Plan and Budget Required Documents Checklist

MODIFIED FY 2014-15

County/City: Santa Barbara County **Fiscal Year:** 2014-15

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County/City: Santa Barbara County **Fiscal Year:** 2014-15

Agency Information Sheet

County/City: Santa Barbara **Fiscal Year:** 2014-15

Official Agency

Name:	Santa Barbara County Public Health Dept	Address:	345 Camino Del Remedio
Health Officer	Takashi Wada, MD		Santa Barbara CA 93110

CMS Director (if applicable)

Name:		Address:	
Phone:			
Fax:		E-Mail:	

CCS Administrator

Name:	Ana Stenersen, PHN	Address:	345 Camino Del Remedio
Phone:	(805) 681-4026		Santa Barbara CA 93110
Fax:	(805) 681-4958	E-Mail:	Ana.stenersen@sbcphd.org

CHDP Director

Name:	Rea Goumas, MD	Address:	345 Camino Del Remedio
Phone:	(805) 681-4027		Santa Barbara CA 93110
Fax:	(805) 681-4958	E-Mail:	Rea.Goumas@sbcphd.org

CHDP Deputy Director

Name:	Sandra Copley, PHN	Address:	345 Camino Del Remedio
Phone:	(805) 681-5476		Santa Barbara CA 93110
Fax:	(805) 681-4915	E-Mail:	Sandra.copley@sbcphd.org

Clerk of the Board of Supervisors or City Council

Name:	Michael Allen	Address:	105 E. Anapamu St Room 407
Phone:	(805) 568-2245		Santa Barbara, CA 93101
Fax:	(805) 568-2249	E-Mail:	allen@co.santa-barbara.ca.us

Director of Social Services Agency

Name:	Daniel Nielson		234 Camino Del Remedio
Phone:	(805) 681-4451		Santa Barbara CA 93110
Fax:	(805) 681-4403	E-Mail:	d.nielson@sbcsocialserv.org

Chief Probation Officer

Name:	Beverly Taylor		117 E. Carrillo St
Phone:	(805) 882-3652		Santa Barbara CA 93101
Fax:	(805) 882-3651	E-Mail:	Stewart@co.santa-barbara.ca.us

Certification Statement - Child Health and Disability Prevention (CHDP) Program

County/City: Santa Barbara County Fiscal Year: 2014-15

I certify that the CHDP Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 6 (commencing with Section 124025), Welfare and Institutions Code, Division 9, Part 3, Chapters 7 and 8 (commencing with Section 14000 and 14200), Welfare and Institutions Code Section 16970, and any applicable rules or regulations promulgated by DHCS pursuant to that Article, those Chapters, and that section. I further certify that this CHDP Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CHDP Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). I further agree that this CHDP Program may be subject to all sanctions or other remedies applicable if this CHDP Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CHDP Deputy Director	10-16-14 Date Signed
Signature of Director or Health Officer	10-16-14 Date Signed
Signature and Title of Other – Optional	Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson	Date

Certification Statement - Child Health and Disability Prevention (CHDP) Program

County/City: Santa Barbara County Fiscal Year: 2014-15

I certify that the CHDP Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 6 (commencing with Section 124025), Welfare and Institutions Code, Division 9, Part 3, Chapters 7 and 8 (commencing with Section 14000 and 14200), Welfare and Institutions Code Section 16970, and any applicable rules or regulations promulgated by DHCS pursuant to that Article, those Chapters, and that section. I further certify that this CHDP Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CHDP Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). I further agree that this CHDP Program may be subject to all sanctions or other remedies applicable if this CHDP Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CHDP Deputy Director — Date Signed: 10-16-14

Signature of Director or Health Officer — Date Signed: 10-16-14

Signature and Title of Other – Optional — Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson — Date

Certification Statement - California Children's Services (CCS)

County/City: Santa Barbara Fiscal Year: 2014-15

I certify that the CCS Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 5, (commencing with Section 123800) and Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000-14200), and any applicable rules or regulations promulgated by DHCS pursuant to this article and these Chapters. I further certify that this CCS Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CCS Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Services Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. Section 701 et seq.). I further agree that this CCS Program may be subject to all sanctions or other remedies applicable if this CCS Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CCS Administrator	Date Signed: 10/20/14
Signature of Director or Health Officer	Date Signed: 10-16-14
Signature and Title of Other – Optional	Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson	Date

Certification Statement - California Children's Services (CCS)

County/City: Santa Barbara Fiscal Year: 2014-15

I certify that the CCS Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 5, (commencing with Section 123800) and Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000-14200), and any applicable rules or regulations promulgated by DHCS pursuant to this article and these Chapters. I further certify that this CCS Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CCS Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Services Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. Section 701 et seq.). I further agree that this CCS Program may be subject to all sanctions or other remedies applicable if this CCS Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CCS Administrator	Date Signed: 10/20/14
Signature of Director or Health Officer	Date Signed: 10-16-14
Signature and Title of Other – Optional	Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson	Date

SANTA BARBARA COUNTY CHILDREN'S MEDICAL SERVICES
AGENCY DESCRIPTION: CHDP and HCPCFC FY 13-14

CHDP

The Child Health and Disability Prevention (CHDP) Program is in the Santa Barbara County Public Health Department and integrated within the Community Health Division. As of February, 2011, the Child Health and Disability Prevention (CHDP) Program was separated from the Primary Care and Family Health Division and integrated within the Community Health Division. CCS and the MTU continue to be under the Primary Care and Family Health Division.

Rea Goumas, MD, CHDP Director (.10 FTE) assumed the oversight of medical direction in June, 2008. Sandra Copley, PHN, CHDP Deputy Director (up to .28 FTE) assumed administrative oversight in February, 2011. Currently there is a CHDP PHN position (1 FTE). HCPCFC (1 FTE), Health Educator (.5 FTE), two positions of Administrative Office Assistant I-II (AOP I-II) (.75 FTE each), one Administrative Office Assistants, level III (.05 FTE).

The number of CHDP providers in Santa Barbara County (SBC) is currently 39 CHDP providers with 1 provider offices pending certification. There was 46,136 PM 160's submitted, excluding partials. 2,187 children with Gateway/CHDP-only received follow-up services by the CHDP office.

The CHDP PHN and Health Educator continue to work collaboratively with community based organizations involved in county-wide efforts for health insurance access, oral health services and access issues, children with $\geq$ 85% BMI, standardized developmental screening and a promotoras coalition for promotion of preventative health issues. County-wide strategic planning efforts enabled increased access to health care and services to all children in SBC. Health activities specific to CHDP State and Federal guidance were maintained and focused on follow-up for abnormal health assessments. Mandated trainings were administered to the Department of Social Services (DSS, CWS, and Probation), CenCal, Head Start, provider offices and community organizations. Audiometry and Vision training have been done every two years and will change to yearly beginning in FY 14-15.

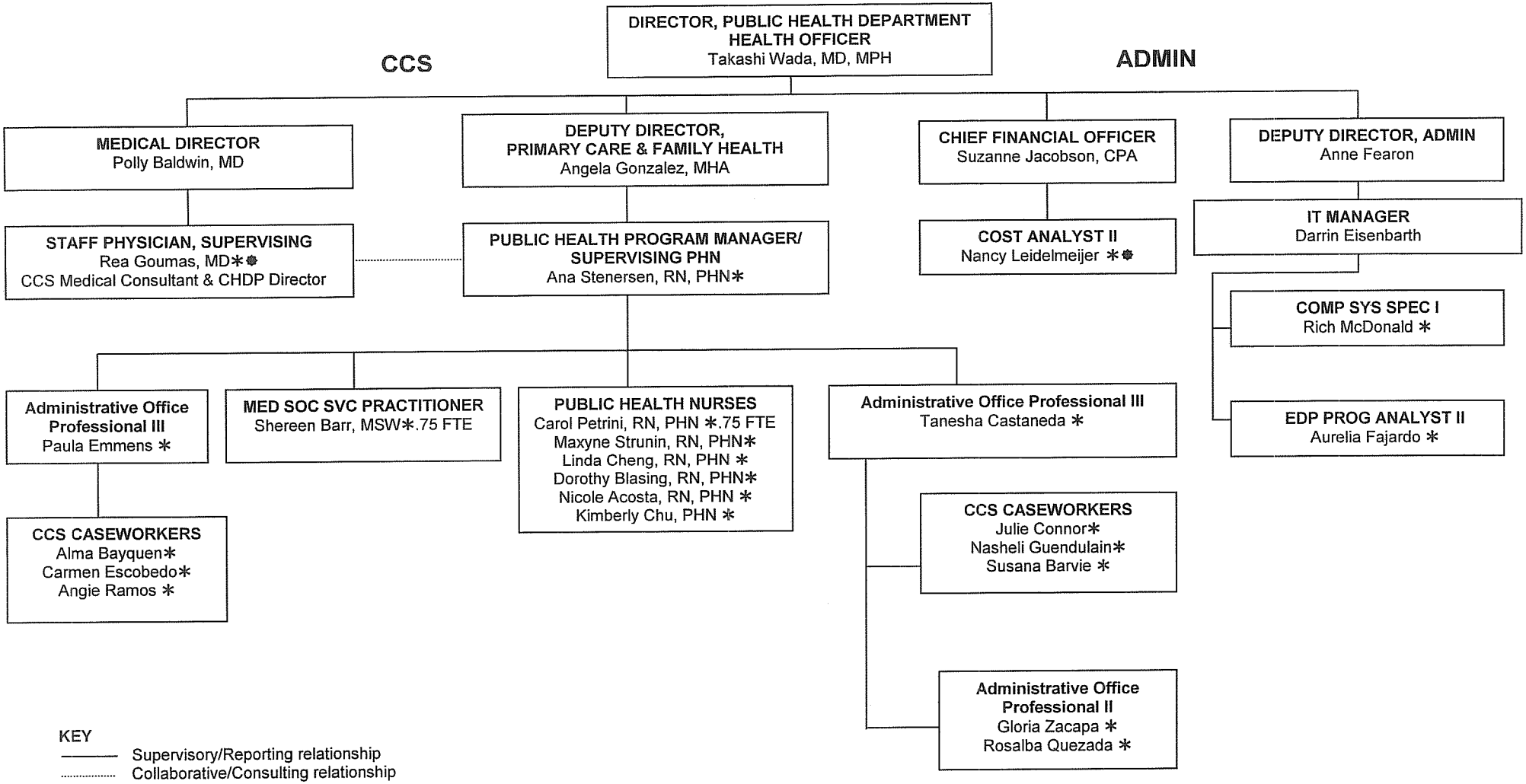
HCPCFC

The Health Care Program for Children in Foster Care (HCPCFC) was reinstated in Santa Barbara County per mandate on March 22, 2010. The HCPCFC MOU between CMS, Probation and the Department of Social Services was reviewed and revised to better serve the population and the needs to the youth who benefit from the program. The program has impacted and improved access to health care for children in foster care.

The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program located in the DSS child welfare service agency and works with probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care. The program has established a process through which PHNs consult and collaborate with the foster care team to promote access to comprehensive preventive health and specialty services. There is a HCPCFC PHN (1FTE) and supervision by the CHDP Deputy Director (.03 FTE). A new PHN was hired in June, 2014.

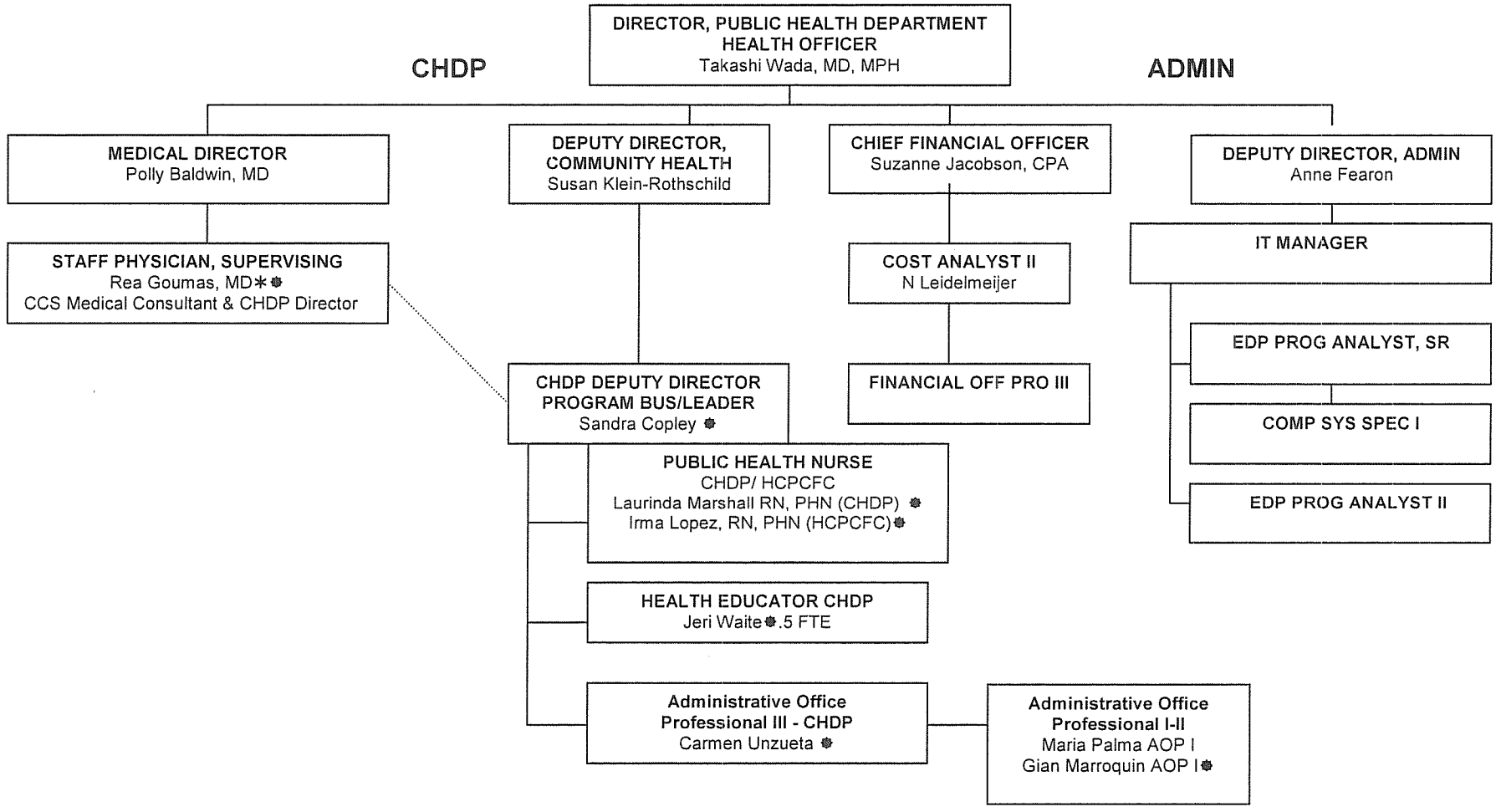
The HCPCFC MOU between CMS, Probation and the Department of Social Services was reviewed and revised for FY 12-13 to better serve the population and the needs to the youth who benefit from the program. The HCPCFC PHN has a case load of 500-600 cases with minimal administrative support. The HCPCFC PHN developed collaborative relationships and instituted creative approaches to maintain the HCPCFC core nursing functions. The HCPCFC has developed trainings of the CWS/DSS staff in coordination with CHDP PHN and begun a training schedule for the FY 13-14.

