPECIFIC ACTIVITIES

A. Contractor will provide FSP intensive services to a caseload of 66 adult consumers open/active at any one time during FY2019/20 (prorated post amendment effective April 1, 2020).

B. In collaboration with the County, ensure that all FSP meet the eligibility criteria as outlined in California Welfare and Institutions Code section 5600 (a), (b) and (c). and California Code of Regulations (Cal. Code Regs.), title 9, section 3621.05.

C. Program Referrals will be determined in collaboration with the Adult Transitions In Care (TIC) Committee held weekly in collaboration with the County and other mental health service providers.

D. For consumers who are already open to the MHP ensure that upon receiving written referral, contact consumer as soon as reasonably possible but no more than 2 working days. In the event that this timeline cannot be met, the Contractor will notify the appointed the County designee within two (2) working days.

E. Provide intensive FSP services utilizing the Assertive Community Treatment (ACT) model to include:

i. Use of a multi-disciplinary team to include case managers, nursing, psychiatry, peers providers, and providers specializing in co-occurring disorders and employment (i.e., may be part of larger SUD or IPS teams through matrix supervision);

ii. Maintain caseloads of 10-12 consumers (this applies to clinicians, case managers/specialist, assistant case managers, and peer specialists);

iii. Promote independence, rehabilitation, community integration, and recovery;

iv. Provision of services in the home and community;

v. Provision of support and services 24/7, 365 days of the year; i.e. use of afterhours warm line;

vi. Utilize a team approach in working with consumers;

vii. Hold a daily team meeting to engage in treatment planning and crisis response;

viii. Utilize the TMACT as a guide to implement the model and self-assess for model fidelity;

ix. Participate in regular Fidelity Evaluation process that includes preparation for the review, being available for two days for external trainers/reviewers visiting team on site, and responding to fidelity evaluation report and recommended changes for improving fidelity annually. Fidelity tracking tools and training resources will be provided by the County.

F. In addition to utilizing the ACT model, the following the following evidenced-based treatment models may be utilized, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Housing First Model and Harm Reduction.
G. Services are provided Monday – Friday 8:30am to 5pm, in addition to a warm line service offered to all consumers for after hours and weekend support 24/7, 365 days of the year.
H. Services will include:
Direct treatment (1:1 therapy, rehab services, groups, collateral support, family therapy, etc.);
    i. Psychiatric medication management and support;
    ii. Nursing support;
    iii. Peer counseling;
    iv. Targeted case management;
    v. FSP support services.
I. Contractor will provide intensive treatment and case management services and the frequency of service shall be consistent with the County's FSP service frequency model. Any changes regarding frequency delivery shall be agreed upon with the County Contract Manager. In general FSP clients should receive 3 contacts with each client per week of which at least 1 contact must be face-to-face by a member of the interdisciplinary team.
J. Provide or ensure linkage to medical care, substance abuse treatment, vocational rehab, educational support (as appropriate), and housing supports.
K. Contractor will provide daily living skills, budget management skills, problem solving skills, conflict resolution skills, symptom management skills, medication management skills, and transportation education and support.
L. Each client will be assigned a Primary Service Coordinator (PSC) who is licensed or license eligible.
M. All FSP consumers will be followed by a Contractor psychiatrist unless program participant decides to use other psychiatric medical provider.
N. Open all partnerships into Avatar Admissions and provide all data elements.
O. Contractor will enter pre-enrollment and post-enrollment participant information into the State of California Data Collection Report (DCR), including:
    i. Initial "Partnership Assessment Form" to be completed at the admission to the FSP program.
    ii. "Quarterly Assessment Form" to be completed on a quarterly basis correlating with the consumer's admission date to an FSP.
    iii. "Key Event Tracking Form" to be completed whenever there is a significant event that requires reporting. The KET is also used to discharge consumers from FSP.
P. Establish an Individual Supports and Services Plan for each person enrolled in a FSP.
Q. Develop a Crisis Management Plan for each FSP client using the form or process determined in collaboration with the County.
R. Develop a WRAP plan with each consumer provided the consumer is actively involved in treatment.

2. GENERAL ACTIVITIES

While providing the specific activities, Contractor agrees to:

A. Provide mental health services that are strengths-based, person-centered, safe, effective, timely and equitable, supported by friends, family, and the community; with an emphasis on promoting whole health, wellness and recovery.
B. Ensure that service frequency is individualized and based upon best practices related to the need of each beneficiary and in accordance with the Solano County Mental Health Plan (MHP) level of care system.

C. Make coordination of service care an integral part of service delivery which includes providing education and support to beneficiaries/family members as well as consulting with community partners including but not limited to: other behavioral health service providers; physical care providers; schools (if appropriate); etc.
D. Maintain documentation/charting according to industry standards and strengths-based best practices. For all beneficiaries entered into the Solano County MHP electronic health record, Contractor shall adhere to documentation standards set forth by the MHP in accordance with Solano Behavioral Health trainings, practices and documentation manuals.
E. Ensure that direct clinical services are provided by licensed, registered or waivered clinicians or trained support counselors or peer specialists.
    1. Assessment activities and clinical treatment services (i.e., 1:1 therapy, family therapy, and group psychotherapy) can only be provided by licensed or registered clinicians.
    2. "Other Qualified Providers", such as mental health specialist level staff or peer specialists, are authorized to bill for Medi-Cal reimbursable mental health services, such as targeted case management, rehabilitative services, collateral, or plan development.
    3. If Contractor employs staff with less education than a BA in a mental health or social work field, and less experience than 2 years in a mental health related field, the Contractor will provide and document training around any service activity for which the staff will be providing.
F. Supervise unlicensed staff in accordance with Medi-Cal and the applicable California State Board guidelines and regulations.
G. Utilize clinical outcome measures and level of care assignment tools prescribed by the County. Such measure and tools will remain in effect until County officially notifies Contractor of a change in practice. Contractor will work with County MHP Quality Improvement when implementing additional measures. County required measures include, but are not limited to:
    1. Adult Needs and Strengths Assessment (ANSA) – Beneficiaries ages 21+
    2. Child and Adolescent Needs and Strengths (CANS) – Beneficiaries age 0-20
    3. Pediatric Symptom Checklist (PSC-35) – Caregiver of beneficiaries 3-18
    4. Additional or replacement measures as allowed or determined by the County MHP.
H. Provide information (including brochures, postings in lobby, after-hours voicemail message, etc.) that communicates how mental health beneficiaries can access 24/7 services (e.g. suicide prevention Lifeline, crisis stabilization unit phone number) when medically necessary.
I. All media related to services provided through contract and provided to the public must include a reference to the Solano County Board of Supervisors, Health and Social Services and include the County logo; any programs also funded by the Mental Health Services Act as the sponsors must also include the MHSA logo.
J. Representatives from the Contractor organization must make efforts to attend the monthly local Mental Health Advisory Board meeting, and participate in the community planning stakeholder meetings, including those for the MHSA Annual Update or Three-Year Plan, planning for housing services, suicide prevention planning, etc.
K. MHSA-funded programs must participate in the quarterly MHSA Partner meeting, specific MHSA stakeholder planning meetings, etc.

