EXHIBIT A

STATEMENT OF WORK

1. **PROGRAM SUMMARY.** The Assertive Community Treatment (ACT) Program, hereafter, "the Program," is an evidence-based psychiatric treatment, rehabilitation and support service for clients with serious mental illness who demonstrate the need for this most intensive level of nonresidential community service. The Program is designed for adults whose symptoms of mental illness cause, or create high risk for, the most substantial levels of disability and functional impairment. The Program will be headquartered at [location].

   The mission of the Program is to assist clients in attaining community stability and reaching their recovery and rehabilitation goals, including helping clients to find and keep employment.

   The Program provides a multidisciplinary team approach that includes a Psychiatrist, a mental health professional who serves as the Team Leader/Administrator, and other staff trained in the areas of social work, nursing, co-occurring substance abuse treatment, rehabilitation and peer support (hereafter 'the ACT Team"). Contractor's staff, in addition to the County psychiatrist and nursing staff, shall be responsible for providing virtually all needed community services to Program clients. This excludes: acute/sub-acute/residential or any other treatment not considered as "out-patient" services.

   The ACT Team shall also include County staff employed by the Santa Barbara County Department of Alcohol, Drug and Mental Health Services (ADMHS). The County staff (Psychiatrist and Nursing staff) will be responsible for providing the psychiatric treatment capacity for the Program. The Program including Contractor and County staff shall be available 24 hours per day, 7 days per week. Contractor shall follow the "National Program Standards for ACT Teams" (Allness and Knoedler, revised June 2003) disseminated by the National Alliance for Mental Illness (NAMI).

2. **PROGRAM GOALS**.

   A. Build relationships with clients based on mutual trust and respect.

   B. Offer individualized assistance. The Program shall emphasize an in-depth process of assessment, carried out over time through listening to and learning about each client's subjective experiences.

   C. Adopt a no-reject approach to clients. Clients are not terminated from the Program if they express anger and frustration with current or past services, if they do not "follow the rules," if they do not "fit in." Instead, such statements or actions offer an opportunity for staff to learn more about each client and his/her experiences with services, with the effects of mental illness and with general life circumstances.

   D. Understand and use the strengths of the local culture in service delivery. Assessment, planning and service delivery should be consistent with the resources and practices of each client's racial and ethnic community.

E. Provide continuity across time. The frequency and type of supports can readily be adjusted in response to clients' changing needs or life situations. As a client's goals and preferences change, the ACT Team follows along as the client "sets the pace."

F. Use a flexible, non-programmatic approach. Program staff shall spend most of their time with clients in the community, offering side by side, "hands on" support to clients who may need help to gain greater control and management of their lives. Adhering to the principle of "whatever it takes," the Program helps prevent mental illness from being the driving force in clients' lives. Service delivery in office or clinic settings should be minimized.

G. Operate as a comprehensive, self-contained service. The Program does not refer clients to a variety of different programs. Rather, Program staff are responsible for providing virtually all of the needed treatment, rehabilitation and support services for clients. If the services of another provider are needed (e.g., medical care), the ACT Team is responsible for providing linkage to and assistance with obtaining the needed services.

H. Consistent with each client's preferences and wishes, the Program shall support family members and others with whom the client has a significant relationship, and assure special consideration to the needs of clients who are parents and to the needs of their minor children.

I. Provide services as long as they are medically needed, not based on predetermined timelines.

3. **CLIENTS/PROGRAM CAPACITY.**

A. Due to the severity of their symptoms and functional issues, Program clients shall have significant need for treatment, rehabilitative and support services in order to live successfully in the community and achieve their individual recovery goals. These individuals often face multiple barriers to stable community living including: co-occurring substance abuse or dependence, homelessness, unemployment, criminal justice involvement, challenges with illness management, physical health concerns, frequent and persistent use of hospital emergency departments as well as inpatient psychiatric treatment.

B. Contractor shall provide the services described herein to a total of X adults ages 18 and over with serious mental illness.

4. **ADMISSION CRITERIA.** Clients shall be adults aged 18 and over who have:

A. Mental illness symptoms that seriously impact their ability to maintain community living.

B. Primary Psychiatric diagnoses of schizophrenia, other psychotic disorders, major depression, and bipolar disorders.

C. Substantial disability and functional impairment informed, in part, by an assessment of level 3 or 4 on the Level of Care and Recovery Inventory (LOCRI).

D. One or more of the following related to their mental illness:

1. Two or more psychiatric inpatient hospitalizations in the past year.

2. Significant independent living instability such that the client would be in a long term residential or hospital placement without intensive community-based rehabilitation, treatment and support services.

3. Co-occurring addictions disorders.

4. Homelessness or high risk of becoming homeless.

5. Frequent use of mental health and related services yielding poor outcomes, such as contacts with the criminal justice system, recent housing evictions or frequent use of emergency departments.

6. Need for mental health services that cannot be met with other available community-based services as determined by an ADMHS Psychiatrist.

7. High risk of experiencing a mental health crisis or requiring a more restrictive setting if intensive rehabilitative mental health services are not provided.

E. All admissions will be voluntary.

5. **REFERRALS.**

A. Contractor shall admit clients referred by the County from County Crisis and Recovery Emergency Services (CARES), CARES Crisis Residential, ADMHS Psychiatric Health Facility, and County Treatment Teams. Referral sources other than these approved by the County must be authorized by designated ADMHS staff. An annual Utilization Management review and ongoing authorization will occur to assure that clients served meet the criteria for the Program.

B. Contractor shall begin the admission process within five (5) days of referral.

C. **REFERRAL PACKET**. Contractor shall maintain a referral packet within its files (hard copy or electronic) for each client referred and treated, which shall contain the following items:

1. A copy of the County referral form.

2. A client face sheet (Form MHS 140).

3. A copy of the most recent comprehensive assessment and/or assessment update.

4. A copy of the most recent medication record and health questionnaire.

5. A copy of the currently valid County Coordination and Service Plan indicating the goals for client enrollment in the ACT and identifying the Contractor as service provider.

6. Client's Medi-Cal Eligibility Database Sheet (MEDS) file printout, as provided to Contractor in the initial Referral Packet. Thereafter, it will be Contractor's responsibility to verify continued Medi-Cal eligibility.

7. Written approval to provide services from public/private conservator or other legal guardian

8. Other documents as reasonably requested by County.

6. **DISCHARGE CRITERIA.** Contractor shall determine the appropriateness of client discharge or transfer to less intensive services on a case by case basis. Criteria for discharge or transfer to less intensive services include:

   A. Client ability to function without assistance at work, in social settings, and at home.

   B. No inpatient hospitalization for one year.

   C. Stable housing maintained for at least one year.

   D. Client is receiving one contact per month from the ACT Team and rated by the ACT Team as functioning independently.

   E. Client declines services and requests discharge, despite persistent, well documented efforts by the ACT Team to provide outreach and to engage the client in a supportive relationship.

   F. Client moves out of North Santa Barbara County for a period greater than 30 days.

   G. When a public and/or private guardian withdraws permission to provide services.

7. **DISCHARGES/TRANSFER/READMISSION POLICY**

   A. **Discharge Requirements**.

      1. The ACT Team shall work in close partnership with each client to establish a written discharge plan that is responsive to the client's needs and personal goals.