SANTA BARBARA COUNTY CHILDREN'S MEDICAL SERVICES ORGANIZATION CHART FOR CCS



KEY
——— Supervisory/Reporting relationship
..... Collaborative/Consulting relationship
* Incumbent in CCS Administration Budget
❁ Incumbent in CHDP Budget

SANTA BARBARA COUNTY CHILDREN'S MEDICAL SERVICES ORGANIZATION CHART FOR CHDP



KEY

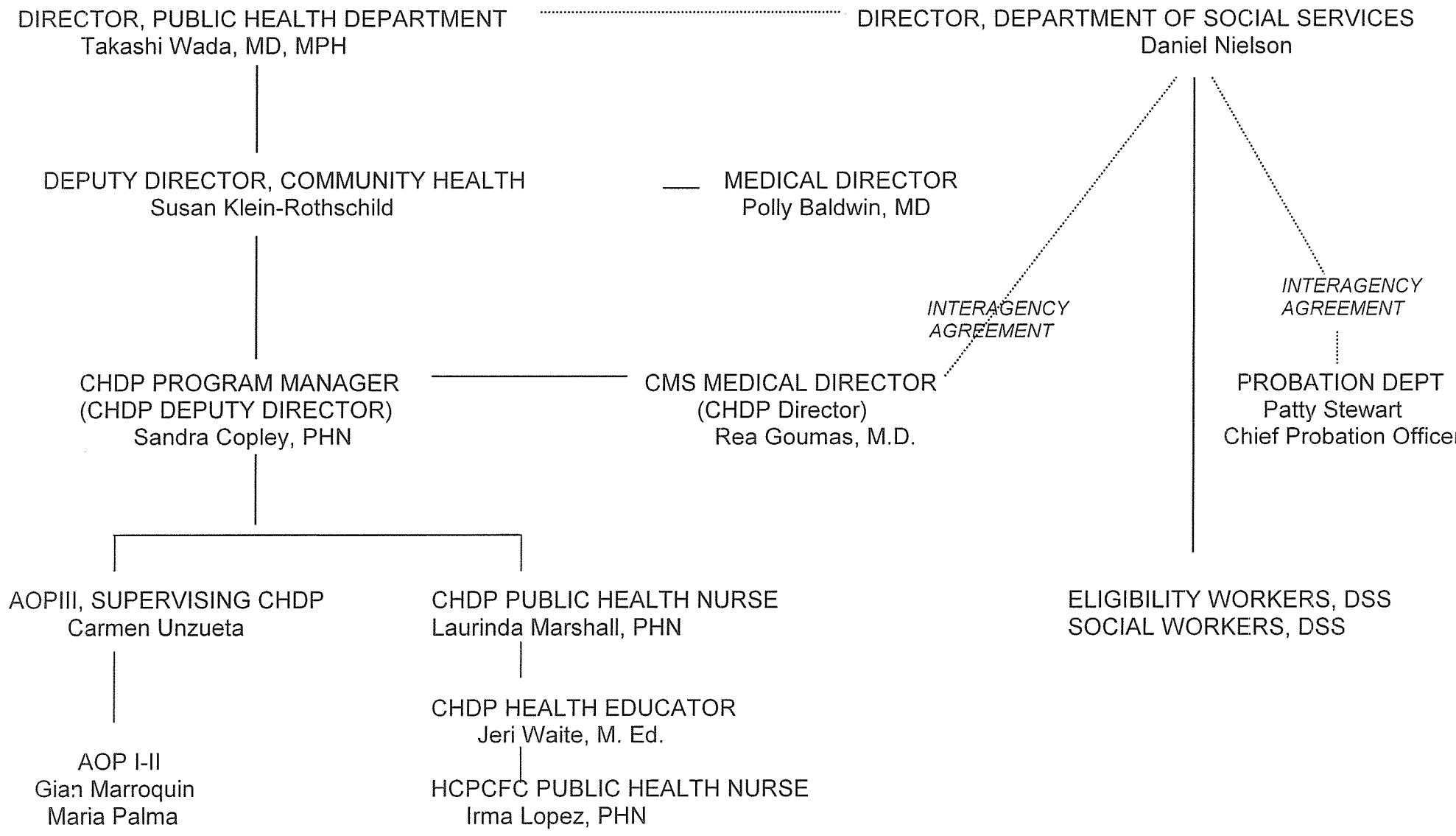
——— Supervisory/Reporting relationship

..... Collaborative/Consulting relationship

* Incumbent in CCS Administration Budget

❁ Incumbent in CHDP Budget

RELATION OF CHDP ADMINISTRATION TO HEALTH DEPARTMENT AND TO SOCIAL SERVICES DEPARTMENT



State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - California Children's Services

For FY 2012-13, complete the table below for all personnel listed in the CCS budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

Identify Nurse Liaison positions using: **MCMC** for Medi-Cal Managed Care; **HF** for Healthy Families; **IHO** for In-Home Operations, and; **RC** for Regional Center.

County/City: **Fiscal Year:**

Job Title	Incumbent Name	FTE % on CCS Admin Budget	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)
Public Health Program Manager/Supervising Public Health Nurse	Ana Stenersen, PHN	100%	No	No
Staff Physician	Rea Goumas, MD	50%	No	No
Public Health Nurse	Carol Petrini, PHN	75%	No	No
Public Health Nurse	Linda Cheng, PHN	100%	No	No
Public Health Nurse	Maxyne Strunin, PHN	100%	No	No

Public Health Nurse	Dorothy Blasing, RN	100%	No	No
Public Health Nurse	Kimberly Chu, RN	100%	No	No
Public Health Nurse	Nicole Acosta, RN	100%	No	No
Medical Social Services Practioner	Shereen Barr, MSW	75%	No	No
Therapy Coordinator	Vacant	50%	No	No
Supervising Caseworker	Tanesha Castenada	100%	No	No
Caseworker	Alma Bayquen	100%	No	No
Caseworker	Juliet Connor	100%	No	No
Caseworker	Carmen Escobedo	100%	No	No
Caseworker	Angelica Ramos	100%	No	No
Caseworker	Nasheli Guendulain	100%	No	No
Caseworker	Susana Barvie	40%	No	No
Administrative Office Professional Sr.	Paula Emmens	100%	No	No
Fiscal Analyst	Nancy Leidelmeijer	5%	No	No
Computer Systems Specialist	Richard McDonald	20%	No	No
EDP Systems Analyst	Aurelia Fajardo	10%	No	No

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - Child Health and Disability Prevention Program

For FY 2010-11, complete the table below for all personnel listed in the CHDP budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: Santa Barbara **Fiscal Year: 2014-15**

Job Title	Incumbent Name	FTE % on CHDP No County/ City Match Budget	FTE % on CHDP County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)
Staff Physician	Rea Goumas, MD	10%		50% CCS 20% Clinic	No	No
Public Health Program Manager	Sandra Copley, PHN	25%		3% HCPCFC 72% MCAH	No	No
Public Health Nurse	Laurinda Marshall	100%			No	No
Health Educator	Jeri Waite, M.Ed	50%			No	No
Administrative Office Professional III	Carmen Unzueta	5%		95% MCAH	No	No
Administrative Office Professional I	Gian Marroquin	75%			No	No

County/City: Santa Barbara **Fiscal Year: 2014-15**

Job Title	Incumbent Name	FTE % on CHDP No County/ City Match Budget	FTE % on CHDP County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)
Administrative Office Professional I	Maria Palma	75%			No	No
Accountant	Nancy Leidelmeijer	3%		97% PHD Fiscal	No	No

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - Health Care Program for Children in Foster Care

For FY 2014-2015, complete the table below for all personnel listed in the HCPCFC and CHDP Foster Care Administrative (County/City) budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: **Santa Barbara** **Fiscal Year: 2014-15**

Job Title	Incumbent Name	FTE % on HCPCFC Budget	FTE % on FC Admin County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)
Public Health Nurse	Irma Lopez, PHN	100%		No	No	No
Program Manager	Sandra Copley, PHN	3%		25% CHDP/ 72% MCAH	No	No

Santa Barbara County, Fiscal Year 2014-2015
CHILDREN'S HEALTH & DISABILITIES PROGRAM STAFF DUTY STATEMENT

PUBLIC HEALTH PROGRAM MANAGER
Sandra Copley, RN, PHN

This position serves as Program Manager, CHDP Deputy Director and Supervisor for HCPCFC. 72% MCAH Director. Civil Service Classification: Business Leader

CHDP: 25%

1. General program administration
2. Coordination and liaison with local and State agencies
3. Assures Nursing and Health Education standards
4. Attends Southern California Regional Directors/Deputy Directors quarterly meetings
5. Participates in policy development and community preventive initiatives related to health issues that may affect the CHDP target population and to facilitate the promotion of child health issues in the community
6. Responsible to develop and submit the annual CHDP related CMS plan and in compiling the data for program evaluation and state reporting

HCPCFC: 3%

1. Direct supervision of the PHN in HCPCFC
2. Assures Public Health Nursing standards of care
3. Liaison with DSS and Probation

STAFF PHYSICIAN
Rea Goumas, MD

This position serves as CHDP Director and CCS Medical Consultant. Civil Service Classification: Staff Physician

CHDP: 10% / CCS: 50% / Clinic: 20%

This position exercises professional medical judgment in responding to the complex needs and problems faced by patients, families, and providers related to delivery of CHDP services, and acts as a resource to CHDP Administration staff in assuring CHDP access for eligible county residents. The incumbent is a board-certified pediatrician licensed in California Examples of duties:

1. Provides consultation to the CHDP professional staff on organization and direction of the CHDP Administrative Office
2. Coordinates medical program management with Regional and State office program personnel and attends appropriate related meetings
3. Assures standards for service set in the CHDP Medical Guidelines
4. Consults with professional staff to coordinate provider standards Maintains and updates standards according to accepted pediatric standards
5. Consults with professional staff on provider recruitment and training, and assists with periodic provider audits for quality assurance
6. Consults and collaborates with other programs and agencies (e.g, WIC, Health Education, Dental Access Resource Team, Immunization Branch, Communicable Disease, etc) to facilitate promotion of child health issues in the community

PUBLIC HEALTH NURSE
Laurinda Marshall RN, PHN; Irma Lopez, RN, PHN

CHDP: 100% nursing oversight of CHDP Administration activities. Civil Service Classification: PHN

1. Provides quality monitoring of CHDP providers countywide (recruitment, certification and re-certification procedures including audits and PM 160 desktop reviews)
2. Provides CHDP providers support (ongoing training, daily phone assistance, site visits, health education materials and other resources)
3. Provides oversight of CHDP program follow-up procedure, assistance with children' follow –ups and referrals in collaboration with the CMS Medical Director
4. Provide case management for newborn hearing screening referred by the southern California Hearing Coordination Center

5. Provides training for eligibility workers and social workers at DSS about informing required for all Medical-Cal beneficiaries and foster care homes in conjunction with the CHDP Health Educator
6. Participates in community outreach opportunities and is the liaison to school staff, head start and other agencies serving the CHDP target population
7. Participates in policy development and community preventive initiatives related to health issues that may affect the CHDP target population
8. Participates in developing the annual CMS plan and in compiling the data for program evaluation and state reporting
9. Attends the Southern Regional CHDP Nurses Subcommittee

HCPCFC: 100% Health care consultation for Probation and DSS workers responsible for children in foster care.
Civil Service Classification: OGB

1. Monitors and evaluates health care coordination services in collaboration with CWS and Probation staff, including identification of health needs and facilitation of access to care
2. Collaborates with community and government agencies, professional groups and private providers to develop health care resources and provide technical assistance on behalf of target population
3. Develops and implements program policies and procedures
4. Attends professional training, meetings on relevant issues
5. Reviews and assesses agency capacity to deliver appropriate health services and develops appropriate educational material
6. Performs quality management activities, including periodic reviews of cases, program procedures and standards, and development of the annual plan
7. Develop and provide health education as necessary to CWS and Foster Parents

HEALTH EDUCATOR
Jeri Waite, MEd

CHDP: 50% Health Education support for CHDP. Civil Service Classification: Health Educator

1. Collaborates with CHDP program staff to train providers and monitor quality of health assessments, including health education needs assessments and biannual newsletter updates.
2. Trains Department of Social Services and other agency staff on CHDP informing/linking.
3. Performs health education needs assessments for care coordination in collaboration with Director and PHN.
4. Participates in community outreach opportunities and is the liaison to school staff, head start and other agencies serving the CHDP target population.
5. Participates in policy development and community preventive initiatives related to health issues that may affect the CHDP target population.
6. Updates resource lists for providers.