3. PERFORMANCE MEASURES

Contractor agrees that services provided will achieve and will report quarterly on the following measures: FSP intensive services to a caseload of 66 adult consumers open/active at any one time during FY2019/20 (prorated post amendment effective April 1, 2020)

A. Contractor will serve a minimum of 66 _ consumers for FY2019/20 (prorated post amendment effective April 1, 2020).

B. Psychiatric hospitalizations: goal of no more than 25% of program participants will be admitted to the hospital for psychiatric treatment during each FY.
C. Legal Involvement: No more than 10% of program participants will have interactions with the legal system that result incarcerations per FY.
D. Homelessness: No more than 15% of FSP consumers will experience an episode of homelessness per FY.
E. Lower levels of care: 15% of consumers will be stepped down/graduate from the program during each fiscal year- consumers transitioning independently to the community.

4. REPORTING REQUIREMENTS

A. Contractor will collect, compile and submit monthly agreed upon contract deliverables and client demographic data by the 15th of each month unless granted an extension by the County Contract Manager or designee and be responsible for the following:

1. Submit the monthly service delivery data using the tool agreed upon with the County Contract Manager. Data required may include but is not limited to:
    a. Number of unduplicated individuals served;
    b. Qualitative outcomes agreed upon in this contract;
    c. Unduplicated count of beneficiaries served in each program activity.
2. Submit the monthly Demographic Report Form to include demographic categories determined by MHSA regulations, which include:
    a. Age group;
    b. Race;
    c. Ethnicity;
    d. Primary Languages;
    e. Sexual orientation;
    f. Gender assigned sex at birth;
    g. Current gender identity;
    h. Disability status;
    i. Veteran status.

B. Contractor will prepare an annual narrative of program activities, submitted by July 15th of each contract year. The following information will be included:

1. Overall program outcome tools used to capture impact of services for consumers or participants served;
2. Overall program milestones/successes and challenges/barriers;
3. Program efforts to address cultural and linguistic needs of service recipients;
4. A program success story.

C. Contractor will prepare a quarterly evaluation of program activities, submitted by September 15th, January 15th, April 15th and July 15th of each contract year including aggregated data and narrative reports on program deliverables. The contract liaison will provide templates and discuss content. The following information should be included:

5. Compilation of all biannual/annual data
6. Narrative of collaborative aspects of the program, if applicable

7. Agreed upon client outcomes and benchmarks for success
8. Any challenges or barriers to the provision of services

5. CONTRACT MONITORING MEETINGS

Contractor shall ensure at least one member of the leadership team is available to meet with the County Contract Manager or designee for monthly check-in technical assistance meetings. Additionally, Contractor shall ensure that staff providing program oversight and management attend the quarterly performance review meeting as scheduled by the County to review the SOW and to discuss performance measures, fiscal expenditures, and clinical progress of program participants as appropriate per contract.

6. PATIENT RIGHTS

A. Patient rights shall be observed by Contractor as provided in Welfare and Institutions Code section 5325 and Title 9 of the California Code of Regulations, HITECH, and any other applicable statues and regulations. County's Patients' Rights advocate will be given access to beneficiaries and facility personnel to monitor Contractor's compliance with said statutes and regulation.

B. Freedom of Choice: County shall inform individuals receiving mental health services, including patients or guardians of children/adolescents, verbally or in writing that:

1. Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
2. They retain the right to access other Medi-Cal or Short-Doyle/Medi-Cal reimbursable services and have the right to request a change of provider or staff persons.

7. CULTURAL & LINGUISTIC RESPONSIVITY

Contractor shall ensure the delivery of culturally and linguistically appropriate services to beneficiaries by adhering to the following:

A. Contractor shall provide services pursuant to this Contract in accordance with current State Statutory, regulator, and Policy provision related to cultural and linguistic competence as defined in California State Department of Mental Health (DMH) Information Notice No: 97-14, "Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements," and the Solano County Mental Health Plan Cultural Competence Policy. Specific statutory, regulatory, and policy provisions are referenced in Attachment A of DMH Information Notice No: 97-14, which is incorporated by this reference.

B. Agencies which provide mental health services to Medi-Cal beneficiaries under Contract with Solano County are required to participate as requested in the development and implementation of specific Solano County Cultural Responsivity Plan provisions. Accordingly, Contractor agrees at minimum:

a. Utilize the national Culturally and Linguistically Appropriate Services (CLAS) standards in Health Care under the QA/QI agency functions and policy making. For more information on the CLAS standards please refer to the following link https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 .
b. Contractors will use the agency Cultural Responsivity Plan developed during the FY19/20 to guide practices and policies in order to ensure culturally and linguistically appropriate services delivery.

a. The agency Cultural Responsivity Plan shall be reviewed and updated at least annually, and a copy submitted to County Quality Improvement by July 30th of each Fiscal Year for the current Fiscal Year.
b. Contractor will submit a revised plan if County determines the plan to be inadequate or not meeting fidelity to the CLAS standards.

3. Develop and assure compliance with administrative and human resource policy and procedural requirements to support the intentional outreach, hiring, and retention of a diverse workforce;
4. Provide culturally sensitive service provision and staff support/supervision, including assurance of language access through availability of bilingual staff or interpreters and culturally appropriate evaluation, diagnosis, treatment and referral services.

C. Contactor will ensure agency representation for the County Cultural Competency Committee held monthly in order to stay apprised of – and inform – strategies and initiatives related to equity and social justice as informed by the goals included in the County Cultural Responsivity Plan and Annual Updates.