      2. Contractor shall notify County Utilization Review Department Liaison within ten (10) days of any pending discharge decision made by the ACT Team.

      3. County Utilization Review Department shall receive a copy of the final discharge plan summary, which shall be prepared by the ACT Team at the time of client discharge. Discharge summaries shall be submitted to ADMHS no later than 10 days after the client's discharge from the Program.

B. **Transfer Requirements**. In the event of client transfer to another service provider, Contractor shall ensure:

1. Partnership with the client throughout the transfer planning process to assure responsiveness to his or her individual needs, goals and preferences.

2. Continuity of client care before and after transfer which shall include a gradual transfer process with a period of overlapping services.

C. **Discharge and Readmission Policy.** Contractor shall maintain a discharge and readmission policy, subject to approval by the designated County staff, to address the following:

1. Discharge of clients to lower or higher levels of care.

2. Discharge based on client requests.

3. Discharge of clients who decline to participate in services or are assessed to be non-compliant with services. The ACT Team shall carry out consistent outreach efforts to establish supportive treatment. All such contacts must be clearly documented with approval from County Utilization Review prior to termination of services and discharge.

4. Re-admission of clients previously enrolled in the Program.

8. **STAFFING REQUIREMENTS.**

A. Contractor shall adhere to the Program staffing requirements outlined below:

1. The Program shall include qualified bilingual and bicultural clinicians and staff able to meet the diverse needs represented in the local community. Hiring activities to meet this goal shall be a major operational priority of the Program. As needed, the Program shall have access to qualified translators and translator services, experienced in behavioral healthcare, appropriate to the needs of the clients served. Contractor shall maintain a list of qualified translators to be used in the event the Program must seek translation services outside of the Team.

2. In hiring all positions for the ACT Team, Contractor shall give strong consideration to qualified clients who are or have been recipients of mental health services.

B. The Program shall include a combination of Contractor and County staff, with County staff assuming responsibility for psychiatric treatment functions (functions performed by a psychiatrist, nurse, or psychiatric technician). With these combined resources, the ACT Team will have a total of 16.0 full time equivalent (FTE) staff.

C. Contractor shall hire 12.0 FTE, described below, by [date]. Staff shall begin providing services immediately, but no later than [date], and shall work collaboratively with County staff as part of the ACT Team, as follows:

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STATEMENT OF WORK

1. One (1.0) FTE Team Leader/Administrator who is the clinical and administrative supervisor of the ACT Team. The Team Leader/Administrator shall have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology or mental health counseling. The Team Leader/Administrator shall have at least two years of direct experience treating adults with serious mental illness, including at least one year of program management or supervisory experience in a mental health setting.

2. One (1.0) FTE Master's level lead clinician to assist the Psychiatrist and Team Leader/Administrator to provide clinical leadership during treatment planning meetings, conduct psychosocial assessments, assume oversight of the more challenging mini-team assignments, assist with the provision of side-by-side supervision and work interchangeably with the lead Registered Nurse (County staff). The lead clinician will provide support and back-up to the Team Leader/Administrator in his or her absence.

3. Two (2.0) FTE mental health professionals with designated responsibility for the role of vocational specialist. At least one FTE shall be required to have a master's degree in rehabilitation counseling and at least one year of experience in providing individualized job development and supported employment on behalf of persons with physical or mental disabilities. If one of the two FTEs has a bachelor's degree, it must be in a related field and the individual must have at least two years of supervised experience in the aforementioned service area.

4. Two (2.0) FTE mental health professionals with designated responsibility for the role of substance abuse specialist. At least one FTE shall be required to have a master's degree and at least one year of supervised experience in providing substance abuse treatment interventions to persons with co-occurring psychiatric and addictions disorders. If one of the 2 FTEs has a bachelor's degree, it must be in a related field and the individual must have at least two years of supervised experience in the aforementioned service area.

5. Three (3.0) FTE Personal Service Coordinators who may be bachelor's level and paraprofessional mental health workers. These staff should have experience working with clients with serious mental illness or related training/work/life experience.

6. One and one-half (1.5) FTE Peer Specialists who are or have been recipients of mental health services for serious mental illness. Peer Specialists provide essential expertise and consultation to the entire team to promote a culture in which each client's subjective experiences, points of view and preferences are recognized, respected and integrated into all treatment, rehabilitation and support services. Peer Specialists participate in all program planning processes and provide direct services in the community that promote client self-determination and decision-making.

7. One (1.5) FTE Administrative Support Personnel (1.0 FTE Business Office Manager and 0.5 FTE Administrative Assistant) who are responsible for coordinating, organizing, and monitoring all non-clinical operations of the Program, providing

receptionist activities including triaging calls and coordinating communication between the ACT Team and clients.

D. County shall employ the following four (4.0) FTE staff who, along with the Contractor's 12.0 FTE staff, will comprise the ACT Team. The County shall assume the responsibility for financial oversight and supervision for these 4.0 FTE staff. County staff shall work in conjunction with Contractor staff to assure provision of seamless multi-disciplinary treatment, rehabilitation and support services.

1. One (1.0) FTE Psychiatrist who works with the Team Leader/Administrator to oversee the clinical operations of the ACT Team, provide clinical services to all ACT clients, work with the Team Leader/Administrator to monitor each client's clinical status and response to treatment, supervise staff delivery of services, provide supervision in the community during routine and crisis interventions and direct psychopharmacologic and medical treatment.

2. Two (2.0) FTE Registered Nurses, who work with the Team Leader/Administrator and Psychiatrist to ensure systematic coordination of medical treatment and the development, implementation and fine-tuning of the medication policies and procedures.

3. One (1.0) FTE Psychiatric Technician, who works with the Psychiatrist and the Registered Nurses to ensure proper medication monitoring, timely medications refills, and the development and implementation of medication policies and procedures.

E. Contractor shall request County approval prior to altering any of the staffing disciplines/specialties or number of staff.

9. **SERVICE INTENSITY/ TREATMENT LOCATION/ STAFF CASELOADS/ HOURS OF OPERATION AND COVERAGE**

A. **Service Intensity.** The Program shall have the organizational capacity to provide multiple contacts per week (flexibly) to clients, based on individual preference and need. These multiple contacts may be as frequent as two to three times per day, seven days per week. Many, if not all, staff shall share responsibility for addressing the recovery needs of all clients requiring frequent contacts. The ACT Team shall provide an average of two to three face-to-face contacts per week for each client.

B. **Treatment Location**. The majority of Program services (at least 75 percent) will occur outside program offices in the community, within the client's life context. The ACT Team will maintain data to verify these goals are met.

C. **Staff to Client Caseload Ratios**. The Program shall operate with a staff to client ratio that does not exceed 1 to 10 (10 clients per one (1.0) FTE staff member), excluding the Psychiatrist, Program Assistant, and Business Office Manager. These staff will not carry an individual caseload. Caseloads of individual staff members will vary based upon their overall responsibilities within the ACT Team (for example, Team Leader/Administrator and nurses will carry smaller caseloads).