Administrative Office Professional III, SUPERVISING (AOP III)
Carmen Unzueta

CHDP: 5% Supervises CHDP clerical staff; MCAH: 95%. Civil Service Classification: AOP III

1. Interviews, recommends hire, evaluates, counsels and recommends discipline for clerical staff
2. Maintains State correspondence and data reporting to and from state
3. Oversees clerical tasks for coordination of informing and referral follow up for CHDP children
4. Attends pertinent meetings and trainings
5. Direct clerical support of CHDP Deputy Director

Administrative Office Professional II (AOP II)
Gian Marroquin, Maria Palma

CHDP: 150% 1.5 FTEs

1. Supports professional and ancillary staff with coordination of program activities
2. Tracks program data including but not limited to PM 160 forms
3. Tracks follows-up with clients and participates in reporting to State
4. Assists families and providers with program issues and follows-up as needed

ACCOUNTANT
Nancy Leidelmeijer

CHDP: 3% this member of the PHD Fiscal staff calculates and tracks quarterly invoices for CMS

Report of CMS Performance Measures
Santa Barbara County CMS
Fiscal Year 2013-14
Narrative

FY 2013-2014 represents the second year in five-year cycle in data collection for CMS performance measures. Business Objects reports were available and applicable to some measures, while customized reports had to be designed to find relevant data. The following is a summary of pertinent changes in methodology and description of those measures that proved challenging.

CHDP Performance Measures

CHDP Performance Measure (PM) 1 - Care Coordination

- Santa Barbara CHDP local database captured relevant information.
- Care coordination is ***initiated*** on children with 'Gateway' or 'CHDP-only' coverage when the PM 160 has a code 4 or 5 in the areas of nutritional, developmental, vision or dental assessment. This results in the CHDP office sending the family an educational letter and referral resources. A phone call for didactic education is then completed two weeks after the letter is sent. A fax is sent to the provider office for PM 160's with code 4 or 5 in other problem areas with a request to send follow-up information on the case to the CHDP office. **Therefore *100% code 4 and 5 follow-up care was 'initiated'.***
- 'Completed' care coordination signifies that the family was contacted by phone, given education and assisted with referrals for code 4/5 nutritional, developmental, vision and dental issues on children with Gateway or CHDP only services. Completed care coordination for other code 4 or 5 conditions signifies that a fax was returned to the CHDP office by the provider stating care was completed.
- 62% (1694/2734) of children with Gateway M/C received a completed follow-up with a verbal phone call and care coordination activities (or) a fax returned by the provider. 75% (227/301) of children with 'CHDP-only' received a completed follow-up and care coordination activities (or) a fax returned by the provider. Multiple attempts are made on each case. Reasons that staff members were unable to reach clients are due to 'no answer' by phone or fax, wrong demographic info and disconnected phones.

CHDP Performance Measure (PM) 2 - New Provider Orientation

- The CHDP PHN tracks provider orientation on an excel sheet in the CHDP shared drive. 52% (11/21) of new providers received a completed orientation. Of the ten providers that were not given a new provider orientation, five providers have been oriented in August of FY 14-15; three providers are currently scheduled in FY 2014-15; and two providers are having difficulties in scheduling the orientation.

CHDP Performance Measure (PM) 3 - Provider Recertification

- The CHDP PHN keeps a record of Provider re-certifications through the CHDP Database.
  11 out of 14 provider sites received a completed a facility review tool and medical record review tool during the required fiscal year (FY). Of the three not recertified, one office received a timely initial review but was not eligible for recertification until the next FY, August 2014, to assess for correction of deficiencies. The other two were recertified on 7/23/2014 and 8/13/2014 respectively.
- In regards to the workload data tracking, there were three new providers, 11 visits for billing issues and resolution of problem areas and seven medical record reviews. There were 30 office visits for updates on the WHO growth chart, oral health, community resources lists, perinatal mental health and substance use folders with resource brochures specific to the provider's region and sample screening tools.

CHDP Performance Measure (PM) 4 - Desktop Review Dental, Lead

- The PHN obtains information for this PM by reviewing a statistically significant sample of PM 160's for children 12-14 months of age from three high-volume providers during the period of Oct. 15 – Dec. 15 (and) June 1, 2014 – July 31, 2014 of this FY. Partials are excluded. We will resume the five year plan of review dates: 10/15 to 12/15 and 4/15 to 6/15 in subsequent years.
- Of the three provider sites, it was found that CHCC SM I continues to need further training in referring for dental services (65% compliance) and lead test/referral (56% compliance) for children in this age range.
- The CHDP PHN has done outreach for CHCC clinic managers and providers to ameliorate the problem. There will be an in-house training for all staff in the fall of 2014.
- The CHDP PHN will educate all three providers on the importance appropriate lead and dental referrals.
- All providers are now given a community resource folder to assist with case management needs.

CHDP Performance Measure 5 - Childhood Overweight

- The PHN obtains information for this PM by reviewing a statistically significant sample of PM 160's for children 12-14 months of age from three high-volume providers during the period of Oct. 15 – Dec. 15 (and) June 1,2014 – July 31, 2014 of this FY. Partials are excluded. We will resume the five year schedule of 10/15 to 12/15 and 4/15 to 6/15 in subsequent years.
- Provider compliance in recording BMI %tile ranged from 77% to 99%.
- This review demonstrated that CHCCC SMI was not routinely recording follow-up care for an abnormal BMI %ile (60% compliance). Further provider site training was given this FY and will be given to all three sites.
- SBC CHDP is involved with Partners for Fit Youth and Health Fairs in preventative activities for childhood overweight issues.

HCPCFC Performance Measures

HCPCFC Performance Measure (PM) 1 – Care Coordination

The HCPCFC PHN uses a combination of PM 160's, Health Care Encounter Forms and CHDP database information to ascertain children with out-of-home placement with code 4-5 that had follow-up care within 120 days. Follow up by HCPCFC PHN was initiated 100% by sending a letter to foster care parents inquiring about follow up. 87.2% completed follow up within 120 days & provided follow up documentation to HCPCFC PHN partially due to the child moving to a new home, city and new provider, initiating the need for new follow-up care.

HCPCFC Performance Measure (PM) 2 – Health and Dental Exams for Children in Out-of-Home Placement

PM 2 data was taken from 'Safe Measures' data. The numerator is obtained from medical documentation obtained & entered by HCPCFC PHN into CMS. The HCPCFC PHN does not always receive medical documentation on foster care children and therefore data may be missing from Safe Measures. When documentation is received, it may take 1-2 months for Safe Measures to update with new information and compile data. Data may not reflect all medical care if documentation is not received.

Rea Goumas, MD
CHDP Director
CCS Medical Consultant

10-20-14
Date

Sandra Copley, RN, PHN
CHDP Deputy Director
CCS Administrator

10-16-14
Date

CHDP Performance Measure 1 - Care Coordination

The degree to which the local CHDP program provides effective care coordination to CHDP eligible children.

Definition: CHDP health assessments may reveal condition(s) requiring follow-up care for diagnosis and treatment. Effective CHDP care coordination is measured by determining the percentage of health condition(s) coded 4 or 5 where follow-up care is initiated[1] within 120 days of local program receipt of the PM 160.

Numerator: Number of conditions coded 4 or 5 where the follow-up care was initiated within 120 days of receipt of the PM 160.

Denominator: Total number of conditions coded 4 or 5 on a PM 160, excluding children lost to contact.

Data Source: Local program tracking system.

Reporting Form:

Element	Number of conditions coded 4 or 5 where follow-up care was initiated (Numerator)	Total number of conditions coded 4 or 5, excluding children lost to contact (Denominator)	Percent (%) of conditions where follow-up care was initiated within 120 days
Conditions found on children eligible for fee-for-service Medi-Cal that required follow-up care	2734 See narrative for completed cases	2734	100% See narrative for completed cases
Conditions found on children eligible for State-funded CHDP services only (Aid code 8Y) that required follow-up care	301 See narrative for completed cases	301	100% See narrative for completed cases

[1] Centers for Medicare and Medicaid Services, Publication #45, the State Medicaid Manual, Chapter 5 EPSDT, Section 5310 A http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

CHDP Performance Measure 2 - New Provider Orientation

The percentage of new CHDP providers with evidence of quality improvement monitoring by the local CHDP program through a New Provider Orientation.

Definition: The number of new CHDP providers (i.e., M.D., D.O., N.P., P.A.) added within the past fiscal year who were oriented by the local program staff.

Numerator: The number of new CHDP providers who completed an orientation within the past fiscal year.

Denominator: The number of new CHDP providers in the county or city (local program) added within the past fiscal year.

Data Source: Local program tracking system.

Reporting Form:

Number of New Providers who Completed Orientation (Numerator)	11
Number of New Providers (Denominator)	21
Percent (%) of New Providers Oriented	52%

Optional Local Program Data Tracking Form:

Provider	Provider Location	Date of Orientation	Number of Licensed Staff in Attendance	Number of Non-Licensed Staff in Attendance
1.				
2.				
3.				
4.				

CHDP Performance Measure 3 - Provider Site Recertification

The percentage of CHDP provider sites (excludes newly enrolled providers) who have completed recertification within the past fiscal year. Provider site visits may occur for other reasons. These can be documented for workload activities. The purpose of this performance measure is to ensure that all providers are recertified at least once every three (3) years. This performance measure is a benchmark to ensure that providers are recertified using the Facility and Medical Review Tools. These tools ensure that providers maintain CHDP standards for health assessments.

Definition: An office visit which includes a medical record review and a facility review or Critical Element Review with a Managed Care Plan.

Numerator: The number of CHDP provider sites who have completed the Recertification within the past fiscal year using the facility review tool and medical record review tool.

Denominator: The number of active CHDP provider sites in the county/city due for recertification within the fiscal year.

Data Source: Local program tracking system.

Reporting Form:

Number of Completed Site Recertifications	(Numerator)	11
Number of Active CHDP Provider Sites Due for Recertification	(Denominator)	14
Percent (%) with Completed Recertifications		79%

Optional Workload Data Tracking Form:
(Other reasons for a provider site visit by local program. This identifies workload.)

Other reasons for provider site visits:	Number of Visits
1. Provider change in location or practice	3 (new providers)
2. Problem resolution such as, but not limited to, billing issues, parental complaints, facility review and/or other issues.[1]	11
3. Medical record review	7
4. Office visits for CHDP updates or in-service activities	30
5. Other - Please specify:	

[1] **CHDP Provider Manual: Program, Eligibility, Billing and Policy**. California Department of Health Care Services, Child Health & Disability Prevention (CHDP) Program. See website for current updates.
Local Program Guidance Manual Chapter 10: Problem Resolution and/or Provider Disenrollment. California Department of Health Care Services, Child Health & Disability Prevention (CHDP) Program, May 2005.
Both references available at: http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CHDPPubs.aspx#dgmp.

CHDP Performance Measure 4 - Desktop Review: Dental, Lead

Within the past fiscal year, identify the percentage of PM 160s with documentation indicating compliance with the CHDP Periodicity Schedule and Health Assessment Guidelines. Local programs may choose to evaluate the same provider sites over the 5-year Performance Measure cycle, or select different provider sites each year.

Definition: A targeted desktop review for three high volume providers within the county/city by determining the percent of PM 160s that have documentation for:

- Referred to a dentist at 1 year exam (12-14 months of age)
- Lead test or a referral for the test at 1 year exam (12-14 months of age)

Numerator: The number of PM 160 elements recorded correctly per selected providers for the specific ages.

Denominator: The total number of PM 160s reviewed per selected providers for the specific ages.

Data Source: Local program tracking system.

Reporting Form:

	Dental Referral			Lead Test or a Referral		
Provider	Number of PM 160s w/ Dental at 1 year exam (Numerator)	Total PM 160s Reviewed (Denominator)	Percent (%) Compliance	Number of PM160s w/ Lead Test or Referral at 1 year exam (Numerator)	Total PM 160s Reviewed (Denominator)	Percent (%) Compliance
1. PMG	171	172	99%	159	172	92%
2. CHCC-SM1	24	37	65%	20	36	56%
3. Lompoc HCC	42	49	86%	31	49	63%

PMG – Pediatric Medical Group – Santa Maria

Lompoc HCC – Lompoc Health Care Center (PHD)

CHCCC SM I – Community Health Centers of the Central Coast – Santa Maria

CHDP Performance Measure 5 - Desktop Review: BMI

Within the past fiscal year, identify the percentage of PM 160s with documentation indicating compliance with the CHDP Periodicity Schedule and Health Assessment Guidelines. Local programs may choose to evaluate the same provider sites over the 5-year Performance Measure cycle, or select different provider sites each year.

Definition: A targeted desktop review for three (3) high volume providers within the county/city by determining the percent of PM 160s that have documentation for:

- Body Mass Index (BMI) Percentile for ages 2 years and over
- If BMI Percentile is abnormal, the description of weight status category[1] and/or a related diagnosis are listed in the Comments Section.