1. Assign an agency staff member designated to become an active committee member attending meetings consistently. Designee will be required to complete the *Cultural Competency Committee Participation Agreement* form.
2. Make an effort to ensure that the designated representative can also participate in ad hoc sub-committee meetings scheduled as needed to work on specific initiatives related to goals in the Cultural Responsivity Plan.
3. Identify a back-up person to attend committee meetings in the absence of designated person.

D. Provision of services in Preferred Language:

1. Contractor shall provide services in the preferred language of the beneficiary and/or family member with the intent to provide linguistically appropriate mental health services per ACA 1557 45 CFR 92, nondiscrimination in healthcare programs. This may include American Sign Language (ASL). This can be accomplished by a bilingual clinician or the assistance of an interpreter. The interpreter may not be a family member unless the beneficiary or family expressly refuses the interpreter provided;
2. Contractor may identify and contract with an external interpreter service vendor, or may avail themselves to using the vendor provided and funded through Solano County Health and Social Services.
3. Contractor shall ensure that interpretation services utilized for communications or treatment purposes are provided by interpreters who receive regular cultural competence and linguistic appropriate training. Training specifically used in the mental health field is recommended.
4. Contractor shall ensure that all staff members are trained on how to access interpreter services used by the agency;
5. Contractor will provide informational materials as required by Section 9.D below, legal forms and clinical documents that the beneficiary or family member may review and/or sign shall be provided in the beneficiary/family member's preferred language whenever possible.
6. Contractor shall at a minimum provide translation of written informing materials and treatment plans in the County's threshold language of Spanish as needed for beneficiaries and/or family members.

E. Cultural Competence Training:

1. Contractor shall ensure that all staff members including direct service providers, medical staff, administrative/office support, recreation staff, and leadership complete at least one training in cultural competency per year.

    a. On a monthly basis, Contractor shall provide County Quality Improvement with an updated list of all staff and indicate the most date of completing Solano MHP approved Cultural Competence Training. Evidence, including sign-in sheets based on organizational charts, of Contractor staff receiving Cultural Competence training, should also be provided to County Quality Improvement at that time.

F. Contractor will participate in County and agency sponsored training programs to improve the quality of services to the diverse population Solano County.

8. QUALITY IMPROVEMENT ACTIVITIES

A. Regulation changes that occur during the life of this agreement:

1. If/When Federal and/or State agencies officially communicate changes/additions to current regulations, County will communicate new expectations via County QI Information Notice, and Such requirements will supersede contractual obligations delineated in this agreement.

B. Medi-Cal Certification:

1. If the Contractor has Medi-Cal claiming programs, then Contractor will meet and maintain standards outlined on the most up-to-date DHCS Certification Protocols, as well as any standards added by the County through the most recent Behavioral Health Division policy.2. Contractor shall inform County of any changes in Contractor status, including changes to ownership, site location, organizational and/or corporate structure, program scope and/or services provided, Clinical Head of Service.

C. Contractor will communicate any such changes within 60 days to County Improvement, utilizing the most up-to-date version of the *Solano County Behavioral Health Division Medi-Cal Certification Update Form*, Staff Credentialing:

1. Contractor shall adhere to credentialing and re-credentialing requirements as stipulated in Department of Health Care Services MHSUDS Information Notice 18-019;

2. All Contractor staff providing services that are entered into the County billing and information system must have the staff names and other required information communicated to County Quality Improvement using County Staff Master form;

3. Contractor shall provide County MHP Quality Improvement with a monthly updated list of Contractor staff by the date provided by the MHP Quality Improvement;

4. Contractor shall not employ or subcontract with any provider excluded from participation in Federal health care programs;

5. Contractor shall notify County Quality Improvement when a staff provider will be terminating and shall demonstrate a good faith effort to notify in writing all individuals who were actively receiving services of the termination within 15 calendar days of receiving the terminations notice from the staff.

D. Access:

1. Contractor must 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 Contractor only serves Medi-Cal beneficiaries, Contractor must provide hours of operation comparable to the hours the Contractor makes

available for Medi-Cal services that are not covered by the contract or another Mental Health Plan;

2. Contractor must meet the state standards for timely access to care and services, taking into account the urgency of need for services. If there is a failure to comply with timely access requirements, corrective action can and will take place;

a. Contractor will ensure that upon receiving written referral or request for service, Contractor will contact beneficiary within 1-2 business days.

b. For urgent service requests, Contractor will offer an assessment appointment that is 3 business days from date of service request from Solano MHP.

c. For routine service appointments, Contractor will offer an assessment appointment within 10 business days from the date of service request form Solano MHS. In the even that this timeline cannot be met:

i. Notification: Contractor will notify the appointed County Contract Manager or the County designee within one business day for Urgent referrals and within two business days for Routine referrals.

ii. NOABD: For beneficiaries with Medi-Cal insurance who are not offered an assessment appointment within 10 business days, a Notice of Adverse Benefit Determination (NOABD) will be completed and sent to the beneficiary and County Quality Improvement in accordance with Solano MHSA guidelines.

d. If Contractor provides psychiatric medication services, Psychiatry appointments (for both adult and children/youth) must be offered to Medi-Cal beneficiaries within 15 business days from the day the beneficiary or provider acting on behalf of the beneficiary, requests a referral for a medically necessary service. Appointment data must be recorded, tracked and submitted to the County Quality Improvement Unit monthly.

3. If Contractor acts as a "point of access" for Solano MHP, the Contractor will utilize the County's electronic health record "Access Screening and Referral" form to screen all new beneficiaries requesting services directly from the Contractor.

4. Contractor will provide staff to work with County Quality Improvement to make multiple (no less than four) test calls for the County businesses and after-hours access telephone line, during one month per fiscal year.

5. Contractor will monitor internally the Contractor's timeliness in terms of responding to requests for service, as indicated above in the "Access" section of this contract. Contractor will review timeliness with County Contract Manager, or designee on a regular basis. Failure to demonstrate consistent adherence to these timeliness standards may result in an official Plan of Correction being issued to the Contractor.

6. Once Contractor initiates the Assessment process with the client (Assessment Start Date), Contractor shall complete and finalize the Assessment and Client Plans for that client as evidenced by provider signature, credential, NPI number, and date, within 10 business days of the Assessment Start Date.

a. Contractor shall only initiate treatment services after the Assessment and Client Plan are completed and finalized. Exceptions include Targeted Case Management for linkage, Crisis Intervention, and urgent Medication Support services, when documentation supports utilization prior to client plan approving these interventions.

b. Contractor shall initiate non-urgent, non-psychiatric treatment services within 10 business days of Assessment/Client Plan completion date.