D. **Hours of Operation and Staff Coverage.**

1. The Program shall be available to provide treatment, rehabilitation and support activities seven days per week, 365 days per year.

    a. The Program shall operate a minimum of 12 hours per day through two overlapping eight (8) hour shifts.

    b. On each weekend day and every holiday the Program shall operate for eight (8) hours with at least two staff providing services.

2. The Program shall operate an after-hours on-call system. Team staff experienced in ACT and skilled in crisis-intervention procedures will be on call and available to respond to clients both by telephone and in person. If a physical response is required, staff shall arrive no later than 30 minutes from the time of the call.

3. County Psychiatrist back up will be available at all times, including evenings, weekends and holidays.

4. Contractor shall ensure that the Team Leader/Administrator or his/her designee shall be available to staff, either in person or by telephone at all times. Contractor shall promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of clients;

E. **Team Organization and Communications.**

1. The Program organizational structure emphasizes a team approach to assure the integration of clinical, rehabilitative and support services. A key to this integrative process is the "team-within-a-team" (hereafter Mini-Team) concept. Through a "Mini-Team" each client has the opportunity to work with a small core of staff whose overall abilities, specialty skills and personality match the client's interests and goals. This "Mini-Team" interfaces with the larger ACT Team and has responsibility for soliciting and blending in the perspective and analysis of all ACT Team members. ACT Team communications are also essential to delivering an individualized mix of treatment, rehabilitation and support services to each client.

2. The overall ACT Team's organization and communication is structured in two major ways – through meetings and documentation. The protocols for these activities are outlined in the NAMI "National Program Standards for ACT Teams."

3. The ACT Team shall conduct Daily Organizational Staff Meetings at a regularly scheduled time that accommodates overlapping shifts, Monday through Friday. The Daily Organizational Staff Meeting shall consist of a daily review of the status of each client to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the ACT Team to assess the day-to-day progress and status of all clients. At the Daily Organizational Staff Meeting, the ACT Team will also revise treatment plans as needed, plan for emergency and crisis situations, and add

service contacts to the daily staff assignment schedule per the revised treatment plans.

4. The ACT Team shall maintain a written daily log of any treatment or service contacts which have occurred during the day, and a concise, behavioral description of the client's daily status.

5. The ACT Team shall maintain a Weekly Client Contact Schedule for each client.

6. The ACT Team shall develop a Daily Staff Assignment Schedule of all the treatment, rehabilitation and service contacts to take place that day, and assign and supervise staff to carry out the treatment, rehabilitation and service activities scheduled to occur that day.

7. The ACT Team will conduct Treatment Planning Meetings under the supervision of the Team Leader/Administrator and the Psychiatrist.

10. **SERVICES**. The Program shall provide an appropriate combination of services individualized to meet each client's needs and to assist each client to achieve and sustain recovery, as described herein. Services offered to Program clients shall be consistent with those described in the "National Program Standards for ACT Teams." Services shall include:

A. **Care Management.** Care Management is a core function provided by the Program. Care management activities are led by one mental health professional on the ACT Team, known as the "primary care manager". The primary care manager coordinates and monitors the activities of the ACT Team staff who have shared ongoing responsibility to assess, plan, and deliver treatment, rehabilitation and support services to each client. The primary care manager:

1. Develops an ongoing relationship with clients based on mutual trust and respect. This relationship should be maintained whether the client is in a hospital, in the community or involved with other agencies (e.g. in a detox center, involved with corrections).

2. Works in partnership with clients to develop a recovery-focused treatment plan.

3. Provides individual supportive therapy and symptom management.

4. Makes immediate revisions to the treatment plan, in conjunction with the client, as his/her needs and circumstances change.

5. Is responsible for working with clients on crisis planning and management.

6. Coordinates and monitors the documentation required in the client's medical record.

7. Advocates for the client's rights and preferences.

8. Provides the primary support to the client's family.

B. **Crisis Assessment and Intervention.** The Program shall ensure availability of telephone and face-to-face contact with clients 24 hours per day, seven days per week. Services may be provided in collaboration with CARES, as appropriate. However, CARES shall augment, not substitute for, ACT Team on-call telephone and face-to-face responsibility.

C. **Symptom Assessment, Management and Individual Supportive Therapy.** These interventions assist clients to address the distressing and disabling problems associated with psychotic symptoms; help to ease the emotional pain associated with having a serious mental illness (e.g., severe anxiety, despair, loneliness, unworthiness and depression) and assist clients with symptom self-management efforts that may reduce the risk of relapse and minimize levels of social disability. These activities, which may be carried out by the ACT Team Psychiatrist, nurses, or other staff include:

1. Ongoing assessment of the client's mental illness symptoms and his or her response to treatment.

2. Education of the client regarding his or her illness and the effects and side effects of prescribed medication, where appropriate.

3. Encouragement of symptom self-management practices which help the client to identify symptoms and their occurrence patterns and develop methods (internal, behavioral, adaptive) to lessen their effects. These may include specific cognitive behavioral strategies directed at fostering feelings of self-control.

4. Supportive psychotherapy to address the psychological trauma of having a major mental illness.

5. Generous psychological support to each client, provided both on a planned and as needed basis, to help the client accomplish personal goals and to cope with the stresses of everyday living.

D. **Medication Prescription, Administration, Monitoring and Documentation.**

1. All ACT Team members shall work closely with the Team Psychiatrist to assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.

2. The ACT Team shall establish medication policies and procedures that identify processes to:

    a. Facilitate client education and informed consent about medication.

    b. Record physician orders.

    c. Order medication.

d. Arrange for all medication related activities to be organized by the ACT Team and documented in the Weekly Client Contact Schedule and Daily Staff Assignment Schedules.

e. Provide security for storage of medications, including setting aside a private area for set up of medications by the ACT Team's nursing staff.

3. Contractor shall provide medication monitoring weekly. At least monthly, each client shall meet with the County Psychiatrist.

E. **Coordination with Health Care and Other Providers.** The Program represents a unique program model, whereby one self-contained team of staff provides an integrated package of treatment, rehabilitation, and support services to each client. There shall be minimal referral to external mental health treatment and rehabilitation services. However, the Program shall provide a high degree of coordination with healthcare providers and others with whom clients may come in contact. The Program shall be responsible for:

1. Coordinating and ensuring appropriate medical, dental and vision services for each client. Based on client consent, the ACT Team will establish close working relationships with primary care physicians to support optimal health and assist in monitoring any medical conditions (e.g., diabetes, high cholesterol).

2. Coordinating with psychiatric and general medical hospitals throughout an individual's inpatient stay. Whenever possible, Team staff should be present when the client is admitted and should visit the hospital daily for care coordination and discharge planning purposes.

3. Maintaining relationships with detoxification and substance abuse treatment services to coordinate care when ACT clients may need these services.

4. Maintaining close working relationships with criminal justice representatives to support clients involved in the adult justice system (e.g., courts, probation officers, jails and correctional facilities, parole officers).