BMI percentile	Weight status category
< 5th %ile	Underweight
85th - 94th %ile	Overweight
95th - 98th %ile	Obese
≥ 99th %ile	Obesity (*severe*)

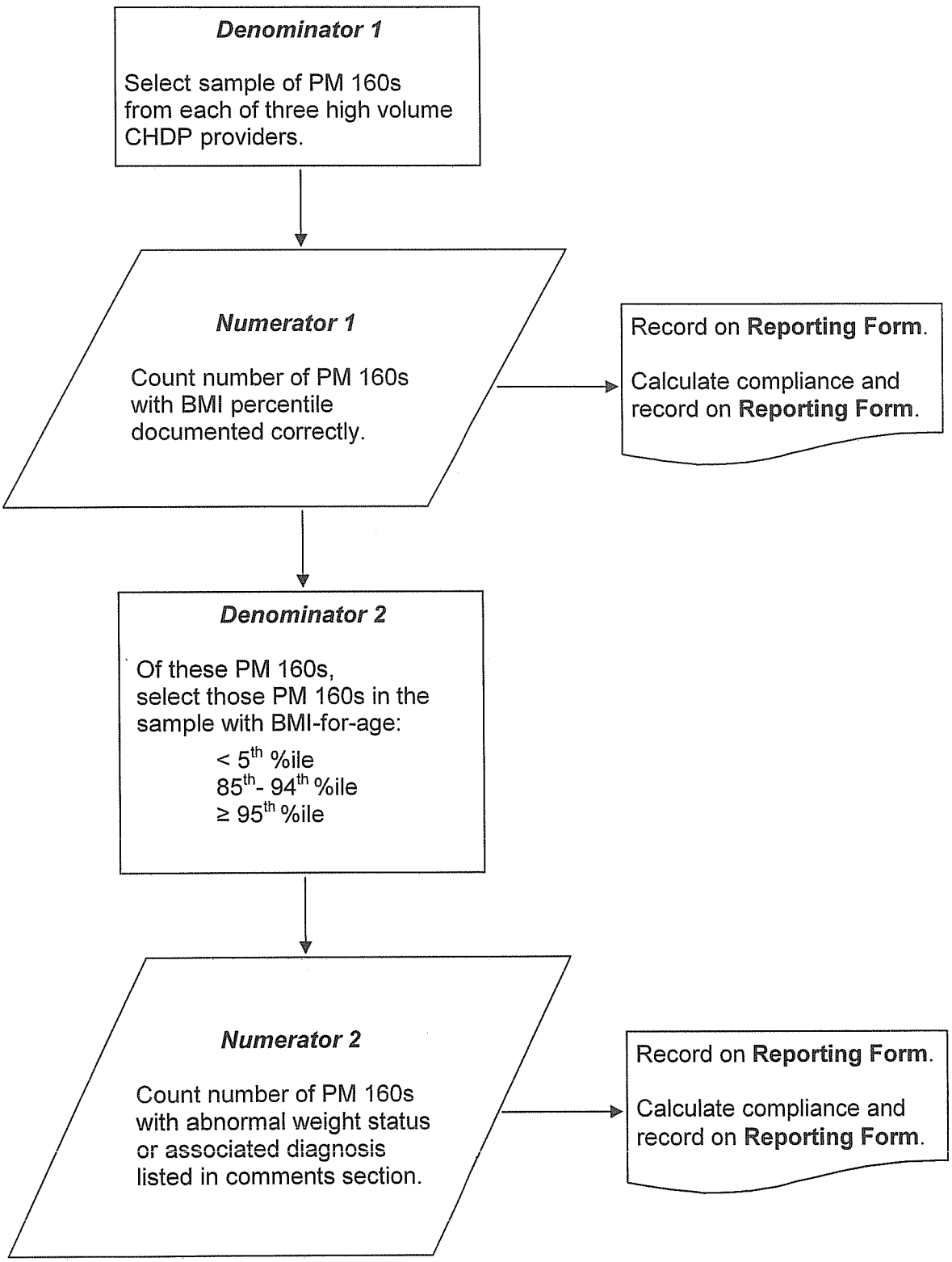
Numerator: The number of PM 160s BMI-related elements correctly documented for ages two (2) years and over.

Denominator: The total number of PM 160s reviewed per selected providers for ages two (2) years and over.

Data Source: Local program tracking system

[1] **CHDP Provider Information Notice No.: 07-13:** Childhood Obesity Implementation Guide from the Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity- 2007. http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppin0713.pdf

BMI Desktop Review Flow Diagram:



COUNTY Santa Barbara **FISCAL YEAR** FY 13-14

Reporting Form for Performance Measure 5-Desktop Review: BMI

Provider	BMI percentile recorded on PM 160s for children ages 2 and older			If BMI percentile is < 5 %, 85 - 94 %, or ≥ 95 %, abnormal weight status category and/or related diagnosis listed in Comments Section		
	Number of PM 160s with BMI %ile recorded (Numerator)	Number of PM 160s reviewed (Denominator)	Percent (%) Compliance	Number of PM 160s with abnormal weight status category/ diagnosis in Comments (Numerator)	Number of PM 160s with abnormal weight status reviewed for diagnosis and follow-up (Denominator)	Percent (%) Compliance
1. PMG	1,225	1,233	99%	391	562	70%
2. CHCC-SM1	189	247	77%	78	129	60%
3. Lompoc HCC	264	273	97%	90	133	68%

PMG – Pediatric Medical Group – Santa Maria

Lompoc HCC – Lompoc Health Care Center (PHD)

CHCCC SM I – Community Health Centers of the Central Coast – Santa Maria

Performance Measure 6 - County/City Use of Childhood Obesity Data

1. **Childhood obesity data shared with CHDP Providers to inform about overweight and obesity prevalence rates:** *(If yes, underline all that apply)*	YES	NO
Presentations, in-services, trainings Discussion of PM 4&5 data and input to two provider offices	X	
Newsletters, media outreach, reports	X	
Provide educational and resource materials related to healthy eating/active living Resource lists and updates on	X	
2. **Childhood obesity data shared to support local assistance grants and implementation of multi-sector policy strategies to create healthy eating and active living community environments (Goal 3, California Obesity Prevention Plan 2010):** *(If yes, underline all that apply)*		
Academic: Universities, Academic Institutions, Educators and Researchers Other (*Please specify)*:		X
Community Coalitions/Committees: Health Advisory Committee, Health Collaboratives/Coalitions Other (*Please specify)*: Children's Health Initiative of SB, Oral Health Exec Committee, Dental Access Resource Team, Child Abuse Prevention Counsel	X	
Community Planning: City Planners, County Land Use Staff, Built Environmental Groups Other (*Please specify):*		X
Community Programs: Faith-based Groups. YMCA/YWCA, After School programs, Parks and Recreation programs, Child Care, University Cooperative Extension Other (*Please specify)*:		X
Health Care: Managed Care Health Plans and Insurers, Hospitals, CCS Program/Special Care Centers, Medical Provider Groups, Medical Societies, Health Associations Other (*Please specify)*:		X
Policy Makers: County Board of Supervisors, City Councils, Community Planners, Legislators Other (*Please specify)*: A SB County Supervisor	X	
Projects or Funding Entities: First Five Commission, Public and Private Foundations/Endowments/Grants Other (*Please specify)*: First 5 Commission	X	
Public Health Programs: WIC, Foster Care, MCAH, Nutrition Network Funded Projects, Health Officers, Epidemiologists, Program Directors Other (*Please specify)*: Medical Director and PH Executives	X	
Schools: School Health Nurses, School Health Coordinators, County Office of Education, Elementary, Junior High and High Schools, Head Start, other preschool programs, student groups and parent groups	X	

HCPCFC Performance Measure 1 - Care Coordination

The degree to which the local HCPCFC provides effective care coordination to CHDP eligible children.

Definition: CHDP health assessments may reveal condition(s) requiring follow-up care for diagnosis and treatment. Effective HCPCFC care coordination is measured by determining the percentage of health condition(s) coded 4 or 5 where follow-up care is initiated within 120 days of local program receipt of the PM 160.

Numerator: Number of conditions coded 4 or 5 where the follow up care was initiated within 120 days of receipt of the PM 160.

Denominator: Total number of conditions coded 4 or 5 on a PM 160, excluding children lost to contact.

Reporting Form:

Number of conditions coded 4 or 5 where the follow-up care was initiated within 120 days of receipt of the PM 160. (Numerator)	102
Total number of conditions coded 4 or 5 on a PM 160, excluding cases lost to no contact. (Denominator)	117
Percent of conditions coded 4 or 5 where the client received follow-up care within 120 days of receipt of the PM 160.	87.2%

Data Source: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department

HCPCFC Performance Measure 2 - Health and Dental Exams for Children in Out-of-Home Placement

The degree to which the local HCPCFC program ensures access to health and dental care services for eligible children according to the CHDP periodicity schedule.

Definition: This measure is based on characteristics that demonstrate the degree to which the PHN in the HCPCFC facilitates access to health and dental services as evidenced by documentation of a health and dental exam in the Health Education Passport.

Numerator 1: Number of children in out-of-home placement with a preventive health exam, according to the CHDP periodicity schedule documented in the Health and Education Passport, and

Numerator 2: Number of children in out-of-home placement with a preventive dental exam, according to the CHDP dental periodicity schedule documented in the Health and Education Passport.

Denominator: Number of children in out-of-home placement during the previous fiscal year supervised by Child Welfare Services or Probation Department.

Reporting Form:

Element	Number of Children With Exams (Numerator)	Number of Children (Denominator)	Percent of Children with Exams
Number of children in out-of-home placement with a preventive health exam according to the CHDP periodicity schedule documented in the Health and Education Passport.	1508	1835	82.2%
Number of children in out-of-home placement with a preventive dental exam according to the CHDP dental periodicity schedule documented in the Health and Education Passport.	859	1504	57.1%

Data Source/Issue: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department.

CHDP Program Referral Data Santa Barbara County

Complete this form using the Instructions found on page 4-8 through 4-10.

County/City:	**FY 11-12**		**FY 12-13**		**FY 13-14**	
Basic Informing and CHDP Referrals						
1. Total number of CalWORKs/Medi-Cal cases informed and determined eligible by Department of Social Services	*					
2. Total number of cases and recipients in "1" requesting CHDP services	Cases	Recipients	Cases	Recipients	Cases	Recipients
a. Number of CalWORKs cases/recipients	2,201	4,734	2,060	4,825	1,425	3,399
b. Number of Foster Care cases/recipients	1,496	1,496	1,578	1,578	1,281	1,281
c. Number of Medi-Cal only cases/recipients	5,885	15,716	4,553	11,463	2,309	5,397
3. Total number of EPSDT eligible recipients and unborn, referred by Department of Social Services' workers who requested the following:						
a. Medical and/or dental services	13,789		11,553		6,570	

b. Medical and/or dental services with scheduling and/or transportation	6,274		5,266		2,428	
c. Information only (optional)	18,391		15,073		8,674	
4. Number of persons who were contacted by telephone, home visit, face-to-face, office visit, or written response to outreach letter	38,454		31,591		20,291	
Results of Assistance						
5. Number of recipients actually provided scheduling and/or transportation assistance by program staff	0	0	0	0	0	0
6. Number of recipients in "5" who actually received medical and/or dental services	0	0	0	0	0	0

*The Santa Barbara County CHDP office is not able to provide the requested numbers for question. The CHDP office does not receive this information from the Department of Social Services.

Memoranda of Understanding/Interagency Agreement List

List all current Memoranda of Understanding (MOUs) or Interagency Agreements (IAAs) in California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care. Specify whether the MOU or IAA has changed. Submit only those MOUs and IAAs that are new, have been renewed, or have been revised. For audit purposes, counties or cities should maintain current MOUs and IAAs on file.

County/City: Santa Barbara **Fiscal Year: 2014-15**

Title or Name of MOU/IAA	Is this a MOU or an IAA?	Effective Dates	Date Last Reviewed by County/ City	Name of Person Responsible for this MOU/IAA?	Did this MOU/IAA Change? (Yes or No)
MOU Santa Barbara Public Health CHDP and CenCal Health – CHDP	IAA	12-20-2012 through 12-20-2014	12-2012	Sandra Copley	No
Santa Barbara County CHDP Interagency Agreement with Department of Social Services – CHDP	IAA	07-01-2013 through 06-30-2015	07-01-2013	Sandra Copley	No
MOU SB County PHD HCPCFC and Department of Social Services and Probation Department - HCPCFC	MOU	07-01-2013 through 06-30-2015	07-01-2013	Sandra Copley	No
SELPA – CCS	IAA	12-09-2009	11-01-2010	Ana Stenersen	No

County/City: Santa Barbara **Fiscal Year: 2014-15**

Title or Name of MOU/IAA	Is this a MOU or an IAA?	Effective Dates	Date Last Reviewed by County/ City	Name of Person Responsible for this MOU/IAA?	Did this MOU/IAA Change? (Yes or No)
Santa Barbara Regional Health Authority – CCS	MOU	01-01-2005	01-01-2008	Ana Stenersen	No
Blue Shield HFP – CCS	MOU	05-21-1998	01-01-2008	Ana Stenersen	No
Blue Cross HFP – CCS	MOU	05-27-1998	01-01-2008	Ana Stenersen	No
SBRHA HFP – CCS	MOU	04-10-1998	01-01-2008	Ana Stenersen	No
VSP HFP – CCS	MOU	10-20-1998	01-01-2008	Ana Stenersen	No
Premier Access Dental HFP – CCS	MOU	6-28-2000	01-01-2008	Ana Stenersen	No
Denticare HFP- CCS	MOU	10-17-1998	01-01-2008	Ana Stenersen	No
Delta Dental HFP – CCS	MOU	11-23-1998	01-01-2008	Ana Stenersen	No
Western Dental HFP – CCS	MOU	07-01-2005	01-01-2008	Ana Stenersen	No
SafeGuard HFP- CCS	MOU	07-01-2005	01-01-2008	Ana Stenersen	No
EyeMed Vision Care HFP - CCS	MOU	07-01-2005	01-01-2008	Ana Stenersen	No

INTERAGENCY AGREEMENT

BETWEEN

SANTA BARBARA COUNTY

SPECIAL EDUCATION LOCAL PLAN AREA

AND

SANTA BARBARA

CALIFORNIA CHILDREN'S SERVICES

FEBRUARY 28, 2014

TABLE OF CONTENTS

INTRODUCTION

The purpose of this agreement is to establish working procedures to encourage interagency cooperation in the provision of services to students with disabilities.

It is the intent of this agreement to:

1. Determine each agency's responsibility to the individual, including which services are to be provided by each agency;

2. Delineate which agency assumes the fiscal responsibility for providing the service to the individual;

3. Ensure that all students with disabilities have a free and appropriate public education as required by federal and state laws, regardless of the public agency administering the program;

4. Provide an uninterrupted flow of education to the individual as indicated in each individualized education plan and therapy services as indicated in the CCS medical therapy plan;

5. Establish procedures for reviewing and updating the interagency agreement as necessary;

6. Establish joint planning at the local level to ensure that resources will be utilized in the most efficient manner;

7. Assure non-duplication of service;

8. Establish and maintain channels of communications between the education agencies and CCS.

9. Reflect the guidelines included in the State Interagency Agreement between California Department of Education (CDE), Special Education Division and Department of Health Services, Children's Medical Services Branch (CMS), California Children's Services (CCS) Medical Therapy Program (MTP).