E. Service Authorization

1 . Per County Behavioral Health Division policy AAA219 – Authorization Standards, Contractor will request prior authorization from the County for the following services:

i. Intensive Home-Based Services
ii. Day Treatment Intensive
iii. Day Rehabilitation
iv. Therapeutic Behavioral Services (TBS)
v. Therapeutic Foster Care (TFC)

2. Also, per County Behavioral Health Division policy AAA219 – Authorization Standards, Contractor will demonstrate medical necessity via a County initiated Quality Review of a client's assessment and client plan prior to providing the following services for which prior authorization is not permitted:

i. Crisis Intervention
ii. Crisis Stabilization
iii. MH Services
iv. Targeted Case Management (TCM)
v. Intensive Care Coordination (ICC)
vi. Medication Support Services

F. Informing Materials:

2. Informing materials include Solano County MHP Guide to Mental Health Services, Provider Directory, Problem Resolution forms, notices of service denial or termination.
3. Contractor shall ensure that informing materials are printable and given to those requesting services within 5 business days.
4. Contractor shall ensure that Informing Materials are made available in County threshold language of Spanish, and alternative formats (audio and large font).
5. Contractor shall provide written taglines communicating the availability of written translations or oral interpretation in specific other languages.
    a. A hardcopy page of taglines in all prevalent non-English languages in the State of California, as provided by County MHP Quality Improvement, must be attached to all written materials provided to those requesting services.
    b. A hard-copy page of taglines must also be available in large print (font no smaller than 18 pt.) for those with visual impairments.

G. Notice of Adverse Benefit Determination:

6. Contractor shall provide an individual requesting services with a Notice of Adverse Benefit Determination (NOABD) [formerly referred to as NOA-A and NOA-E], per County MHP's Policy and Procedure AAA201 Notices of Adverse Benefits Determination Requirements under the following circumstances:
    a. The denial, limited authorization, or modification of a requested service, including determinations based on the type or level of service, based on the type or level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
    b. The failure to provide services in a timely manner (within 10 business days from point of access to initial assessment);
    c. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

H. Contractor shall maintain medical records in such a manner that all required documentation for every beneficiary is stored in a secure medical record. Additionally, documentation will be completed with an emphasis on both timeliness and clinical accuracy, in order to establish medical

necessity for all specialty mental health services provided by the Contractor, as outlined in Solano County Behavioral Health Quality Improvement documentation trainings and manual.

7. Only one assessment and treatment plan covering the annual service period is necessary to justify medical necessity for services. If another program is the Primary Service Coordinator and has completed and assessment and treatment plan, Contractor will utilize the already completed documentation to establish medical necessity for treatment or complete a brief update to any area in need of supplemental information.
8. Required documentation includes, but is not limited to, the following:
    a. Informing Materials;
    b. Clinical Behavioral Health Assessment;
    c. Beneficiary Treatment Plan;
    d. Service Authorization (when/if preauthorization is required);
    e. General Consent for Treatment;
    f. Medication Consent;
    g. Authorizations to Release Medical Records;
    h. Acknowledgement of Receipt of Notice of Privacy Practices;
    i. Notices of Action (if applicable, must be sent to Quality Improvement within 5 business days).

I. Quality Review of MH Assessments and Client Plans:

9. Contractor shall coordinate with County Quality Improvement, once the contractor has established medical necessity for a client's care, to provide an Assessment, Beneficiary Treatment Plan, and any other relevant documents deemed necessary by County prior to providing planned services.
10. Contractor will respond to County Quality Improvement's request for clinically amended documentation and resubmit documentation within 5 business days of receiving County's request in order to complete the Clinical Quality Review process.

J. Problem Resolution:

11. Contractor shall adopt and implement the County Health and Social Services Department, Behavioral Health Division's Problem Resolution process.
    a. The County Problem Resolution process include Grievance, Appeal, and Expedited Appeals, as stipulated in County policy *ADM141 Beneficiary Problem Resolution Process – Grievances, ADM142 Beneficiary Problem Resolution Process – Appeals, ADM143 Beneficiary Problem Resolution Process – Expedited Appeals, ADM132 Request to Change Service Provider, AAA210 Beneficiary Right of a Second Opinion, and Mental Health Services Act Issues.*
12. Contractor duties regarding Problem Resolution include, but are not limited to, the following:
    a. Contractor shall post County notices and make available County forms and other materials informing beneficiaries of their right to file a grievance and appeal. Required materials include the following brochures: "Beneficiary Rights & Problem Resolution Guide", "Appeal Form", "Compliment/Suggestion Form", "Grievance Form", "Request to Change Service Provider, and the "MHSA Grievance From". Contractor shall aid beneficiaries in filing a grievance when requested and shall not retaliate in any manner against anyone who files a grievance.

b. Contractor shall forward all Problem Resolution Process brochures written and completed by or on behalf of a beneficiary of the MHP to County Quality Improvement, immediately but no later than 24 hours from receipt, whether or not Contractor has resolved the problem.
c. Contractor shall provide "reasonable assistance" to individuals completing problem resolution forms, such as providing interpreting services and free access to TTY/TTD services.
d. Contractor shall communicate and collaborate directly with the County Quality Improvement Problem Resolution Coordinator to provide any additional information needed regarding any follow up actions to investigate/resolve the problem identified through the problem resolution process.
e. Contractor shall provide at no cost and sufficiently in advance of a resolution timeframe for appeals, information and the beneficiary may want to use to support the case, including parts of their medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Plan in connection with the appeal of adverse benefit determination.

J. Serious Incident Reports (SIRs):

13. Contractor will communicate the occurrence of serious incidents to the County by completing an official County Serious Incident Report form following the process outlined in County policy ADM-1.10 Serious Incident Reporting, including but not limited to the following:
    a. Contractor shall verbally notify County Quality Improvement immediately but not later than 4 hours after a serious incident;
    b. Contractor shall submit the SIR electronically to County Quality Improvement within 24 hours of the incident or sooner via Comply Track: website;
    c. Contractor shall communicate directly with the County Quality Improvement designee to provide any additional information needed regarding the reported incident;
    d. Contractor and County Behavioral Health Administration/Quality Improvement shall discuss and develop recommendations to achieve more desired outcomes in the future. An Adverse Outcome meeting may be scheduled, in which the contractor may need to attend, in order to discuss the SIR, interventions and recommendations for policy/program quality improvement;
    e. Data breaches or security incidents are required to be reported to both County Quality Improvement and County Health and Social Service Compliance Unit concurrently immediately upon discovery and no later than 24 hours.