5. Knowing when to be proactive in situations when an individual may be a danger to self or others. Staff should maintain relationships with local emergency service systems as backup to the ACT Team's 24-hour on-call capacity.

6. Establishing close working relationships with self-help groups (AA, NA, etc.), peer support and advocacy resources and education and support groups for families and significant others.

7. Fostering close relationships with local housing organizations.

8. Creating a referral and resource guide for self-help groups and other community resources (e.g., legal aid organizations, food co-ops).

F. **Substance Abuse Services.** The Program shall provide substance abuse treatment services, based on each client's assessed needs. Services shall include, but not be limited to, individual and group interventions to assist individuals who have co-occurring mental illness and substance abuse problems to:

1. Identify substance use, effects and patterns.
2. Recognize the relationship between substance use and mental illness and psychotropic medications.
3. Provide the client with information and feedback to raise their awareness and hope for the possibility of change.
4. Employ various strategies for building client motivation for change.
5. Enable the client to find the best change action specific to their unique circumstances.
6. Help the client to identify and use strategies to prevent relapse.
7. Help the client renew the processes of contemplation, determination and action, without being stuck or demoralized because of relapse.
8. Develop connections to self-help groups such as Double Trouble and Dual Recovery programs.

G. **Housing Services and Support.** The Program shall provide housing support services, but not housing, and support to help clients obtain and keep housing consistent with their recovery objectives. Safe, affordable housing is essential to helping clients fully participate in, and benefit from, all other assistance the Program offers. Many clients referred for Program services may be homeless or have unstable living arrangements. It is important for Program staff to be familiar with the availability and workings of affordable housing programs. Affordable housing units or subsidies may be accessed from other agencies and the general public or private housing market. Program staff shall develop and maintain working relationships with local housing agencies from whom housing units, any necessary rental subsidies, and other available housing-related services or resources may be accessed on behalf of clients. Program housing services and support shall include but not be limited to assisting clients in:

1. Finding apartments or other living arrangements.
2. Securing rental subsidies.
3. Developing positive relationships with landlords.
4. Executing leases.
5. Moving and setting up the household.
6. Meeting any requirements of residency.

7. Carrying out household activities (e.g., cleaning).

8. Facilitating housing changes when desirable or necessary.

H. **Employment and Educational Supports.** Work-related support services help clients who want to find and maintain employment in community-based job sites. Educational supports help clients who wish to pursue the educational programs necessary for securing a desired vocation.

1. Program staff shall use their own expertise, service capacities and counseling assistance to help clients pursue educational, training or vocational goals. Program staff shall maintain relationships with employers, academic or training institutions, and other such organizations of interest to clients.

2. Program staff can help clients find employment that is part or full time, temporary or permanent, based on the unique interests and needs of each client. As often as possible, however, employment should be in real life, independent integrated settings with competitive wages.

3. Services shall include but not be limited to:

    a. Assessment of educational and job-related interests and abilities, through a complete education and work history assessment, as well as on-site assessments in educational and community-based job sites.

    b. Assessment of the effect of the client's mental illness on employment or educational learning, with identification of specific behaviors that interfere with the client's work or learning performance and development of interventions to reduce or eliminate those behaviors.

    c. Development of an ongoing supportive educational or employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job or to remain in an educational setting.

    d. Benefits counseling expertise to help clients understand how gainful employment will affect Social Security Administration (SSA) disability payments and health coverage. The counseling will also be expected to address work incentive benefits available through SSA and other agencies.

    e. Individual supportive therapy to assist clients to identify and cope with symptoms of mental illness that may interfere with work performance or learning

    f. On-the-job or work related crisis intervention to address issues related to the client's mental illness such as interpersonal relationships with co-workers and/or symptom management.

g. Work-related supportive services, such as assistance with grooming or personal hygiene, securing of appropriate clothing, wake-up calls, transportation, etc.

h. Building of cooperative relationships with publicly funded "mainstream" employment, education, training, and vocational rehabilitation agencies/organizations in the community.

I. **Social System Interventions (e.g. Supportive Socialization, Recreation, Leisure-Time Activities, Peer Support).** Social system interventions help clients maintain and expand a positive social network to reduce social isolation. Contractor shall work with each client to:

1. Assess and identify the client's joys, abilities and accomplishments in the present and in the past, and also what the client would like to occur in the future.

2. Identify the client's beliefs and meanings and determine what role they play in the client's overall well being (e.g. how does the client make sense of his/her life experience? How is meaning or purpose expressed in the person's life? Are there any rituals and practices that give expression to the person's sense of meaning and purpose? Does this client participate in any formal or informal communities of shared belief, etc?).

3. Identify and address potential obstacles to establishing positive social relationships (e.g., shyness; anxiety; client's expectations for success and failure).

4. Provide side-by-side support and coaching, as needed, to build client's confidence and success in relating to others.

5. Provide supportive individual therapy (e.g., problem-solving, role-playing, modeling and support), social-skill teaching and assertiveness training.

6. Make connections to peer advocates or peer supports.

7. Help make plans with peers or friends for social and leisure time activities within the community.

J. **Activities of Daily Living.** Contractor shall provide services to support activities of daily living in community-based settings include individualized assessment, problem-solving, side-by-side assistance and support, skills training, ongoing supervision (e.g., monitoring, encouragement) and environmental adaptations to assist clients to gain or use the skills required to:

1. Carry out personal care and grooming tasks.

2. Perform activities such as cooking, grocery shopping and laundry.

3. Procure necessities such as a telephone, microwave.

4. Develop ways to budget money and resources.

5. Use available transportation.

K. **Support Services.** Contractor shall help clients access needed community resources, including but not limited to:

1. Medical and dental services (e.g., having and effectively using a personal physician and dentist).

2. Financial entitlements.

3. Social services.

4. Legal advocacy and representation.

L. **Peer Support Services.** Contractor shall provide services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery, as well as services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma:

1. Peer counseling and support.

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

3. Recovery-oriented training including WRAP (Wellness Recovery Action Plan), UCLA/PAL Independent Living Skills modules, and RCCS (Recovery Centered Clinical Services).

M. **Education, Support, and Consultation to Clients' Families and Other Major Supports.** Contractor shall provide services regularly to clients' families and other major supports, with client agreement or consent, including:

1. Individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process.

2. Interventions to restore contact, resolve conflict, and maintain relationships with family and or other significant people.

3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT Team and the family.

4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

a. Services to help clients throughout pregnancy and the birth of a child.

b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children.

c. Services to help clients restore relationships with children who are not in the client's custody.

11. **DOCUMENTATION REQUIREMENTS.** Contractor shall complete the following for each client, consistent with the NAMI "National Program Standards for ACT Teams":

A. A diagnostic assessment that establishes the presence of a serious mental illness, providing a basis for the medical necessity of ACT-level services and a foundation for the treatment plan. The diagnostic assessment shall be completed by the ACT Team Psychiatrist or by another team member who is a properly licensed mental health professional within thirty (30) days of admission and updated at least every six (6) months or prior to discharge, or at discharge, whichever comes first;

B. A treatment plan that provides overall direction for the ACT Team's work with the client shall be completed within thirty (30) days of admission and reviewed and updated at least every six (6) months with the client. The treatment plan shall include:

1. Client's recovery goals or recovery vision, which guides the service delivery process.

2. Client's major rehabilitation goals, which typically identify one- to two-year targets for the rehabilitative process and may serve as intermediate steps toward the achievement of the client's recovery goals or vision.