A. INDIVIDUAL'S SERVICE NEED: Standards	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children Services Program will:
1. Under the Individuals with Disabilities Education Improvement Act of 2004 ("IDEA") and related state law, students with disabilities have a right to a free and appropriate public education ("FAPE"). FAPE is made up of special education and related services. Related services, also called designated instruction and services, "include in pertinent part, developmental, corrective, and supportive services such as PT and OT, as may be required to assist a child with a disability to benefit from special education." 20 U.S.C. §1401(a)(26); Ed. Code §56363.	1. Provide physical and occupational therapy services under medical supervision to individuals in accordance with standards established by the CCS Program. 2. Assure that the services provided by physicians, physical therapists, and occupational therapists in the CCS Medical Therapy Program are in accordance with state licensure and professional ethics. 3. Provide diagnostic and medical treatment services to individuals in accordance with standards established by the CCS program. 4. Provide and maintain durable medical equipment as prescribed by a CCS panel physician for the sole use of the CCS client e.g. wheelchairs, crutches, per CCS treatment program eligibility standards.

B. INDIVIDUAL'S SERVICE NEED: Referrals	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Refer any individual birth to 21 years of age who has or is suspected of having a neuromuscular, musculoskeletal, or other physical disability requiring medically necessary occupational or physical therapy to the local California Children's Services Program (see Appendix A and B for CCS eligible conditions) utilizing the procedure outlined below: • Complete referral packet (Appendix C) including all items on the "Checklist for LEA Referrals for CCS Medical Therapy Program Services." • Include all the information requested on the forms. • Send to CCS administrative office, 345 Camino del Remedio, Santa Barbara, CA 93101. 2. Refer the parent to the CCS Therapy Services Coordinator when a student has been receiving CCS Therapy in another county and moves into the Santa Barbara County SELPA. 3. Using the procedure outlined in item #1, refer the parent of students from out-of-state who have been receiving OT/PT per their IEP and are suspected of having a CCS eligible condition to CCS for review of their records to determine medical eligibility and need based on CCS eligibility criteria. Students not suspected of having a CCS eligible condition will be referred to SBCSELPA.	1. Review all referrals which appear to meet CCS criteria or which are questionable and determine medical eligibility for services (see Appendix A & B). 2. Provide diagnostic, treatment, and medical therapy services in accordance with standards established by the California Children's Services Program. 3. Refer any individual suspected of needing educational support services to the director/coordinator of the local education agency as listed in Appendix F.

B. INDIVIDUAL'S SERVICE NEED: Referrals (CONTINUED)	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
4. Refer any individual, birth to 21 years of age, who has or is suspected of having a medical condition which is eligible for CCS diagnostic or treatment services (see Appendix B) by completing the CCS Request for Service packet (Appendix C) and forwarding the form to the CCS office at the address listed on the form, attaching any relevant medical records.	

C. INDIVIDUAL'S SERVICE NEED: Assessment	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Assess students according to assessment requirements of federal and state laws. 2. With parental consent, will forward a copy of the assessment report to the CCS MTU.	1. Assess all medically eligible individuals in accordance with State CCS standards and federal and state law for medically necessary physical and/or occupational therapy services. 2. With parental consent will send a copy of the CCS physical and/or occupational therapy evaluation to the LEA.

D. INDIVIDUAL'S SERVICE NEED: CCS Medical-Therapy Conference	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Release personnel, when appropriate, for attendance at a pupil's scheduled CCS Medical-Therapy Conference Appointment.	1. Use a CCS Medical-Therapy Conference Team as needed to evaluate and determine the rehabilitation needs of medically eligible individuals including bracing, surgery, physical therapy, occupational therapy, and equipment.

E. INDIVIDUAL'S SERVICE NEED: IEP Development, Implementation, and Review

EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Provide prior notice to the appropriate CCS Medical Therapy Unit for all IEP meetings of students receiving CCS occupational and/or physical therapy services. LEAs will provide 10 days notice to CCS. 2. Ensure that the student's IEP reflects the current level of CCS therapy services provided by attaching a copy of the current approved CCS Medical Therapy Plan/Prescription to IEP when provided. (Appendix D-5). CCS services may also be noted in the IEP notes. 3. Identify specialized equipment in the IEP when needed to provide the student with a free and appropriate public education (FAPE). 4. Include transportation to and from therapy in the IEP when needed. This should be documented in the IEP notes. 5. With parental consent send a copy of the IEP to the designated MTU when CCS therapy services and/or transportation to/from the therapy site are included in the IEP notes.	1. Participate, with parental consent, in the development of the IEP in accordance with State CCS standards and state and federal laws. Such participation may include attendance by a CCS staff member at the IEP meeting, provision of written information concerning the need for CCS occupational and/or physical therapy, or conference calls, together with written recommendations. 2. Provide, with parental consent, a copy of the current approved CCS Medical Therapy Plan Prescription, within 15 days of MD signature to the LEA Administrator or designee for the purpose of updating the IEP. (Appendix D-5) 3. Provide at least 10 days prior notice to the LEA Administrator or designee noted as the contact person on the IEP Notification of Meeting form and the parent of a possible change in the CCS medical therapy program services which may necessitate a change in the IEP. This notice will be in the form of a copy of the Medical Therapy Conference Notice. (See Appendix D-4)

E. INDIVIDUAL'S SERVICE NEED: IEP Development, Implementation, and Review (CONTINUED)	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
6. If CCS notifies LEA and SBCSELPA administrator or designee that CCS is unable to provide services in the approved CCS Medical Therapy Plan/IEP, the SBCSELPA administrator shall engage in the following process: a. Interagency team meets to discuss recruitment plan. b. Reimbursement at current contract rate or a negotiated rate between SBCSELPA and CCS plus an administrative fee of 15% shall be paid by CCS to the SBCSELPA.	4. Upon request from LEA, provide consultation regarding durable medical equipment needed for the implementation of the student's IEP. 5. Inform the student's district transportation provider when transportation to and/or from therapy is needed. 6. CCS will inform the LEA administrator or designee if the student with an IEP is discharged from MTU services. 7. CCS will notify the LEA and SBCSELPA administrator if CCS is unable to provide services as stated in approved CCS Medical Therapy Plan and contained in the IEP

F. INDIVIDUAL'S SERVICE NEED: Least Restrictive Environment	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Ensure that, to the maximum extent appropriate, students with disabilities, including students in public or private institutions, are educated with students who are not disabled.	1. Assist the LEA in evaluating those aspects of the pupil's physical disability relating to placement in the least restrictive environment, e.g., architectural considerations and special equipment needs.

G. INDIVIDUAL'S SERVICE NEED: Medical Therapy Unit Facilities and Equipment	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Provide and maintain the necessary facilities, equipment and supplies as specified in Statewide Facilities Standards for CCS MTUs on a twelve month a year basis. 2. Repair and replace equipment, facilities and supplies as necessary. 3. Establish an annual budget for supplies, equipment and facilities used by the Medical Therapy Units. 4. On an annual basis, jointly review with the CCS Therapy Services Coordinator the projected equipment and facility needs for Medical Therapy Units in the SBCSELPA. 5. Identify through revisions to the SBCSELPA Local Plan any changes in fiscal/administrative responsibility for the provision and maintenance of necessary MTU space, equipment and supplies.	1. Coordinate with the Director of the Santa Barbara County SELPA the provision and maintenance of MTU facilities as specified in the SBCSELPA Local Plan and in the Statewide Facilities Standards for CCS MTUs. 2. On an annual basis, jointly review with the SBCSELPA Director the projected equipment and facility needs for Medical Therapy Unit services in the SBCSELPA.

H. INDIVIDUAL'S SERVICE NEED: MTU Satellite Facilities and Equipment	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Coordinate with local school districts the provision and maintenance of MTU satellite facilities as specified in the SBCSELPA Local Plan and Statewide Facility Standards for MTUs. 2. On an annual basis jointly review with the CCS Therapy Services Coordinator the projected equipment and facility needs for satellite services in the SBCSELPA. 3. Identify through revisions to the SBCSELPA Local Plan any changes in fiscal/administrative responsibility for the provision and maintenance of necessary satellite space, equipment and supplies. 4. Jointly establish a plan for the use of classrooms or MTU Satellite space when educational or therapy services are not being provided 5 days per week.	1. Coordinate with the Director of the Santa Barbara County SELPA the provision and maintenance of MTU satellite facilities as specified in the SBCSELPA Local Plan and Statewide Standards for MTUs. 2. On an annual basis, jointly review with the SBCSELPA Director the projected equipment and facility needs for satellite services in the SBCSELPA taking into consideration the number of hours of prescribed services and space required to provide those services. 3. Jointly establish a plan for the use of classrooms or MTU Satellite space when educational or therapy services are not being provided 5 days per week taking into consideration the number of hours of prescribed services and space required to provide those services.

I. INDIVIDUAL'S SERVICE NEED: Location of MTU and Satellite Sites	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Annually, with the local CCS, re-evaluate the appropriateness of MTU and satellite locations and adequacy of space needed per current state guidelines. 2. Jointly plan with the local and state CCS for MTU and satellite establishment and relocation per current state guidelines. 3. In the event the relocation of an MTU or MTU Satellite shall become necessary, the LEA will notify CCS by July 1 of the prior school year. 4. CCS shall be notified by January 15 of the prior school year of the of the proposed new MTU or MTU Satellite location; the proposed new MTU or MTU Satellite location shall be mutually agreed upon by county.	1. Annually, with the SBCSELPA, re-evaluate the appropriateness of MTU and satellite locations and adequacy of space needed per current state guidelines. 2. Jointly plan with the SBCSELPA for MTU and satellite establishment and relocation per current state guidelines.

J. INDIVIDUAL'S SERVICE NEED: Resolution of Disagreements and Due Process	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Inform parents of their rights to due process. 2. Refer parents with concerns about their CCS Therapy Program to the CCS Therapy Staff. 3. Encourage parents to participate in an IEP meeting for resolution of disagreements relating to their student's IEP.	1. Inform parents of their rights to a second medical opinion appeal using the CCS Medical Therapy Program Dispute Resolution Process - 2nd Expert Opinion. (see Appendix E) 2. Refer parents with concerns about their child's educational placement or program to the LEA Staff. 3. Encourage parents to participate in the CCS MTU Conference/Clinic for resolution of therapy related disagreements.

K. INDIVIDUAL'S SERVICE NEED: Confidentiality and Exchange of Information	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Acknowledge the protections afforded to student health information under regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), students' records under the Family Educational Rights and Privacy Act of the Education Code, and under provisions of state law relating to privacy. The Parties will ensure that all activities undertaken under this MOU will conform to the requirements of these laws. 2. Provide to CCS in a timely manner relevant information concerning the pupil with a disability upon receipt of the parent's informed consent.	1. Acknowledge the protections afforded to student health information under regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), students' records under the Family Educational Rights and Privacy Act of the Education Code, and under provisions of state law relating to privacy. The Parties will ensure that all activities undertaken under this MOU will conform to the requirements of these laws. 2. Provide to the Local Education Agency in a timely manner relevant information concerning the pupil with a disability upon receipt of the parent's informed consent.

L. STAFF DEVELOPMENT	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Cooperate and collaborate in the provision of appropriate staff development activities to ensure implementation of the Interagency Agreement. 2. Share information with CCS staff regarding relevant SBCSELPA staff development activities.	1. Cooperate and collaborate in the provision of appropriate staff development activities to ensure implementation of the Interagency Agreement. 2. Share information with SBCSELPA staff regarding relevant CCS staff development activities. 3. MTU staff will participate in all site emergency preparedness training and inservices, including fire and earthquake drills

M. ADMINISTRATION	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. The Director of the Santa Barbara County SELPA shall serve as the liaison for the Santa Barbara County SELPA to California Children's Services. 2. The contact person for each LEA within the SBCSELPA is listed in Appendix F of this agreement. 3. It is the policy of the Department of Education that the LEA accept the CCS assessment determinations for medically necessary physical therapy and occupational therapy. 4. It is understood that the SBCSELPA and its participating LEAs shall not presume or determine CCS eligibility nor make CCS service recommendations.	1. The CCS Coordinator of Therapy and Clinic Services shall serve as the liaison for California Children's Services to the Santa Barbara County SELPA. 2. The contact person for each Santa Barbara County California Children's Services MTU is listed in Appendix F of this agreement. 3. It is the policy of the Department of Health that the local CCS accept the LEA assessment determination for educational placement and services. 4. It is understood that CCS shall not presume or determine eligibility for special education nor make educational programs or service recommendations. 5. In the event that a parent makes a request from CCS for a recommendation for specialized equipment to be used in a school based program, CCS will refer the parent to their special education case manager to request a consultation with CCS.

N. DISPUTE RESOLUTION	
EDUCATION	CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County Special Education Local Plan Area will:	Santa Barbara County California Children's Services Program will:
1. Agree to work cooperatively with CCS to minimize interagency disputes and if such disputes occur will seek a speedy resolution. 2. Make every attempt to resolve the dispute at the lowest possible administrative level. 3. Seek resolution of disputes through involvement of the SBCSELPA Director prior to requesting intervention by the JPA Board. 4. Ensure that the dispute procedures shall not interfere with the right of a pupil with a disability to receive a free appropriate public education.	1. Agree to work cooperatively with SBCSELPA and the SBCSELPA LEAs to minimize interagency disputes and if such disputes occur will seek a speedy resolution. 2. Make every attempt to resolve the dispute at the lowest possible administrative level. 3. Seek resolution of disputes through involvement of the CCS Coordinator of Therapy Services prior to requesting intervention by the Southern California Regional Office of CCS. 4. Ensure that the dispute procedures shall not interfere with the right of a pupil with a disability to receive a free appropriate public education.