K. Contractor Quality Improvement Process:

14. Contractor will establish and maintain an internal agency quality improvement and quality assurance process, including but not limited to the following:
    a. Internal Quality Improvement Work Plan – the plan will set goals around Access, Timeliness, Quality and Outcomes for the Contractor and will be evaluated at least annually. A new plan will be created annually, and a copy submitted to County Quality Improvement by July 30th of each Fiscal Year for the current Fiscal Year. Contractor will submit a revised plan if County determines the plan to be inadequate;

b. Internal review of Assessments/Plans – Contractor will internally review at least 25% of all Assessments and Treatment plans. A quarterly report will be sent to County Quality Improvement;
c. Internal review of provider progress notes – Contractor will internally review at least 10% of every provider's progress notes. A quarterly report will be sent to County Quality Improvement;
d. Monitoring safety and effectiveness of medication practices – if Contractor provides medication services, Contractor will establish official policy for monitoring medication practices, including operating a Medication Prescriber peer review process. Contractor policy will specifically address procedures Contractor utilizes to monitor prescribing to children and youth.

L. Quality Improvement Committee:

15. Contractor will provide a representative to participate in County quarterly Quality Improvement Committee (QIC).
16. If Contractor's place of business is not located within Solano County boundaries, Contractor's representative may request to participate remotely via conference call and/or or web-based interface.
17. Contractor will provide data related to objectives/goals outlined in the County Quality Improvement Plan in a timely fashion prior to quarterly QIC meeting as requested by the County designee.

M. Annual County review of Contractor service delivery site and chart audit:

18. County will engage in a site and chart review annually, consistent with practices outlined in the most up-to-date- version of the County *Mental Health Utilization Review Handbook*;
19. Contractor will provide all requested medical records and an adequate, private space in which for County staff to conduct the site review and chart audit;
20. If Contractor operates a fee-for-services program and the chart audit results in service disallowances, County will subtract the audit disallowance dollars from a future vendor claim, once County audit report is finalized;
21. County, State or Federal Officials have the right to audit for 10 years from any previous audit, therefore Contractor will retain records for 10 years from the completion of any audit.

N. Compliance Investigations:

22. At any time during normal business hours and as often as the County may deem necessary, Contractor shall make available to County, State or Federal officials for examination all of its records with respect to all matters covered by this Contract. Additionally, Contractor will permit County, State or Federal officials to audit, examine and make excerpts or transcripts from such records, and to make audits of all invoices, materials, payrolls, records of personnel, information regarding beneficiaries receiving services, and other data relating to all matters covered by this Contract.

O. Service Verification:

23. Contractor will submit an executed copy of Contractor Service Verification Policy once created and will provide County a copy of Contractor's revised policy any time policy is revised/updated;
24. Contractor policy will contain measures as strict or stricter than the current County policy QI620 Service Verification Requirements;
25. Contractor will provide evidence of following policy to Quality Improvement Service Verification Coordinator at intervals during the fiscal year as stipulated by County policy QI620.

P. Conflict of Interest – Expanded Behavioral Health Contract Requirements:

26. Contractor will abide by the requirements outlined in County policy ADM146 Disclosure of Ownership, Control and Relationship Information of Contracted Agencies, including but not limited to the following:
    a. Contractor will disclose the name of any person who holds an interest of 5% or more of any mortgage, deed of trust, not or other obligation secured by the Contractor to the County;
    b. Contractor will ensure all service providers receive a background check as a condition of employment as stringent as the County background policy requirements;
    c. Contractor will require any providers or any other person within the agency with at least a 5% ownership interest to submit a set of fingerprints for a background check;
    d. Contractor will terminate involvement with any person with a 5% ownership interest in the Contractor who has been convicted of a crime related to Medicare, Medicaid, or CFR title XXI within the last 10 years.

Q. Contractor will ensure that all Contractor staff, including administrative, provider, and management staff, receive formal Compliance training on an annual basis.

27. Contractor will provide evidence, including sign-in sheets, training syllabi, certificates of completion, and tracking sheets based on organizational charts, of Contractor staff receiving compliance training to County Quality Improvement annually by July 15th each Fiscal Year for the training the year prior.

R. Performance Data (1915b Waiver Special Terms and Conditions):

28. Contractor will provide County with any data required for meeting 1915b Waiver Special Terms and Conditions requirements communicated by California DHCS, within the timeline required by DHCS.

S. Utilization Management:

29. Contractor will work with the County Contract Manager to monitor the following Contractor efforts:
    a. Expected capacity to serve Medi-Cal Eligible beneficiaries;
    b. Expected service utilization;
    c. Number and types of providers needed in terms of training, experience and specialization;
    d. Number of Contractor providers not accepting new clients;
    e. Geographical location to beneficiaries in terms of distance, travel time, means of transportation typically used by beneficiaries, and physical access for disabled beneficiaries;
    f. Contractor ability to communicate with limited English proficient beneficiaries in their preferred language;

g. Contractor's ability to ensure: physical access; reasonable accommodations; culturally competent communications; accessible equipment for beneficiaries with physical or mental disabilities;
h. Available triage lines or screening systems;
i. Use of telemedicine or other technological solutions, if applicable.

30. Additional areas of monitoring include:
    a. Blocked billing due to missing treatment plans or MH diagnosis that results in lost revenue.

T. Performance Outcome Measures:

31. Adult
    a. Adult Programs will utilize Adult Needs & Strength Assessment (ANSA) measures, Reaching Recovery Measures, or another set of measures approved by County Contract Manager and County Quality Improvement for adult clients ages 18 and older. Frequency of reevaluation is determined by County Quality Improvement.
    b. Adult services contractors will also be required to complete a Child Adolescent Needs & Strengths (CANS) measure with any young adults, ages 18-20.
    c. Adult services contractors will also be required to request authorization from any 18 year old client to complete Pediatric Symptom Checklist (PSC-35) with the client's identified parent/caregiver. PSC-35 shall only be initiated if client authorizes the caregiver to participate in the treatment process.

32.

33. Child and Adolescent Services Providers:
    a. Child Adolescent Needs & Strengths (CANS) measures shall be used with all County beneficiaries 0-17 years old. Pediatric Symptom Checklist (PSC-35) shall be provided to the caregiver of any beneficiaries 3-17 years old. These measures shall be completed every six months.