3. Objectives describing the skills and behaviors that the client will learn as a result of the Team's rehabilitative interventions during the following three (3) to six (6) months.

4. Interventions planned for the following three to six months to help the client reach the objectives.

C. Electronic progress notes that describe the interventions conducted by the Team, as described in Exhibit A, Section 6, Billing Documentation, and Attachment A, Section 3, Progress Notes and Billing Records, including, at minimum:

1. Actual start and stop times.

2. The goal from the rehabilitation plan that was addressed in the encounter.

3. The intervention that was provided by the staff member.

4. The response to that intervention by the client.

5. The plan for the next encounter with the client, and other significant observations.

12. **POLICIES AND PROCEDURES.** The Program shall develop written policies and procedures to set expectations for Program staff and establish consistency of effort. The written policies and procedures should be consistent with all applicable state and federal standards and should cover:

    A. Informed consent for treatment, including medication.

    B. Client rights, including right to treatment with respect and dignity, under the least restrictive conditions, delivered promptly and adequately.

    C. Process for client filings of grievances and complaints.

    D. Management of client funds, as applicable, including protections and safeguards to maximize clients' control of their own money

    E. Admission and discharge (e.g. admission criteria and process; discharge criteria, process and documentation).

    F. Personnel (e.g. required staff, staffing ratios, qualifications, orientation and training).

    G. Hours of operation and coverage, service intensity, staff communication and planning emphasizing a team approach, and staff supervision.

    H. Assessment and treatment processes and documentation (e.g. comprehensive assessment, treatment planning, progress notes).

    I. Treatment, rehabilitation and support services.

    J. Client medical record maintenance.

    K. Management of client funds, as applicable.

    L. Program evaluation and performance (quality assurance).

    M. Procedures for compliance with applicable State and Federal laws, including all Equal Employment Opportunity (EEO)/Affirmative Action (AA) requirements. Contractors must comply with the Americans with Disabilities Act.

13. **PHYSICAL SPACE.** The physical set-up of the Program space shall include:

    A. Easy access for clients and families, including access for persons who have physical handicaps.

    B. Common work space to facilitate communication among staff.

    C. Three or four rooms which can also serve as office space for the Team Leader/Administrator and the Psychiatrist or as interview rooms or quiet workspace for all staff to use.

D. Space for temporary storage of client possessions.

E. Room for medication storage.

F. Space for office machines (copy machine, fax machine) and storage of office supplies.

G. Parking for ACT staff, clients and families.

14. **PROGRAM EVALUATION, PERFORMANCE AND OUTCOME MEASURES.** In addition to the requirements described in Exhibit A, Section 3, Contractor shall work with County to ensure satisfactory data collection and compliance with the Outcomes described in Exhibit E, Program Goals, Outcomes and Measures.

A. Implementation Progress Reports. The Program will be required to submit a bi-monthly Implementation Progress Report during the first year of operation. ADMHS will use the reports to:

1. Identify Program areas requiring technical assistance/consultation support.

2. Assess Program status changes that put the Program out of compliance with one or more contract standards or that place the program at risk of non-compliance in any area.

3. Request a Plan for Correction in areas that are not in compliance.

B. Client Outcomes, as further described in Exhibit E.

1. Yearly goals will be established for key Program outcomes, using the measures described in Exhibit E.

2. Each Program outcome will be reviewed, at a minimum, every six months by County and adjustments will be made as necessary. The Contractor(s) must have in place mechanisms to collect outcome data, analyze the data and incorporate the knowledge gained into the design and/or operation of the program.

3. During the Program start-up phase, County shall work with the Contractor to reach agreement on specific methods for measuring and collecting outcome information.

4. In addition to Implementation Reports and Client Outcomes, other methods County will use to evaluate the Program may include:

a. Periodic review of encounter data to ensure that clients are receiving the majority of needed services from the Program and not from external sources (e.g., hospitals/ERs and other programs).

b. Regular review of a random sample of client assessment, treatment plans and progress notes to assess the quality of the ACT Team's planning and service delivery activities.

c. Annual on-site Fidelity Reviews to ensure that the Program is adhering to the NAMI "National Program Standards for ACT Teams." This will include a comprehensive review of program activities and operations, including:

i. Policies and procedures.

ii. Admission/discharge criteria.

iii. Service capacity.

iv. Staff requirements.

v. Program organization.

vi. Assessment and treatment planning.

vii. Services provided.

viii. Performance improvement/program evaluation.

ix. Client and family satisfaction.

15. **REPORTS**

A. **FISCAL -** Contractor shall submit monthly Expenditure and Revenue Reports and Year-End Projection Reports to County. These reports shall be on a form acceptable to, or provided by, County and shall report actual costs and revenues and anticipated year-end actual costs and revenues for Contractor**'**s program(s) or cost center(s) described in the Services section of this Exhibit A. Such reports shall be received by County no later than twenty (20) calendar days following the end of the month reported.

B. **STAFFING - Contractor** shall submit monthly Staffing Reports to County. These reports shall be on a form acceptable to, or provided by, County and shall report actual staff hours worked by position, Documented Service Hours (DSH'S) provided by position, caseload by position, and shall include the employees' names, licensure status, bilingual and bicultural capabilities, budgeted monthly salary, actual salary, and hire and/or termination date. The reports shall be received by County no later than twenty (20) calendar days following the end of the month being reported.

C. **PROGRAMMATIC -** Contractor shall submit quarterly programmatic reports to County, which shall be received by County no later than twenty (20) calendar days following the end of the quarter being reported. Programmatic reports shall include a narrative description of Contractor's progress in implementing the provisions of this Agreement, number of active cases, number of Client's admitted/ discharged, details of outreach activities and their results, any pertinent facts or interim findings, staff changes, status of Licenses and/or Certifications, changes in population served and reasons for any such changes. Contractor shall state whether it is or is not progressing satisfactorily in achieving all the terms of this Agreement and if not, shall specify what steps will be taken to achieve satisfactory progress.

D. **PROGRAM EVALUATION, PERFORMANCE AND OUTCOME MEASURES**. Contractor shall work with County to ensure satisfactory data collection and compliance with the Outcomes described in Exhibit E, Program Goals, Outcomes and Measures.

E. **ADDITIONAL REPORTS** - Upon County's request, Contractor shall make such additional reports as required by County concerning Contractor's activities as they affect the services hereunder. County will be specific as to the nature of information requested and allow thirty (30) days for Contractor to respond.

EXHIBIT B

FINANCIAL PROVISIONS

(With attached Schedule of Rates [Exhibit B-1])

This Agreement provides for reimbursement for children's mental health services up to a Maximum Contract Amount. For Title XIX Early Periodic Screening Diagnosis and Treatment Medi-Cal (EPSDT), Title XXI Healthy Families, and all other services provided under this Agreement, Contractor will comply with all applicable requirements necessary for reimbursement in accordance with Welfare and Institutions Code §§5704-5724, and other applicable Federal, State and local laws, rules, manuals, policies, guidelines and directives.