INTERAGENCY AGREEMENT APPROVAL

INDEMNITY. Except as otherwise expressly provided, Santa Barbara California - Children's Services and the Santa Barbara County SELPA shall defend, indemnify, and hold each other harmless from and against all claims, liability, loss, and expense, including reasonable costs, collection expenses and attorneys' fees incurred, which arise by reason of the acts of omissions of the indemnifying party, its agent or employees in the performance of its obligations under this agreement.

This agreement shall commence on the effective date of approval by the signatures. The agreement shall be reviewed annually and revised as necessary. It shall remain in effect until any revisions are mutually agreed upon or either party provides 20 days written notice to terminate.

DAN COOPERMAN, CHAIRPERSON
SANTA BARBARA COUNTY SELPA
JOINT POWERS AGENCY BOARD

DATE 6/2/14

TAKASHI MICHAEL WADE, MDMPH
DIRECTOR/ HEALTH OFFICER
SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT

DATE 6/12/14

JANICE BUTTERFIELD, DIRECTOR
SANTA BARBARA COUNTY SELPA

DATE 6/2/14

ANA STENERSEN, PROGRAM MANAGER
CHILDREN'S MEDICAL SERVICES

DATE

STACY TOLKIN, COORDINATOR
SANTA BARBARA COUNTY SELPA

DATE 6/2/14

HEATHER BOUVIER, SUPERVISING THERAPIST
CHILDREN'S MEDICAL SERVICES

DATE 6/10/14

APPENDIX A

California Children's Services Medical Eligibility for the Medical Therapy Program
22 CA ADC § 41517.5

Barclays Official California Code of Regulations
Title 22. Social Security
Division 2. Department of Social Services -Department of Health Services
Subdivision 7. California Children's Services
Chapter 3. Client Application and Eligibility Requirements
Article 2. Medical Eligibility

22 CCR § 41517.5 - Medical Therapy Program.

(a) CCS applicants with at least one of the following conditions shall be medically eligible for participation in the CCS Medical Therapy Program:

(1) Cerebral palsy as specified in Section 41517.3(a)(2).

(2) Neuromuscular conditions that produce muscle weakness and atrophy, such as poliomyelitis, myasthenias, and muscular dystrophies.

(3) Chronic musculoskeletal and connective tissue diseases or deformities such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputations, and contractures resulting from burns.

(4) Other conditions manifesting the findings listed in section 41517.3(a) above, such as ataxias, degenerative neurological disease, or other intracranial processes.

(b) CCS applicants under three years of age shall be eligible when two or more of the following neurological findings are present:

(1) Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity);

(2) Increased Deep Tendon Reflexes (DTRs) that are 3+ or greater;

(3) Abnormal posturing as characterized by the arms, legs, head, or trunk turned or twisted into an abnormal position;

(4) Hypotonicity, with normal or increased DTRs, in infants below one year of age. (Infants above one year must meet criteria described in (a)(1)); or

(5) Asymmetry of motor findings of trunk or extremities.

APPENDIX B

California Children's *Services*

Eligible Medical Conditions

A. Infectious Diseases (ICD-9-CM 001-139) (Section 41515.2)

In general, these conditions are eligible when they:

- involve the central nervous system and produce disabilities requiring surgical and/or rehabilitation services;
- involve bone;
- involve eyes leads to blindness;
- are congenitally acquired and for which postnatal treatment is required and appropriate.

B. Neoplasms (ICD-9-CM 140-239) (Section 41516)

All malignant neoplasms, including those of the blood and lymph systems.

Benign neoplasms when they constitute a significant disability, visible deformity, or significantly interfere with function.

C. Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders (ICD-9-CM 240-279) (Section 41516.1)

In general, these conditions are eligible. Examples of eligible conditions include diseases of the pituitary, thyroid, parathyroid, thymus, adrenal, pancreas, ovaries and testes; growth hormone deficiency, diabetes mellitus, diseases due to congenital or acquired immunologic deficiency manifested by life-threatening infections, inborn errors of metabolism; cystic fibrosis.

Nutritional disorders such as failure to thrive and exogenous obesity are not eligible.

D. Diseases of Blood and Blood-Forming Organs (ICD-9-CM 280-289) (Section 41516.3)

In general, these conditions are eligible. Common examples of eligible conditions are: sickle cell anemia, hemophilia, and aplastic anemia.

Iron or vitamin deficiency anemias are only eligible when they present with life-threatening complications.

E. Mental Disorders and Mental Retardation (ICD-9-CM 290-319) (Section 41517)

Conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition.

F. Diseases of the Nervous System (ICD-9-CM 320-389) (Section 41517.3)

Diseases of the nervous system are, in general, eligible when they produce physical disability (e.g., paresis, paralysis, ataxia) that significantly impair daily function.

Idiopathic epilepsy is eligible when the seizures are uncontrolled, as per regulations. Treatment of seizures due to underlying organic disease (e.g., brain tumor, cerebral palsy, inborn errors of metabolism) is based on the eligibility of the underlying disease.

Specific conditions not eligible are those which are self-limiting and include acute neuritis and neuralgia; and meningitis that does not produce sequelae or physical disability. Learning disabilities are not eligible.

G. Diseases of the Eye (ICD-9-CM 360-379) (Section 41517.7)

Strabismus is eligible when surgery is required.

Chronic infections or diseases of the eye are eligible when they may produce visual impairment and/or require complex management or surgery.

H. Diseases of the Ear and Mastoid (ICD-9-CM 380-389) (Section 41518)

- Hearing loss, as defined per regulations;
- Perforation of the tympanic membrane requiring tympanoplasty;
- Mastoiditis;
- Cholesteatoma.

I. Diseases of the Circulatory System (ICD-9-CM 390-459) (Section 41518.2)

Conditions involving the heart, blood vessels, and lymphatic system are, in general, eligible.

J. Diseases of the Respiratory System (ICD-9-CM 460-519) (Section 41518.3)

Lower respiratory tract conditions are eligible if they are chronic, cause significant disability, and respiratory obstruction; or complicate the management of a CCS-eligible condition.

Lungs: chronic lung disease of infancy is eligible; chronic lung disease of immunologic origin is eligible, as per regulations.

K. Diseases of the Digestive System (ICD-9-CM 520-579) (Section 41518.3)

Diseases of the liver, chronic inflammatory disease of the gastrointestinal (GI) tract and most congenital abnormalities of the GI system are eligible; and gastroesophageal reflux, as per regulations.

Malocclusion is eligible when there is severe impairment of occlusal function and is subject to CCS screening and acceptance for care.

L. Diseases of the Genitourinary System (ICD-9-CM 580-629) (Section 41518.5)

Chronic genitourinary conditions and renal failure are eligible. Acute conditions are eligible when complications are present.

M. Diseases of the Skin and Subcutaneous Tissues (ICD-9-CM 680-709) (Section 41518.6)

These conditions are eligible if they are disfiguring, disabling, and require plastic or reconstructive surgery and/or prolonged and frequent multidisciplinary management.

N. Diseases of the Musculoskeletal System and Connective Tissue (ICD-9-CM 710-739) (Section 41518.7)

Chronic diseases of the musculoskeletal system and connective tissue are eligible. Minor orthopedic conditions such as toeing-in, knock knee, and flat feet are not eligible. However, these conditions may be eligible if expensive bracing, multiple casting, and/or surgery is required. See Q. below for acute injuries.

O. Congenital Anomalies (IDC-9-CM 740-759) (Section 41518.8)

Congenital anomalies of the various systems are eligible if the condition limits a body function, is disabling or disfiguring, amenable to cure, correction, or amelioration, as per regulations.

P. Perinatal Morbidity and Mortality (ICD-9-CM 760-779)

Neonates who have a CCS-eligible condition and require care in a CCS-approved neonatal intensive care unit (NICU) because of the eligible condition.

Critically ill neonates who do not have an identified CCS-eligible condition but who require one or more of the following services in a CCS-approved NICU:

- Invasive or non-invasive positive pressure ventilatory assistance.
- Supplemental oxygen concentration by hood of greater than or equal to 40 percent.

- Maintenance of an umbilical artery (UA) or peripheral arterial catheter (PAC) for medically necessary indications, such as monitoring blood pressure or blood gases.
- Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications, such as pressure monitoring or cardiovascular drug infusion.
- Maintenance of a peripheral line for intravenous pharmacological support of the cardiovascular system.
- Central or peripheral hyperalimentation.
- Chest tube.

Neonates and infants who do not have an identified CCS-eligible condition but who require two or more of the following services in a CCS-approved NICU:

- Supplemental inspired oxygen.
- Maintenance of a peripheral intravenous line for administration of intravenous fluids, blood, blood products or medications other than those used in support of the cardiovascular system.
- Pharmacological treatment for apnea and/or bradycardia episodes.
- Tube feedings.

Q. Accidents, Poisonings, Violence, and Immunization Reactions (ICD-9-CM 800-999) (Section 41518.9)

Injuries of the central or peripheral nervous and vital organs may be eligible if they can result in permanent disability or death. Fractures of the skull, spine, pelvis, or femur which when untreated would result in permanent loss of function or death. Burns, foreign bodies, ingestion of drugs or poisons, lead poisoning, and snake bites may be eligible, as per regulations.

APPENDIX C

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

Takashi M. Wada, MD, MPH Director
Anne M. Fearon Deputy Director
Suzanne Jacobson, CPA Chief Financial Officer
Susan Klein-Rothschild, MSW Deputy Director
Daniel Reid, MPA Deputy Director Interim
Peter Hesler, MD Medical Director
Charity Thoman, MD, MPH Health Officer

L.E.A. REFERRALS
FOR CCS MEDICAL THERAPY PROGRAM SERVICES

The following information and forms are required per section 60320 of CCR. Without this information, the CCS program will be unable to process the L.E.A. referral:

( ) CCS Request for Service form: (DHCS-4488) which includes the required demographic and clinical information. Specify Medical Therapy Program and whether OT and/or PT are being requested.

( ) CCS Application for Services completed by child's parent or legal guardian

( ) Current medical records or a completed SELPA "Physician's Referral For Related Services" form that documents the child's medical diagnosis requiring occupational or physical therapy.

( ) Parental permission for exchange of information between agencies

( ) A copy of the current IEP or IFSP if the student is receiving special education services.

See the current Interagency Agreement between Santa Barbara County SELPA and Santa Barbara County CCS for details and forms.

If all of the above items are supplied with the referral, the L.E.A. will receive notice of action on determination of Medical Eligibility for CCS Therapy Services within 15 days from receipt of the referral

For questions, please contact CCS at 681-5360.

State of California—Health and Human Services Agency

Department of Health Care Services
California Children's Services/Genetically Handicapped Persons Program

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
	( )	( )

Client Information

8. Client name—last | first | middle

9. Alias (AKA)	10. Gender	11. Date of birth (mm/dd/yy)
	☐ Male ☐ Female	

12. CCS/GHPP case number	13. Contact phone number	14. Medical record number (hospital or office)
	( )	

15. Residence address (number, street) (DO NOT USE P.O. BOX) | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence	18. Language spoken	19. Name of parent/legal guardian

20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number
		( )

Insurance Information

23.a. Enrolled in Medi-Cal?	23.b. If yes, client index number (CIN)	23.c. Client's Medi-Cal number
☐ Yes ☐ No		

24. Enrolled in Healthy Families	If yes, name of plan
☐ Yes ☐ No	

25. Enrolled in commercial insurance plan	If yes, type of commercial insurance plan	Name of plan
☐ Yes ☐ No	☐ PPO ☐ HMO ☐ Other	

Diagnosis

26.

Diagnosis (DX)/ICD-9:_____ DX/ICD-9:_____ DX/ICD-9:_____

Requested Services

27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached	34. Enter facility name (where requested services will be performed, if other than office).
☐ Yes	

Inpatient Hospital Services

35. Begin date	36. End date	37. Number of days

Additional Services Requested from Other Health Care Providers

38. Provider's name	Provider number	Telephone number	Contact person
		( )	

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

39. Provider's name	Provider number	Telephone number	Contact person
		( )	

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

40. Signature of physician/provider or authorized designee	41. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
32. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
36. End date: Enter the end date for the inpatient stay requested.
37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form or whose out-of-pocket medical expenses for a child who qualifies are expected to be more than 20 percent of family income; or the child has Healthy Families coverage.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost; or
- have Healthy Families coverage.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- complete the application form on page 3 and return it to their county CCS office;
- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

- CCS must keep this information confidential.[2]
- CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes

1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term **"applicant"** means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth—county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. box)	City	County	ZIP code

5. Gender ☐ Male ☐ Female	6. Race/ Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Name of applicant's physician	10. Physician's phone number ( )

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. box)	City	County	ZIP code

14. Mailing address (if different from 13)	City	ZIP code

15. Day phone number ( )	16. Evening phone number ( )	17. Message phone number ( )	18. What language do you speak at home?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? ☐ Yes ☐ No	If yes, what is the applicant's Medi-Cal number?	Is there a share-of-cost? ☐ Yes ☐ No	If yes, what amount do you pay per month? $

20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No	If yes, what is the name of the plan?

21 Does the applicant have other health insurance? ☐ Yes ☐ No	If yes, what is the name of the insurance plan or company?

Type of insurance plan or company

☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:_____

22. Does the applicant have dental insurance? ☐ Yes ☐ No	23. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

___ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

___ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

___ I certify that I have read and understand the information or have had it read to me.

___ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office (see page 6). Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

   - Alaskan Native
   - Amerasian
   - American Indian
   - Asian
   - Asian Indian
   - Black/African American
   - Cambodian
   - Chinese
   - Filipino
   - Guamanian
   - Hawaiian
   - Hispanic/Latino
   - Japanese
   - Korean
   - Laotian
   - Samoan
   - Vietnamese
   - White
   - Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write down the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Daytime phone number:** Please write the phone number where you can be reached during the day.
16. **Evening phone number:** Please write the phone number where you can be reached during the evening.
17. **Message phone number:** Please write your message phone number if applicable.
18. **Language(s) spoken:** Write down the language you speak at home.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check "No" and go to number 20. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes" and fill in the amount of your shared cost. If you don't, check "No" and go to number 20.
20. If the applicant receives health insurance from the Healthy Families program please check "Yes" and fill in the name of the plan. If the applicant does not, check "No." Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask your county CCS program about how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check "No" and go to number 22. If the applicant has health insurance, check "Yes" and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."
23. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

Santa Barbara County
PUBLIC Health
DEPARTMENT

Children's Medical Services
345 Camino del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

AUTHORIZATION FOR RELEASE OF INFORMATION

These records are protected under federal regulations governing confidentiality of patient records (42 CFR Section 2.1, 45 CFR Parts 160 and 164), and California regulations governing privacy of health information (Civil Code 56.10-56.36, Health & Safety Code 123100-123149.5, and Welfare and Institutions Code 5328).