34. Only one set of measures shall be completed at each required interval per beneficiary. The Primary Service Coordinator will administer the measures.
35. When actin as the Primary Service Coordinator, Contractor shall administer the CANS and PSC-35measures at the required intervals of initial assessment, every 6 months thereafter, and at discharge from treatment.
36. Primary Service Coordinators and Treatment planning teams shall use Outcome measure data to determine treatment progress, areas of treatment focus, and level of care.
37. Contractor shall manually data enter or submit a data upload of CANS and PSC-35 data monthly by the deadline established by County MHP Quality Improvement.

U. Network Adequacy Certification:

38. Contractor must submit network adequacy data to the County at a frequency (either quarterly or monthly), in a manner and format determined by the County, by or before deadlines officially communicated to the Contractor by County Quality Improvement Unit.

39. Contractor will maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered by this contract, per California MHSUDS Information Notice 18-011 (dated February 13, 2018).

V. Provider Directory:

40. Contractor will ensure that Contractor's Provider Directory captures various elements about their providers, including their license number and type, NPI, language(s), cultural capabilities, specialty, services, if the provider is accepting new beneficiaries, and any group affiliations.
41. Contractor will also ensure that the Provider Directory captures basic information about the facility where the provider serves beneficiaries to include address, telephone number, email address, website URL, hours of operation, and whether the providers' facility is accessible to persons with disabilities.
    1. Any changes to the Provider Directory must be reported to the County monthly per MHSUDS Info. Notice No. 18-020 (dated April 24, 2018) – Federal Provider Directory Requirements for Mental Health Plans (MHPs) and by deadlines established by the County.

W. Physical Accessibility Requirements:

42. Contractor must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.
43. County Quality Improvement will provide Physical Accessibility ratings for Contractor's facilities/offices during Medi-Cal certification site visits. Contractor's facilities/offices will be rated as having "Basic" or "Limited" accessibility for seniors and persons with disabilities.
    a. "Basic" access is granted when the facility/office demonstrates access for the members with disabilities to parking, interior and exterior building, elevator, treatment/interview rooms, and restrooms.
    b. "Limited" accessibility is granted when the facility/office demonstrates access for a member with a disability are missing or incomplete in on or more features for parking, building, elevator, treatment/interview rooms, and restrooms.
    c. If Contractor's facility/offices are given a "Limited" rating, a Plan of Correction will be issued.
44. If there is a change to the physical accessibility of the contracted agency/individual, it must be reported to the County via the County's MHP monthly Provider Directory update process.

X. Language Line Utilization:

45. Contracted agencies/individual must submit language line utilization data monthly detailing use of interpretation services for beneficiaries' face-to-face and telephonic encounters.
46. Language line utilization data submission should include (for each service encounter that required language line services):
    a. The reporting period;
    b. The total number of encounters requiring language line services;
    c. The language utilized during the encounter requiring language line services;
    d. The reason services were not provided by a bilingual provider/staff or via face-to-face interpretation.

47. Language line utilization data must be submitted to and as requested by County MHP Quality Improvement, using the template provided by the County MHP Quality Improvement and following the instructions contained on the reporting tool.

Y. Program Integrity:

48. Contractor shall ensure that contracted providers are enrolled through the State's Provider Enrollment process, following all requirements within Department of Health Care Services MHSUDS Information Notice 17-027.
49. Contractor must have a mechanism in place to report to the County when it has received an overpayment, to return the overpayment to the County within 45 calendar days after the date of the overpayment was identified, and to notify the MHP in writing of the reason for the overpayment.

5. CONFIDENTIALITY OF MENTAL HEALTH RECORDS

A. Contractor warrants that Contractor is knowledgeable of Welfare and Institutions Code section 5328 respecting confidentiality of any information regarding beneficiaries (or their families) receiving Contractor's services. Contractor may obtain such information from application forms, interviews, tests or reports from public agencies, counselors or any other source. Without the beneficiary's written permission, Contractor shall divulge such information only as necessary for purposes related to the performance or evaluation of services provided pursuant to this Contract, and then only to those persons having responsibilities under this Contract, including those furnishing services under Contractor through subcontracts.

B. Contractor and staff will be responsible for only accessing beneficiary data from the County's electronic health record for beneficiaries for which they have open episodes of care and for which individual staff have a specific business purpose for accessing. All attempts to access beneficiary data that do not meet those requirements will be considered data breaches and Contractor is responsible for reporting such breaches to County Quality Improvement and HSS Department Compliance unit immediately or within 4 hours of discovery.

C. In the event of a breach or security incident by Contractor or Contractor's staff, any damages or expenses incurred shall be at Contractor's sole expense.

III. COUNTY RESPONSIBILITIES

1. Provide technical assistances in the form of phone consultations, site visits and meetings to provide clinical guidance and address challenges in the clinical program, implementation and/or performance of the Contract SOW;
2. Provide training and technical assistance on the use of the Netsmart Avatar electronic health record system (only if vendor will be entering services into Avatar);

3. Assign a QI Liaison for programs under the MHP billing Medi-cal.

4. Provide feedback on performance measures objectives and fiscal expenditures in a timely manner to seek a proactive solution;
5. Provide tools and training support for the implementation of the ACT model to fidelity;
6. Make available electronically all policies and procedures referenced herein and inform the Contractor as policies are reviewed and updated so that the Contractor is aware of changes.

EXHIBIT B

BUDGET DETAIL AND PAYMENT PROVISIONS

1. METHOD OF PAYMENT

A. Upon submission of an invoice and a Solano County vendor claim by Contractor, and upon approval by County, County shall, in accordance with the "Contract Budget" attached to this Contract as Exhibit "B-1-1" and incorporated into this Contract by this reference, pay Contractor monthly in arrears for fees and expenses actually incurred the prior month, up to the maximum amount set forth in **Section 3 of the Standard Contract**. Monthly claims for payment should be submitted to County by the 15th day of the subsequent month.