I. PAYMENT FOR SERVICES

A. Performance of Services. Contractor shall be compensated on a cost reimbursement basis for provision of the Units of Service (UOS) established in Exhibit B-1 based on satisfactory performance of the children's mental health services described in Exhibit A.

B. Medi-Cal Services. The services provided by Contractor's Program described in Exhibit A are covered by the Medi-Cal Program and will be reimbursed by County from Fifty Percent (50%) Federal Financial Participation (FFP), Forty-five Percent (45%) State share (EPSDT), and Five Percent (5%) local share, as specified in Exhibit B-1.

C. Healthy Families. The services provided by Contractor's Program described in Exhibit A may be covered by the Healthy Families Program and, as such, will be reimbursed by County from Sixty-five Percent (65%) Federal Financial Participation (FFP) and Thirty-five Percent (35%) local share, only to the extent specified in Exhibit B-1 and only when Contractor has obtained prior authorization from ADMHS to provide services to any Health Families participant. Funds for these services are included within the Maximum Contract Amount, and are subject to the same requirements as funds for services provided pursuant to the Medi-Cal program.

D. Non-Medi-Cal Services. County recognizes that the services provided by Contractor's Program described in Exhibit A may be provided to individuals who are not Medi-Cal eligible and such services will be reimbursed by other County funds only to the extent specified in Exhibit B-1. Funds for these services are included within the Maximum Contract Amount, and are subject to the same requirements as funds for services provided pursuant to the Medi-Cal program.

E. Limitations on Use of Funds Received Pursuant to this Agreement. Contractor shall use the funds provided by County exclusively for the purposes of performing the services described in Exhibit A to this Agreement. Expenses shall comply with the requirements established in OMB A-87 and applicable regulations. Violation of this provision or use of County funds for purposes other than those described in Exhibit A shall constitute a material breach of this Agreement.

II. MAXIMUM CONTRACT AMOUNT

The Maximum Contract Amount has been calculated based on the total UOS to be provided pursuant to this Agreement as set forth in Exhibit B-1 and shall not exceed **$«NewContrMaxAmt».** The Maximum Contract Amount shall consist of County, State, and/or Federal funds as shown in Exhibit B-1. Notwithstanding any other provision of this Agreement, in no event shall County pay Contractor more than this Maximum Contract Amount for Contractor's performance hereunder without a properly executed amendment.

III. OPERATING BUDGET AND PROVISIONAL RATE

A. Operating Budget. Prior to the Effective Date of this Agreement, Contractor shall provide County with an Operating Budget on a format acceptable to, or provided by County, based on costs net of revenues as described in this Exhibit B, Section IV (Accounting for Revenues)**.** Contractor's approved Operating Budget, attached to this Agreement as Exhibit B-2, shall be used to confirm the Provisional Rate to be paid to Contractor as set forth in Exhibit B-1, for the services to be provided pursuant to this Agreement.

B. Provisional Rate. County agrees to reimburse Contractor at a Provisional Rate (the "Provisional Rate") during the term of this Agreement. The Provisional Rate shall be established by using the rates from the Contractor's most recently filed cost report, as set forth in Exhibit B-1. At any time during the term of this agreement, Director shall have the option to adjust the Provisional Rate to a rate based on allowable costs less all applicable revenues, as reflected in Contractor's approved Operating Budget. Payment will be based on the UOS accepted into the County's MIS system on a monthly basis.

C. Adjustment of Provisional Rates. Contractor acknowledges that the Provisional Rates shall be adjusted at the time of the settlement specified in this Exhibit B, Section VIII (Pre-Audit Cost Report Settlement).

IV. ACCOUNTING FOR REVENUES

A. Accounting for Revenues**.** Contractor shall comply with all County, State, and Federal requirements and procedures, as described in WIC Sections 5709, 5710 and 5721, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP) (2) the eligibility of patients/clients for EPSDT/Medi-Cal, Healthy Families, Medicare, private insurance, or other third party revenue, and (3) the collection, reporting and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. Grants, and any other revenue, interest and return resulting from services/activities and/or funds paid by County to Contractor shall also be accounted for in the Operating Budget.

B. Internal Procedures. Contractor shall maintain internal financial controls which adequately ensure proper billing and collection procedures. Contractor's procedures shall specifically provide for the identification of delinquent accounts and methods for pursuing such accounts. Contractor shall pursue payment from all potential sources in sequential order,

with EPSDT Medi-Cal as payor of last resort. Contractor is to attempt to collect first from Medicare (if site is Medicare certified), then from insurance. All fees paid by or on behalf of patients/clients receiving services under this Agreement shall be utilized by Contractor only for the delivery of mental health service units specified in this Agreement.

V. REALLOCATION OF PROGRAM FUNDING

Contractor shall make written application to Director, in advance, to reallocate funds as outlined in Exhibit B-1 between programs, for the purpose of meeting specific program needs or for providing continuity of care to its clients. Contractor's application shall include a narrative specifying the purpose of the request, the amount of said funds to be reallocated, and the sustaining impact of the reallocation as may be applicable to future years. The Director's decision of whether to allow the reallocation of funds shall be in writing to Contractor prior to implementation by Contractor.

VI. BILLING AND PAYMENT PROCEDURES AND LIMITATIONS:

A. Submission of Claims and Invoices. Claims for services, are to be entered into the County's Management Information System (MIS) within 10 calendar days of the end of the month in which mental health services are delivered, although late claims may be submitted as needed in accordance with State and federal regulations. In addition to claims submitted into MIS, Contractor shall submit a written invoice within 10 calendar days of the end of the month in which mental health services are delivered that: i) summarizes the information submitted into MIS, including the UOS provided for the month, ii) states the amount owed by County, and iii) includes the contract number and signature of Contractor's authorized representative. Invoices shall be delivered electronically to the County designated representative or to:

Santa Barbara County Alcohol, Drug, and Mental Health Services
ATTN: Accounts Payable
300 North San Antonio Road Bldg. 3
Santa Barbara, CA 93110 –1316

Contractor agrees that it shall be solely liable and responsible for all data and information submitted by the County to the State on behalf of Contractor. Payment will be based on the UOS accepted into MIS on a monthly basis.

The Director or designee shall review the monthly claim(s) and invoice to confirm accuracy of the data submitted. With the exception of the final month's payment under this Agreement, County shall make provisional payment for approved claims within thirty (30) calendar days of the receipt of said claim(s) and invoice by County subject to the contractual limitations set forth below.

B. Monthly Expenditure and Revenue Report and Projection Report**.** Contractor shall submit a monthly Expenditure and Revenue Report and Projection Report as described in the Reports Section of Exhibit A to this Agreement.

C. Withholding Of Payment for Non-submission of MIS and Other Information**.** If any required MIS data, invoice or report(s) is not submitted by Contractor to County within the time limits

described in this Agreement or if any such information is incomplete, incorrect, or is not completed in accordance with the requirements of this Agreement, then payment shall be withheld until County is in receipt of complete and correct data and such data has been reviewed and approved by Director or designee. Director or designee shall review such submitted service data within sixty (60) calendar days of receipt.