RE: _____ DOB: ___/___/___ CCS# _____

I, the undersigned, hereby consent to, request and authorize the use and disclosure of medical and educational records between California Children Services, Santa Barbara Public Health Department, and those individuals and agencies listed below who have provided or are providing medical or educational services to the above named person.

I understand that these records will be used only to coordinate medical and educational services to the above named person and that California Children Services protects the confidentiality of client information and releases information only according to policies based on federal and state law.

Does the above named person receive special education services or have an Individual Educational Plan (IEP)? ☐ Yes ☐ No
Does he/she receive Early Start services or have an Individual Family Service Plan (IFSP)? ☐ Yes ☐ No

MEDICAL PROVIDERS		
Name of Primary Care Physician	Address/City/Zip	Phone Number
Name of Other Medical Providers	Address/City/Zip	Phone Number
EDUCATIONAL PROVIDERS		
School District/Local Education Agency	Address/City/Zip	Phone Number
TRI-COUNTIES REGIONAL CENTER		
Name of Service Coordinator	Address/City/Zip	Phone Number
OTHER AGENCIES (Name)		
Name of Service Coordinator	Address/City/Zip	Phone Number

I understand that the County does not condition my eligibility, enrollment, treatment or benefits based upon signing this **Authorization for Release of Information**. I understand that there is the potential for this information to be disclosed by the recipient and that the County is not responsible for other providers' or agencies' use and disclosure. I have the right to inspect, obtain copies, or amend the health information that I am authorizing California Children's Services to disclose.

I understand that this **Authorization for Release of Information** is valid until the above named person turns 21 years of age or until their California Children Services case is closed (whichever comes first). All or part of the **Authorization for Release of Information** may be canceled upon receipt of written notification from the undersigned to the address listed above.

A copy of this **Authorization for Release of Information** is as valid as the original. The person signing this consent has the right to obtain a copy.

Name of Parent/Legal Guardian or Client (if over age 18): _____

Signature of Parent/Legal Guardian or Client (if over age 18): _____ Date: _____

Signature of Witness: _____ Date: _____
Revised 05/23/05

INFORMACIÓN SOBRE LOS SERVICIOS PARA LOS NIÑOS DE CALIFORNIA (CCS)

¿Qué son los Servicios para los Niños de California?

CCS es un programa estatal que trata a niños con ciertas limitaciones físicas y con problemas y enfermedades de salud crónicos. CCS puede autorizar y pagar el costo de servicios y equipos médicos específicos provistos por especialistas aprobados por CCS. El Departamento de Servicios de Salud de California administra el programa CCS. Los condados de mayor tamaño operan sus propios programas CCS, mientras que los condados de menor tamaño comparten la operación de su programa con las oficinas regionales estatales de CCS en Sacramento, San Francisco y Los Angeles. El programa está financiado con fondos provenientes de impuestos estatales, del condado y federales, y con algunos honorarios que pagan los padres.

¿Qué ofrece CCS a los niños?

Si usted o el médico de su hijo piensa que su hijo puede tener un problema médico que cumple con los requisitos de CCS, es posible que CCS pague o provea una evaluación médica para determinar si el problema de su hijo está cubierto.

Si su hijo cumple con los requisitos, CCS podrá pagar o brindar:

- Tratamiento, como servicios médicos, cuidados en el hospital y de cirugía, fisioterapia y terapia ocupacional, pruebas de laboratorio, radiografías, aparatos ortopédicos y equipo médico.
- Manejo de casos médicos para ayudar a obtener médicos especialistas y cuidados para su hijo si son médicamente necesarios, así como remisión a otros organismos, incluyendo enfermería de salud pública y centros regionales.
- Programa de Terapia Médica (MTP, por sus siglas in inglés), que puede prestar servicios de fisioterapia y/o de terapia ocupacional en escuelas públicas para niños que cumplen con ciertos requisitos médicos.

¿Quiénes cumplen con los requisitos para CCS?

El programa está a disposición de todos los que:

- son menores de 21 años de edad;
- tienen o pueden tener un problema médico cubierto por CCS;
- son residentes de California y
- tienen un ingreso familiar de menos de $40,000, según se informe en el ingreso bruto ajustado del formulario impositivo del estado **o se espera** que tendrán gastos médicos de bolsillo, para un niño que cumple con los requisitos, de más del 20 por ciento del ingreso familiar; o bien, el niño tiene cobertura de Healthy Families.

El ingreso familiar no es un factor determinante en el caso de los niños que:

- necesitan servicios diagnósticos para confirmar un problema médico que cumple con los requisitos de CCS; o
- fueron adoptados con conocimiento de que tenían un problema médico que cumple con los requisitos de CCS; o
- sólo están solicitando servicios mediante el Programa de Terapia Médica; o
- tienen Medi-Cal completo, sin compartir el costo; o
- tienen cobertura de Healthy Families.

¿Qué problemas médicos cubre CCS?

Sólo ciertos problemas están cubiertos por CCS. En general, CCS sólo cubre problemas médicos que causan impedimentos físicos o requieren servicios médicos, quirúrgicos o de rehabilitación. También puede haber ciertos criterios que determinan si el problema médico de su hijo cumple con los requisitos. La lista a continuación contiene las categorías de problemas médicos que pueden estar cubiertos y **algunos ejemplos** de cada uno de ellos:

- Problemas del corazón (enfermedad cardíaca congénita)
- Neoplasmas (cánceres, tumores)
- Enfermedades de la sangre (hemofilia, anemia de células falciformes)
- Enfermedades endocrinas, de nutrición y metabólicas (problemas de tiroides, PKU [fenilcetonuria], diabetes)
- Enfermedades del sistema genito-urinario (problemas crónicos serios de los riñones)
- Problemas del sistema gastrointestinal (enfermedad inflamatoria crónica, enfermedades del hígado)
- Defectos de nacimiento serios (paladar hendido, labio leporino, espina bífida)
- Enfermedades de los órganos sensoriales (pérdida del oído, glaucoma, cataratas)
- Enfermedades del sistema nervioso (parálisis cerebral, ataques no controlados)
- Enfermedades del sistema musculosquelético y de los tejidos conectivos (artritis reumatoide, distrofia muscular)
- Enfermedades graves del sistema inmune (infección por el VIH)

- Problemas que causan impedimentos o intoxicaciones que requieren cuidados intensivos o rehabilitación (lesiones graves de la cabeza, el cerebro o la médula espinal, quemaduras graves)
- Complicaciones del nacimiento prematuro que requieren cuidados intensivos
- Enfermedades de la piel y del tejido subcutáneo (hemangioma grave)
- Mala oclusión que causa impedimentos médicos (dientes muy torcidos)

Si tiene preguntas, la oficina CCS de su condado se las puede responder.

¿Qué tiene que hacer el solicitante o la familia para cumplir con los requisitos?

Las familias (o el solicitante, si cumplió los 18 años o es un menor de edad emancipado) deben:

- completar el formulario de solicitud en la página 3 y enviarlo a la oficina CCS de su condado;
- dar a CCS toda la información solicitada, para que CCS pueda determinar si la familia cumple con los requisitos;
- solicitar Medi-Cal si CCS cree que el ingreso de la familia la habilita para registrarse en el programa Medi-Cal. (Si una familia califica para Medi-Cal, el niño también está cubierto por CCS. CCS aprueba los servicios y los pagos se efectúan mediante Medi-Cal).

¿Cómo se protege mi privacidad?

La ley de California requiere que se dé a las familias que soliciten servicios información sobre cómo CCS protege su privacidad.[1]

Para proteger su privacidad:

- CCS tiene que mantener esta información confidencial.[2]
- CCS puede compartir la información que figura en el formulario con personal autorizado de otros programas de salud y bienestar **únicamente** si usted firmó un formulario de consentimiento.

Usted tiene derecho a ver su solicitud y los datos de CCS relativos a usted o a su hijo. Si desea ver estos datos, póngase en contacto con la oficina CCS de su condado. Por ley, la información que usted da a CCS es archivada por el programa.[3]

¿Tengo derecho a apelar una decisión?

Tiene derecho a estar en desacuerdo con las decisiones que tome CCS.[4] Esto se llama hacer una apelación. El proceso de apelación permite que el padre, el tutor o el solicitante trabaje con el programa CCS para encontrar soluciones a los desacuerdos. Para información sobre el proceso de apelación, póngase en contacto con la oficina CCS de su condado.

¿Dónde puedo obtener más información sobre CCS?

Para más información o ayuda para llenar esta solicitud, póngase en contacto con la oficina CCS de su condado. Por lo general, el número de teléfono de dicha oficina figura en la sección de gobierno del directorio telefónico local. Busque bajo *California Children's Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

Notas

1 Código Civil, Sección 1798.17
2 De conformidad con la Sección 41670, Título 22, Código de Reglamentaciones de California y la ley de Datos Públicos de California (Código de Gobierno, Secciones 6250–6255)
3 Sección 123800 et. seq. del Código de Salud y Seguridad de California
4 Código de Reglamentaciones de California, Título 2, Secciones 42702–42703

SOLICITUD PARA DETERMINAR SI EL SOLICITANTE PUEDE PARTICIPAR EN EL PROGRAMA CCS

Esta solicitud debe ser completada por el padre, el tutor o el solicitante (si cumplió los 18 años de edad o es un menor de edad emancipado) para determinar si el solicitante cumple con los requisitos para recibir servicios y beneficios de CCS. El término **"solicitante"** significa el niño, la persona de 18 años de edad o más o el menor de edad emancipado para el que se solicitan los servicios. Para obtener instrucciones sobre cómo completar este formulario, consulte la página 4. Escriba a máquina o claramente en letras de molde.

A. Información sobre el solicitante

1. Nombre del solicitante [apellido] [nombre] [segundo nombre]	Nombre en el certificado de nacimiento (si es diferente)	Algún otro nombre por el que se conoce al solicitante

2. Fecha de nacimiento (mes, día, año) _____ / _____ / _____	3. Lugar de nacimiento, condado y estado	País, si nació fuera de EE.UU.

4. Dirección del solicitante (número y calle) (no usar casilla postal)	Ciudad	Condado	Código postal

5. Género ☐ Masculino ☐ Femenino	6. Raza/ etnia	7. Número del seguro social *(optativo)* ___ ___ ___ - ___ ___ - ___ ___ ___ ___

8. ¿Cuál es el problema o la discapacidad del solicitante que se sospecha que cumple con los requisitos de CCS?

9. Nombre completo del médico del solicitante	10. Número de teléfono del médico ( )

B. Información sobre el padre o tutor (los solicitantes de 18 años de edad o mayores o los menores emancipados saltean los números 11 y 13).

11. Nombre(s) completo(s) del/de los padre(s) o tutor(es)	12. Nombre de la madre (si no se identificó en 11)	Apellido de soltera

13. Dirección (número y calle) (no usar casilla postal)	Ciudad	Condado	Código postal

14. Dirección postal (si no es la misma que la del 13)	Ciudad	Código postal

15. Nº de teléfono diurno ( )	16. Nº de teléfono nocturno ( )	17. Nº para mensajes telefónicos ( )	18. ¿Qué idioma se habla en su casa?

C. Información sobre el seguro de salud

19. ¿Tiene Medi-Cal el solicitante? ☐ Sí ☐ No	Si tiene, ¿cuál es el número de Medi-Cal del solicitante?	¿Comparte el costo? ☐ Sí ☐ No	Si lo comparte, ¿cuánto paga por mes? $

20. ¿Está inscrito el solicitante en el programa Healthy Families? ☐ Sí ☐ No	Si lo está, ¿cómo se llama el plan?

21. ¿Tiene el solicitante otro seguro de salud? ☐ Sí ☐ No	Si lo tiene, ¿cómo se llama el plan o la compañía de seguros?

Tipo de plan o compañía de seguros

☐ Proveedor Preferente (PPO) ☐ Organización para el Mantenimiento de la Salud (HMO) ☐ Otro:_____

22. ¿Tiene seguro dental el participante? ☐ Sí ☐ No	23. ¿Tiene seguro de la vista el solicitante? ☐ Sí ☐ No

D. Certificación (Coloque sus iniciales y firme a continuación. Su firma autoriza al programa CCS a proceder con esta solicitud).

___ Solicito el programa CCS para determinar el cumplimiento de requisitos para obtener servicios y beneficios. Entiendo que completar esta solicitud no garantiza la aceptación del solicitante en el programa CCS.

___ Doy permiso para que se verifique mi dirreción, información sobre la salud u otras circunstancias que se requieran para determinar el cumplimiento de requisitos para recibir servicios y beneficios CCS.

___ Certifico que he leído y comprendo la información o que me la han leído.

___ También certifico que la información que escribí en este formulario es verdadera y correcta.

Firma de la persona que llenó la solicitud	Relación con el solicitante	Fecha

Firma del testigo (sólo si la persona firmó con una marca)	Fecha

Envíe este formulario por correo a la oficina CCS de su condado. Consulte la página 6 para obtener una lista de direcciones.

INSTRUCCIONES PARA COMPLETAR EL FORMULARIO PARA SOLICITAR SERVICIOS PARA NIÑOS DE CALIFORNIA (DHCS 4480)

Escriba claramente en letras de molde para que su solicitud se pueda tramitar lo más rápidamente posible.

Llene cada sección completamente. Si no da toda la información, CCS no podrá proceder con su solicitud. Si necesita ayuda para llenar este formulario, póngase en contacto con la oficina CCS de su condado.