B. Claims submitted by Contractor must meet the criteria set forth in section I.E and be documented by a fiscal monitoring report (Exhibit B-2). **Each invoice must specify actual charges incurred.**

C. Contractor must request prior written approval, which approval may be withheld at the sole and absolute discretion of County, for transfers between budget categories or the addition of line items within the operating expenses category, which are set forth in Exhibit B-1-1, when the cumulative amount of such transfers or additions exceed the lesser of $50,000 or 10% of the total Contract budget for the fiscal year. County may authorize the proposed transfers between budget categories or the addition of line items within a budget category under this section, except for personnel, subcontractors, indirect costs and capital expenditures (equipment or real property), provided that such transfers or additions do not substantially change the scope of services to be provided under this Contract and do not increase the Contract amount. Requests for transfers between budget categories or addition of budget line items within a budget category over the aforementioned threshold must be presented to the County on the County's "Budget Modification Request Form". Budget modifications below the threshold must be presented on Exhibit B-2 Fiscal Monitoring Report and submitted with the monthly vendor claim and invoice. Contractor is limited to two budget modifications per fiscal year which must be requested by May 31st.

D. Contractor must repay the County for any disallowed costs identified by County through monthly reports, audits, Quality Assurance monitoring, or other sources within thirty days of receipt of notice from County that the costs have been disallowed. Contractor agrees that funds to be disbursed under the terms of this Contract will be withheld if repayment is not received by the County within thirty days of receipt of notice from County. If the disallowance is related to a billable service, the disallowed amount will be calculated based on the vendor's interim Medi-Cal billing rate (Exhibit B-3). Contractor may submit a written appeal to a disallowance to the County Health and Social Services Behavioral Health Deputy Director, or designee, within fifteen days of receipt of a disallowance notice. The appeal must include the basis for the appeal and any documentation necessary to support the appeal. No fees or expenses incurred by Contractor in the course of appealing a disallowance will be an allowable cost under this Contract and will not be reimbursed by County. The decision of the County regarding the appeal will be final.

E. The following criteria apply to Contract Budget submitted by Contractor under this Contract:

1. Requests for payment of personnel costs must include positions, salary, and actual percentage of time for each position. If Contractor provides fringe benefits to part time employees, salary and fringe benefits must be pro-rated for non-full-time employees. Salaries are fixed compensation for services performed by staff who are directly employed by Contractor and who are paid on a regular basis. Employee benefits and employer payroll taxes include Contractor's contributions or expenses for social security, employee's life and health insurance plans, unemployment insurance, pension plans, and other similar expenses that are approved by County. **These expenses are allowable when they are included and in accordance with Contractor's approved written policies and allocation plan.**

2. Salaries and benefits of personnel involved in more than one contract, grant, or project must be charged to each grant based on the actual percentage of time spent on each grant or project. Timesheets and time studies for each employee whose time is charged to this Contract must be maintained by Contractor and available upon request by the County.

3. Allowable operating expenses are defined as necessary expenditures exclusive of personnel salaries, benefits, equipment or payments to subcontractors. The expenses must be to further the program objectives as defined in Exhibit A of this Contract and be incurred during the invoiced period. County reserves the right to make the final determination if an operating expense is allowable and necessary.

4. Indirect costs are shared costs that cannot be directly assigned to a particular activity but are necessary to the operation of the organization and the performance of the program. The costs of operating and maintaining facilities, accounting services and administrative salaries are examples of indirect costs. Contractor must use a negotiated indirect cost rate with a federal agency. A Contractor who does not have a negotiated indirect cost rate agreement may claim an indirect cost rate of up to 13% of modified total direct costs.

5. Regardless of whether Contractor claims indirect costs through a negotiated indirect cost rate, Direct Allocation Method or the 13% of modified total direct costs, Contractor must provide the County with a cost allocation plan that clearly differentiates between direct and indirect costs. Contractor ensures that the same costs that have been treated as indirect costs have not been claimed or budgeted as direct costs, and that similar types of costs in like circumstances have been accounted for consistently. Contractor will provide this plan to County upon request. In the event that Contractor is unable to provide County with an acceptable cost allocation plan, County may disallow any indirect cost billed amounts.

2. ACCOUNTING STANDARDS

A. Contractor shall establish and maintain a system of accounts for budgeted funds that complies with generally accepted accounting principles and practices for organizations/governmental entities as described in Exhibit C – section 13C. Additionally, Contractor must submit claims for payment under this Contract using either a cost allocation method or a direct allocation method.

B. Contractor's cost allocation method must be supported by a cost allocation plan with a quantifiable methodology validating the basis for paying such expenditures. The cost allocation plan should be prepared according to Department of Healthcare Services (DHCS) and cost report procedures.

C. Contractor shall document all costs by maintaining complete and accurate records of all financial transactions associated with this Contract, including, but not limited to, invoices, time studies, and other official documentation that sufficiently support all charges under this Contract.

3. PERSONAL PROPERTY

Contractor shall develop and maintain a system to track the acquisition of tangible personal property purchased with County funds having a cost of at least $1,500 and submit, upon County's request, an annual accounting of all such property purchased that includes information on cost and acquisition date. Contractor shall ensure adequate safeguards are in place to protect such assets and shall exercise reasonable care over such assets to protect against theft, damage or unauthorized use. Contractor shall, upon County's request, return such assets to the County upon Contract termination; unless the depreciated value of the asset is $0, based on a straight-line method of depreciation (refer to CFR part 200.436).

4. FINANCIAL STATEMENTS AND AUDITS

A. Contractor agrees to furnish annual audited financial statements to the County, which must be submitted within 30 days of its publication. If Contractor is not required by federal and/or state regulations to have an independent audit of its annual financial statements, Contractor agrees to furnish unaudited financial statements by September 1.

B. Contractor agrees to furnish all records and documents within a reasonable time, in the event that the County, State or Federal Government conducts an audit of the County and/or Contractor's services.

5. BILLING EXPECTATIONS

A. Prior to submitting an invoice for services rendered under this Contract, Contractor must determine if there are any available revenues from all possible sources other than the County that can be claimed for reimbursement for treatment of services provided under this Contract and submit claims for funding accordingly. Such revenues shall include, but are not limited to, Short Doyle Medi-Cal, patient fees, patient insurance, Medicare and payments from other third party payers. Contractor shall provide the County with the necessary payer financial information in a form and manner prescribed by the County so that all revenues can be claimed timely. Amounts of claims against other revenue sources which remain unpaid due to untimely, incomplete, or improper information received from the Contractor shall be recouped from the Contractor.

B. Determination of patient eligibility for coverage under Medicare and other reimbursement programs is the responsibility of the Contractor. County does not assume responsibility for such determination.