D. Withholding Of Payment for Unsatisfactory Clinical Documentation**.** Director or designee shall have the option to deny payment for services when documentation of clinical services does not meet minimum State and County written standards.

E. Claims Submission Restrictions**.**

1. Six-Month Billing Limit. Unless otherwise determined by State or federal regulations (e.g. Medi-Medi cross-over), all original (or initial) claims for eligible individual persons under this Agreement must be received by County within six (6) months from the date of service to avoid possible payment reduction or denial for late billing. Original (or initial) claims received after this six month billing limit without an acceptable delay reason code are subject to reduction and/or denial by either the State or County. Exceptions to the six month billing limit can be made for months seven through twelve following the month in which the services were rendered if the reason for the late billing is allowed by WIC Section 14115 and Title 22, California Code of Regulations section 51008.5.

2. No Payment for Services Provided Following Expiration/ Termination of Contract**.** Contractor shall have no claim against County for payment of any funds or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Contract. Should Contractor receive any such payment, it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Contract shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Contract.

F. Claims Certification and Program Integrity. Contractor shall certify that all UOS entered by Contractor into MIS for any payor sources covered by this Agreement are true and accurate to the best of Contractor’s knowledge.

G. Tracking of Expenses. Contractor shall inform County when seventy-five percent (75%) of the Maximum Contract Amount has been incurred based upon Contractor's own billing records. Contractor shall send such notice to those persons and addresses which are set forth in the Agreement, Section 2 (NOTICES).

VII. COST REPORT

A. Submission of Cost Report. Within forty-five (45) days after the close of the Fiscal Year covered by this Agreement, Contractor shall provide County with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the prior fiscal year. The

Annual Cost Report shall be prepared by Contractor in accordance with all applicable federal, state and County requirements and generally accepted accounting principles. Contractor shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by Contractor shall be reported in its annual Cost Report, and shall be used to offset gross cost. Contractor shall maintain source documentation to support the claimed costs, revenues and allocations which shall be available at any time to Director or Designee upon reasonable notice.

B. Cost Report to be Used for Final Settlement. The Cost Report shall be the final financial and statistical report submitted by Contractor to County, and shall serve as the basis for final settlement to Contractor. Contractor shall document that costs are reasonable and allowable and directly or indirectly related to the services to be provided hereunder.

C. Withholding Payment. County shall withhold the final month's payment under this Agreement until such time that Contractor submits its complete Annual Cost Report.

D. Penalties. In addition, failure of Contractor to submit accurate and complete Annual Cost Report(s) by the ninetieth (90^{th}) day after the close of the Fiscal Year or the expiration or termination date of this Agreement shall result in:

1. A Late Penalty of ONE HUNDRED DOLLARS ($100) for each day that the accurate and complete Annual Cost Report(s) is (are) not submitted. The Late Penalty shall be assessed separately on each outstanding Annual Cost Report. The Late Penalty shall commence on the ninety-first (91^{st}) day following either the end of the applicable Fiscal Year or the expiration or termination date of this Agreement. County shall deduct the Late Penalty assessed against Contractor from the final month's payment due under the Agreement.

2. In the event that Contractor does not submit accurate and complete Annual Cost Report(s) by the one-hundred fiftieth (150^{th}) day following either the end of the applicable Fiscal Year or the expiration or termination date of this Agreement, then all amounts covered by the outstanding Annual Cost Report(s) and paid by County to Contractor in the Fiscal Year for which the Annual Cost Report(s) is (are) outstanding shall be repaid by Contractor to County**.** Further, County shall terminate any current contracts entered into with Contractor for programs covered by the outstanding Annual Cost Reports.

F. Audited Financial Reports: Each year of the Contract, the Contractor shall submit to County a copy of their audited annual financial statement, including management comments. This report shall be submitted within thirty (30) days after the report is received by Contractor.

G. Single Audit Report: If Contractor is required to perform a single audit, per the requirements of OMB circular A-133, Contractor shall submit a copy of such single audit to County within thirty (30) days of receipt.

VIII. PREAUDIT COST REPORT SETTLEMENT

A. Pre-audit Cost Report Settlement. Based on the Annual Cost Report(s) submitted pursuant to this Exhibit B Section VII (Cost Reports) and State approved UOS, at the end of each Fiscal Year or portion thereof that this Agreement is in effect, the State and County will perform a pre-audit cost report settlement. Such settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or federal statutes, regulations, policies and procedures, or requirements pertaining to cost reporting and settlements for applicable federal and/or State programs. Settlement shall be adjusted to the lower of:

1. Contractor's published charge(s) to the general public, as approved by the Contractor's governing board; unless the Contractor is a Nominal Charge Provider. This federal published charges rule is applicable only for the outpatient, rehabilitative, case management and 24-hour services.

2. The Contractor's actual costs.

3. The State's Schedule of Maximum Allowances (SMA).

4. The Maximum Contract Amount (MCA) of this Agreement.

B. Issuance of Findings. County's issuance of its pre-audit cost report settlement findings shall take place no later than one-hundred-twenty (120) calendar days after the receipt by County from the State of the State's Final Cost Report Settlement package for a particular fiscal year.

C. Payment. In the event that Contractor adjustments based on any of the above methods indicate an amount due the County, Contractor shall pay County by direct payment within thirty (30) days or from deductions from future payments, if any, at the sole discretion of the Director.

IX. AUDITS, AUDIT APPEALS AND POST-AUDIT EPSDT/MEDI-CAL FINAL SETTLEMENT

A. Audit by Responsible Auditing Party. At any time during the term of this Agreement or after the expiration or termination of this Agreement, in accordance with State and federal law including but not limited to the WIC Sections 14170 et. seq., authorized representatives from the County, State or Federal governments (Responsible Auditing Party) may conduct an audit or site review of Contractor regarding the mental health services/activities provided hereunder.

B. Settlement. Settlement of the audit findings will be conducted according to the Responsible Auditing Party's procedures in place. In the case of a State EPSDT/Medi-Cal audit, the State and County will perform a post-audit EPSDT/Medi-Cal settlement that is based on State audit findings. Such settlement will take place when the State initiates its settlement action which customarily is after the issuance of the audit report by the State and before the State's audit appeal process. However, if the Responsible Auditing Party

stays its collection of any amounts due or payable because of the audit findings, County will also stay its settlement of the same amounts due or payable until the Responsible Auditing Party initiates its settlement action with County.

C. Invoice for Amounts Due. County shall issue an invoice to Contractor for any amount due County after the Responsible Auditing Party issues an audit report. The amount on the County invoice is due by Contractor to County thirty (30) calendar days from the date of the invoice.

D. Appeal. Contractor may appeal any such audit findings in accordance with the audit appeal process established by the party performing the audit.

EXHIBIT B-1

EXHIBIT B-1
ALCOHOL, DRUG AND MENTAL HEALTH SERVICES
SCHEDULE OF RATES AND CONTRACT MAXIMUM

CONTRACTOR NAME: **XYZ Agency** **FISCAL YEAR: 2008-09**

		PROGRAM			
		Program A	Program B	Program C	**TOTAL**
	DESCRIPTION/MODE/SERVICE FUNCTION:	NUMBER OF UNITS PROJECTED (based on history):			
	Outpatient - Placement/Brokerage (15/01-09)	6,667	2,667	3,333	12,667
	Outpatient Mental Health Services (15/10-59)	280,000	112,000	140,000	532,000
	SERVICE TYPE: M/C, NON M/C	M/C			
	UNIT REIMBURSEMENT	minute	minute	minute	
	COST PER UNIT/PROVISIONAL RATE:				
	Outpatient - Placement/Brokerage (15/01-09)	$1.50			
	Outpatient Mental Health Services (15/10-59)	$1.75			
	GROSS COST:	$ 500,000	$ 200,000	$ 250,000	$950,000
	LESS REVENUES COLLECTED BY CONTRACTOR: (as depicted in Contractor's Budget Packet)				
A	PATIENT FEES				$0
B	PATIENT INSURANCE				$0
C	CONTRIBUTIONS				$0
D	FOUNDATIONS/TRUSTS				$0
E	SPECIAL EVENTS				$0
F	OTHER (LIST):				$0
	TOTAL CONTRACTOR REVENUES	$ -	$ -	$ -	$0
	MAXIMUM CONTRACT AMOUNT:	**$ 500,000**	**$ 200,000**	**$ 250,000**	**$ 950,000**
	SOURCES OF FUNDING FOR MAXIMUM CONTRACT AMOUNT				
A	MEDI-CAL/FFP	$ 250,000	$ 100,000	$ 125,000	$ 475,000
B	OTHER FEDERAL FUNDS				$ -
C	REALIGNMENT/VLF FUNDS				$ -
D	STATE GENERAL FUNDS				$ -
E	COUNTY FUNDS	$ 25,000	$ 10,000	$ 12,500	$ 47,500
F	HEALTHY FAMILIES				$ -
G	TITLE 4E				$ -
H	AB 3632				$ -
I	EPSDT	$ 225,000	$ 90,000	$ 112,500	$ 427,500
J	FIRST 5 GRANT				$ -
K	MHSA				$ -
L	OTHER (LIST):				$ -
	TOTAL (SOURCES OF FUNDING)	$ 500,000	$ 200,000	$ 250,000	$ 950,000

CONTRACTOR SIGNATURE: _____

STAFF ANALYST SIGNATURE: _____

FISCAL SERVICES SIGNATURE: _____

* Medi-Cal services may be offset by AB 3632 qualifying services (funding).
** Medi-Cal services may be offset by Healthy Families qualifying services (funding) with prior ADMHS approval.

EXHIBT B-2
ALCOHOL, DRUG AND MENTAL HEALTH SERVICES
CONTRACTOR BUDGET PACKET

LINE #	COLUMN # 1	2	3	4	5	6
	I. REVENUE SOURCES:	TOTAL AGENCY/ ORGANIZATION BUDGET	COUNTY ADMHS PROGRAMS TOTALS	Enter PROGRAM NAME (Fac/Prog)	Enter PROGRAM NAME (Fac/Prog)	Enter PROGRAM NAME (Fac/Prog)
1	Contributions		$ -			
2	Foundations/Trusts		$ -			
3	Special Events		$ -			
4	Legacies/Bequests		$ -			
5	Associated Organizations		$ -			
6	Membership Dues		$ -			
7	Program Service Fees		$ -			
8	Sales of Materials		$ -			
9	Investment Income		$ -			
10	Miscellaneous Revenue		$ -			
11	ADMHS Funding		$ -			
12	Other Government Funding		$ -			
13	Other (specify)		$ -			
14	Other (specify)		$ -			
15	Other (specify)		$ -			
16	Other (specify)		$ -			
17	Other (specify)		$ -			
18	Total Other Revenue (Sum of lines 1 through 17)	$ -	$ -	$ -	$ -	$ -
	I.B Client and Third Party Revenues:					
19	Medicare		-			
20	Client Fees		-			
21	Insurance		-			
22	SSI					
23	Other (specify)		-			
24	Total Client and Third Party Revenues (Sum of lines 19 through 23)	-	-	-	-	-
25	GROSS PROGRAM REVENUE BUDGET (Sum of lines 18 + 24)	-	-	-	-	-

EXHIBT B-2
ALCOHOL, DRUG AND MENTAL HEALTH SERVICES
CONTRACTOR BUDGET PACKET

LINE #	COLUMN # 1	2	3	4	5	6
	III. DIRECT COSTS	TOTAL AGENCY/ ORGANIZATION BUDGET	COUNTY ADMHS PROGRAMS TOTALS	Enter PROGRAM NAME (Fac/Prog)	Enter PROGRAM NAME (Fac/Prog)	Enter PROGRAM NAME (Fac/Prog)
26	Salaries (Complete Staffing Schedule)		$ -			
27	Employee Benefits		$ -			
28	Consultants		$ -			
29	Payroll Taxes		$ -			
30	Personnel Costs Total (Sum of lines 26 through 29)	$ -	$ -	$ -	$ -	$ -
31	Professional Fees		$ -			
32	Supplies		$ -			
33	Telephone		$ -			
34	Postage & Shipping		$ -			
35	Occupancy (Facility Lease/Rent/Costs)		$ -			
36	Rental/Maintenance Equipment		$ -			
37	Printing/Publications		$ -			
38	Transportation		$ -			
39	Conferences, Meetings, Etc		$ -			
40	Insurance		$ -			
41	Other (specify)		$ -			
42	Other (specify)		$ -			
43	Other (specify)		$ -			
44	Other (specify)		$ -			
45	Other (specify)		$ -			
46	SUBTOTAL DIRECT COSTS	$ -	$ -	$ -	$ -	$ -
	III. INDIRECT COSTS					
47	Administrative Indirect Costs		$ -			
48	GROSS DIRECT AND INDIRECT COSTS (Sum of lines 46+ 47)	$ -	$ -	$ -	$ -	$ -

EXHIBIT E
PROGRAM GOALS, OUTCOMES AND MEASURES

Program Goal	Outcome	Measure
❖ Reduce mental health and substance abuse symptoms resulting in reduced utilization of involuntary care and emergency rooms for mental health and physical health problems	• Decreased incarceration rates • Decreased inpatient/acute care days and length of hospital stay • Decreased emergency room utilization • Decreased use of substances	➢ Number of incarceration days ➢ Number of hospital admissions; length of hospital stay ➢ Number of emergency room visits for physical and/or psychiatric care ➢ Client and staff reports of a decline in substance use and of gains in working toward the long-term goal of abstinence.
❖ Assist clients in their mental health recovery process and with developing the skills necessary to lead independent, healthy and productive lives in the community	• Reduced homelessness by maintaining stable/permanent housing • Increased life skills needed to participate in purposeful activity and increase quality of life	➢ Number of days in stable/permanent housing ➢ Number of clients employed, enrolled in school or training, or volunteering ➢ Number of clients graduating to a lower level of care