C. Contractor understands and agrees that Contractor and any subcontractors will bill Short Doyle Medi-Cal for services provided. The authorized billing codes are listed in Exhibit B-3 as Contract Billing Codes.

D. Contractor will enter services into Avatar, the County approved computerized billing system. County will provide Contractor access to Solano County's computerized billing system.
E. Contractor will submit adequate supporting documentation as to Medi-Cal services provided no later than sixty (60) days after the last day of the month in which those services were provided.
F. County will reconcile supporting documentation with the services in Avatar. Documentation not accurately reconciled to services entered into Avatar will be returned to the Contractor for corrections to be resubmitted within thirty (30) days.
G. Periodically, Contractor will meet with County to review Medi-Cal reimbursable units and any disallowances. The amount of disallowances identified from the Avatar will be deducted from a following months invoice provided that the disallowance was due to delays in Contractor providing County the necessary information for billing.

6. SUBMISSION OF COST REPORT

A. County will, at its discretion, schedule a cost report briefing in October of each fiscal year. Contractor will submit its cost report by the deadline set by the County. Contractor's cost report must be complete, accurate and formatted within the guidelines provided by the Solano County Health and Social Services Department.

B. If Contractor is currently out of compliance with the cost report's submission requirement, Contractor agrees that funds to be disbursed under the terms of this contract will be withheld until such time as Contractor submits an acceptable Cost report. County will not be liable for any interest that may accrue as a result of delay in payment caused by Contractor's failure to submit an appropriate Cost report.

C. If Contractor provides services to multiple counties, it must use the Net Cost Method, reporting only the costs (activities) directly attributable to County.

D. Contract will establish a tracking and reporting system to distinguish between expenditures for direct services and expenditures for client supports. DMH Letter No. 06-08, incorporated by this reference, outlines the need and definition of the new service function codes which have been added:
Service Function Code 70 – Client Housing Support Expenditures

Service Function Code 71 – Client Housing Operating Expenditures

Service Function Code 72 – Client Flexible Support Expenditures

Service Function Code 75 – Non-Medi-Cal Capital Assets

Service Function Code 78 – Other Non-Medi-Cal Client Support Expenditures

This information will be required at the same time that the annual cost report is due to the County.

EXHIBIT B-1-1
Caminar Full Service Partnership (FSP) Program
FY 2019-2020

Contract Budget Line Items	Salary	Projected FTE	Total Projected Cost
Personnel (Management and Admin Support)			
Regional Executive Director	$150,000	0.10	$ 36,967
Director of Services	$110,000	0.35	$ 22,493
Program Director	$80,000	0.50	$ 40,000
Assistant Program Director	$67,000	0.6	$ 40,200
Executive Assistant	$75,000	0.3	$ 22,500
Administrative Support	$75,000	0.09	$ 10,144
Administrative Assistant	$39,811	0.60	$ 23,887
Personnel (Direct Client Services)			
RN Manager	$109,824	0.525	$ 14,414
Registered Nurse	$89,980	0.50	$ 45,536
Nurse Practitioner	$132,000	0.31	$ 83,244
Licensed Vocational Nurse	$56,160	0.60	$ 8,424
Clinical Supervisor	$77,000	0.70	$ 13,475
Case Manager (BA Level)	$50,000	3.00	$ 150,000
Case Manager (Registered/Licensed)	$60,000	2.70	$ 130,500
Assistant Case Manager	$41,600	1	$ 41,600
Medical Doctor		0.28	$ 103,889
Warm Line			$ 4,985
Total Personnel Salary			**$ 792,258**
Benefits			$ 213,911
Subtotal Personnel			**$ 1,006,169**
Operating Expenses			
(Non-benefited Part-time Personnel)			
Psychiatrist		0.28	$ 38,275
Medical Director		0.28	$ 41,755
(Other Operating Expenses)			
IT Support			$ 17,049
Rent : Office			$ 32,580
Building, Maintenance/Supplies & Repairs			$ 6,000
Insurance Expense			$ 5,335

Utilities			$	5,000
Agency Vehicle and Insurance			$	3,000
Transportation and Travel			$	17,600
Equipment Rental			$	3,000
Equipment/Printers Purchase			$	500
Office Supplies			$	5,000
Postage, Shipping and Delivery			$	200
Printing and Publications			$	800
Communication			$	10,656
Staff Conference and Training			$	7,210
Memberships, Dues and Subscriptions			$	1,000
Screening / Certifications			$	3,000
Staff Recruitments / Advertising			$	3,000
(Direct Client Expenses)				
Client Rent			$	51,000
Client Activities and Expenses				$ 5,000
Sub-Contractor & Other Contracted Services				
Licensed Clinical Supervisor			$	11,480
Contracted Services			$	2,095
Subtotal Operating Expenses			**$**	**270,535**
Indirect Costs		**up to** 13%	**$**	**165,971**
Grand Total Expenses			**$**	**1,442,675**

EXHIBIT B-3
BILLING CODES

Avatar Service Code	Mode	Service Function Code	Description	Rate	Unit of Service
NOSHOW	15	0	Participant No Show	0.00	per minute
PRVCAN	15	0	Clinician Cancellation	0.00	per minute
CLTCAN	15	0	Participant Cancellation	0.00	per minute
90887I	15	10	Collateral	2.61	per minute
MEDEVAL	15	60	Medication Evaluation	4.82	per minute
H2010	15	60	Medication Support	4.82	per minute
90791	15	30	Assessment	2.61	per minute
H2015	15	40	Individual	2.61	per minute
H2017I	15	40	Individual Rehab	2.61	per minute
H0032	15	40	Plan Development	2.61	per minute
90853	15	50	Group	2.61	per minute
H2017G	15	50	Group Rehab	2.61	per minute
90887G	15	40	Collateral - Group	2.61	per minute
H0034	15	60	Medication Support & Education	4.82	per minute
H2011	15	70	Crisis Intervention	3.88	per minute
90882	15	1	Brokerage and Placement	2.02	per minute
99499	15	0	Non-Billable Treatment Services	0.00	per minute
T1017	15	1	Case Management Services	2.02	per minute
90847	15	40	Family Therapy w/client	2.61	per minute
MEDREFILL	15	60	Medication Refills (w/o contact)	4.82	per minute
FSPSVC	15	0	Full Service Partnership Client Services and Support	0.00	per minute
MHSVCLOCK	15	0	MH Service Provided in a Lockout Setting	0.00	per minute