Después de completar la solicitud, envíela por correo a la oficina CCS de su condado (consulte la página 6). No olvide firmar el formulario y colocarle la fecha.

Sección A: Información sobre el solicitante ("Solicitante" significa el niño, la persona de 18 años de edad o mayor, o el menor de edad emancipado para el que se solicitan los servicios).

1. **Nombre del solicitante:** Escriba el apellido, el nombre y el segundo nombre del solicitante. En la casilla que sigue, escriba el nombre completo del solicitante como aparece en su certificado de nacimiento si no es igual a su nombre. Si el solicitante se conoce por cualquier otro nombre, escriba ese nombre en la última casilla.
2. **Fecha de nacimiento del solicitante:** Escriba el mes, el día y el año del nacimiento del solicitante.
3. **Lugar de nacimiento:** Escriba el condado y el estado en los que nació el solicitante. Si el solicitante nació fuera de EE.UU., escriba el país.
4. **Dirección:** En este espacio, escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar donde vive ahora el solicitante. No use ninguna casilla de correo.
5. **Género del solicitante:** Ponga una marca √ o una X en la casilla que corresponda al género (masculino o femenino).
6. **Raza o etnia:** Ponga la categoría de la lista que aparece más abajo que mejor describa la raza o etnia principal del solicitante:

   - Nativo de Alaska
   - Amerasiático
   - Indígena norteamericano
   - Asiático
   - Indio asiático
   - Negro/afronorteamericano
   - Camboyano
   - Chino
   - Filipino
   - Guaymeño
   - Hawaiano
   - Hispano/latino
   - Japonés
   - Coreano
   - Laosiano
   - Samoano
   - Vietnamita
   - Blanco
   - Otro

7. **Número del seguro social del solicitante (optativo):** Escriba el número de nueve cifras del seguro social del solicitante.
8. **Problema o discapacidad que se sospecha que cumple con los requisitos de CCS:** Escriba la discapacidad o la necesidad especial de atención de la salud del solicitante que trataría el CCS. La descripción adjunta de los problemas que cumplen con los requisitos de CCS lo puede ayudar (consulte "¿Qué problemas médicos cubre CCS?" en la página 1). Si no sabe, pregunte al médico del solicitante o deje el espacio en blanco. Si hace falta más información, CCS se pondrá en contacto con el médico del solicitante.
9. **Nombre completo del médico del solicitante:** Escriba el nombre completo del médico del solicitante.
10. **Número de teléfono del médico:** Escriba el número de teléfono del médico que puso en el número 9.

Sección B: Información sobre el padre o tutor (Los solicitantes de 18 años de edad o mayores o los menores de edad emancipados saltean los números 11 y 13).

11. **Nombres completo(s) del/de los padre(s) o tutor(es):** Escriba el/los nombre(s) del/de los padre(s) del solicitante o del/de los tutor(es) del solicitante.
12. **Nombre y apellido de soltera de la madre:** Escriba el nombre y el apellido de soltera de la madre del solicitante.
13. **Dirección:** Escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar en que usted vive ahora. No use ninguna casilla de correo.
14. **Dirección postal:** Si la dirección es diferente de la del número 13, escriba el número de la calle, el nombre de la calle, la ciudad y el código postal.
15. **Número de teléfono diurno:** Escriba el número de teléfono al que se lo puede llamar durante el día.
16. **Número de teléfono nocturno:** Escriba el número de teléfono al que se lo puede llamar durante la noche.
17. **Número para mensajes telefónicos:** Si corresponde, escriba el número de teléfono para dejarle mensajes telefónicos.

18. **Idioma(s) que habla:** Escriba el idioma que usted habla en su casa.

Sección C: Información sobre el seguro de salud

Si CCS cree que usted puede cumplir con los requisitos de participación, le pedirán que solicite Medi-Cal si en la actualidad no está recibiendo beneficios Medi-Cal para la atención de la salud.

19. Si el solicitante no recibe Medi-Cal, marque "No" y pase al número 20. Si el solicitante recibe Medi-Cal, marque "Sí" y escriba el número de Medi-Cal del solicitante. Si usted paga una parte del costo de su seguro Medi-Cal, marque "Sí" y escriba la cantidad del costo que comparte. De lo contrario, marque "No" y pase al número 20.
20. Si el solicitante recibe seguro de salud del programa Healthy Families, marque "Sí" y escriba el nombre del plan. Si el solicitante no recibe ese seguro, marque "No". Healthy Families es un programa de seguro especial para las familias de ingresos moderados a bajos. Si le parece que puede cumplir con los requisitos, pregúntele al programa CCS de su condado cómo puede solicitar participar en el programa Healthy Families.
21. Si el solicitante no tiene otro seguro de salud, marque "No" y pase al número 22. Si el solicitante tiene seguro de salud, marque "Sí" y escriba el nombre del plan o de la compañía de seguros. Después marque la casilla que corresponda, dependiendo de la clase de seguro que sea. Sus formularios de seguros le indican la clase de seguro de salud que tiene. Si no está seguro puede llamar a su compañía de seguros y preguntarles.
22. Si el solicitante tiene seguro dental, marque "Sí". Si el solicitante no tiene seguro dental, marque "No".
23. Si el solicitante tiene seguro de la vista, marque "Sí". Si el solicitante no tiene seguro de la vista, marque "No".

Sección D: Certificación

Asegúrese de firmar y poner la fecha con tinta. Si firma con una marca, pida a un testigo firme y ponga la fecha.

En la sección "Relación con el solicitante", coloque padre, madre, tutor o sí mismo (en el caso de las personas de 18 años de edad o mayores, de los menores de edad emancipados).

Presentación de su solicitud

Envíe por correo o entregue su solicitud a la oficina CCS de su condado. Para encontrar la oficina CCS de su condado visite www.dhcs.ca.gov/services/ccs o busque en la sección de gobierno del directorio telefónico local bajo *California Children's Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

Santa Barbara County
PUBLIC Health
DEPARTMENT

Children's Medical Services
345 Camino del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

AUTORIZACION PARA CEDER INFORMACION MEDICA

Estos expedients son protegidos bajo los reglamentos federales governado la confidencialidad de los archivos medicos del paciente (42 CFR Seccion 2.1, 45 CFR partos 160 y 164), y los reglamentos de California governando la privacidad de información médica (Civil Code 56.10-56.38, Health & Safety Code 123100-123149.5, and Welfare and Institutions Code 5328).

RE: _____ FDN: ___/___/___ CCS#: _____

Yo, el abajo firmante, por la presente doy mi consentimiento que soliciten y autorizo el uso y revelación de mi expediente médico y educativo entre Servicios de los Niños de California, el Departamento de Salud Pública de Santa Bárbara, y los individuos y agencies que figuran abajo que han dado o esten dando servicios medicos o educativos a la persona que figura ariba.

Entiendo que estos expedients serán usados para coordinar los servicios medicos y educacionales de la persona que figura ariba y que el Servicio de los Niños de California protége la confidencialidad de la información del cliente y revela solamente información de acuerdo con las polizas basadas en la ley federal y estatal de California.

¿La persona que figura ariba recibe servicios de educación especial o tiene un Plan Educativo Individual? ☐Sí ☐No
¿Recibe el/ella servicios de primeras etapar (Early Start) o el plan de Servicio Individual de Familia? ☐Sí ☐No

PROVEEDORES MEDICOS		
Nombre de su Médico Particular	Domicilio/Ciudad/Código Postal	Número de teléfono
Nombre de Otros Proveedores Médicos	Domicilio/Ciudad/Código Postal	Número de teléfono
PROVEEDORES EDUCATIVOS		
Distrito Escolar/Agencia Local de Educación	Domicilio/Ciudad/Código Postal	Número de teléfono
EL CENTRO REGIONAL DE LOS TRES CONDADOS		
Nombre del Coordinador de Servicios	Domicilio/Ciudad/Código Postal	Número de teléfono
OTRAS AGENCIAS (Nombre)		
Nombre del Coordinador de Servicios	Domicilio/Ciudad/Código Postal	Número de teléfono

Entiendo que el Condado no acondiciona mi eligibilidad, inscripción, tratamiento o beneficios al firmar esta **Autorización para Ceder Información Médica**. Entiendo que esta información ya en poder de Agencias o profesionales Medicos, potencialmente pudiera ser desiminada y que el Condado de Santa Bárbara no es responsible por el uso o desiminación de Información por parte de otras agencias, Instituciones y profesionales de salud. Y tengo el derecho de inspeccionar, obtener copias, amendar la información médica que yo autorizo al Servicio de los Niños de California que puedan reveler.

Entiendo que esta **Autorización para Ceder Información Médica** es valida hasta que la persona que figura ariba llegue a la edad de 21 años o hasta que se cierre el caso bajo los Servicios de los Niños de California (cual llegue primero). Toda o parte de la **Autorización para Ceder Información Médica** puede ser cancelada al recibir por escrito notificación del abajo firmante al domicilio que figura ariba.

Una copia del la **Autorización para Ceder Información Médica** es tan válida como la original. El abajo firmante de este consentimiento tiene el derecho de obtener una copia.

Nombre del padre/Tutor Legal o el Cliente (si es mayor de 18 años): _____

Firma del Padre/Tutor Legal o el Cliente (si es mayor de 18 años): _____ Fecha: _____

Firma de Testigo: _____ Fecha: _____

Santa Barbara County
Special Education Local Plan Area_____*A Joint Powers Agency*

PHYSICIAN'S INFORMATION FORM FOR RELATED SERVICES

PART I: *TO BE COMPLETED BY PARENT OR SCHOOL DISTRICT PERSONNEL*

CHILD'S LEGAL NAME: *Last* *First* *Middle* *Date of Birth*

ADDRESS: *Number* *Street* *City* *Zip* *Telephone*

MOTHER'S NAME: *Last* *First* *Middle* **FATHER'S NAME:** *Last* *First* *Middle*

PARENT'S ADDRESS: (*If different from above*) **PHONE:** *Home* *Daytime*

NAME OF PERSON MAKING REFERRAL: _____

RELATIONSHIP TO CHILD: _____ **DAYTIME PHONE:** _____

HAS THIS CHILD BEEN REFERRED TO REGIONAL CENTER (TCRC)? ☐ NO ☐ YES

IS THIS CHILD A CLIENT OF TCRC? ☐ NO ☐ YES

THE COMPLETED FORM SHOULD BE RETURNED TO:

NAME: _____ DISTRICT/COUNTY OFFICE: _____

ADDRESS: _____
Street *City* *Zip*

PART II: *TO BE COMPLETED BY THE PHYSICIAN* (*See directions below*)

1. **DIAGNOSIS OR SUSPECTED CONDITION(S): Please include all disabling conditions and a short description of each**

2. **MEDICATIONS:** _____

3. **PRECAUTIONS/CONTRADICTIONS:** _____

Physician Signature Date

Physician Printed Name

Address

( ) Telephone

DIRECTIONS FOR COMPLETION OF SELPA 16

To District Personnel: Part I of the Physician's Form for Related Service must be completed by the District or parent before being submitted to the physician. It is recommended that Part I and Part II of this form be completed and included in the CCS referral packet but it is not required. This is a District responsibility. For referrals to CCS, a CCS Request for Services, CCS Application for Services, and Parent Release of Information form must also be provided. **To the Physician:** Please complete Part II and return the completed information to the District/County Office listed in Part 1 of this form. Thank you.

APPENDIX D

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

Takashi M. Wada, MD, MPH Director
Anne M. Fearon Deputy Director
Suzanne Jacobson, CPA Chief Financial Officer
Susan Klein-Rothschild, MSW Deputy Director
Daniel Reid, MPA Deputy Director Interim
Peter Hecker, MD Medical Director
Charity Thoman, MD, MPH Health Officer

MEDICAL ELIGIBILITY NOTIFICATON

To: _____ **Date:** _____

Re: Child _____ **Birth date:** _____

Dear Parent/Legal Guardian:

Your child has been determined to be medically eligible for the California Children Services (CCS) Medical Therapy Program (MTP). Within fifteen days you will be contacted by the therapy staff at the following Medical Therapy Unit to schedule an appointment for an initial physical or occupational therapy assessment/evaluation.

Santa Barbara Medical Therapy Unit
4400 Cathedral Oaks Road
Santa Barbara, CA 93110
(805) 967-7758
Unit Supervisor: Jeanine Johnson-Caloudes OTR

If you have not heard from the MTU within this time period, please contact the Unit Supervisor listed.

If you have any questions, please feel free to contact 681-5360.

cc: LEA
MTU
Referring MD

RR4sb

CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

Original

Client Name:
Birth Date:
Case #:
County: Santa Barbara
CIN #:

NOTICE OF ACTION (NOA)

Dear

This is a Notice of Action. We call it NOA for short. This NOA is to tell you that referral, services or eligibility to California Children's Services is denied as of:

This will not affect h's Medi-Cal or Healthy Families benefits, if applicable.

Your child's health is important to us, but you have not met CCS program requirements, therefore, CCS eligibility cannot be approved.

There is no documentation of medical eligibility for the CCS Medical Therapy Program (MTP) at this time. Eligibility for the MTP is therefore denied.

Citations: Health and Safety Code 123830; California Code of Regulations, Title 2, Section 60300(j); California Code of Regulations, Title 22, Sections 41515.1, 41517.3, and 41517.5.

If you disagree with this decision, you may appeal. The deadline to appeal is , which is 30 days from the date of this NOA. Read the enclosed information to learn more about your right to appeal.

If you have questions, or would like to give us more information, please call Santa Barbara County CCS Office at (805) 681-5360.

Sincerely,

California Children's Services

5007591-2011

Included with this letter:

How to Appeal

This NOA is required by California Code of Regulations, Title 22, Sections 42140 and 42160.

We sent a copy of this letter to:

CALIFORNIA CHILDREN'S SERVICES
Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

How to Appeal

* What is an appeal?

An appeal is a way to ask us to reconsider our decision. The parent, the applicant, the legal guardian or an authorized representative can ask for an appeal.

* How do I ask for an appeal?

The CCS Family Handbook has more information about appeals.
Send us a letter asking for an appeal. In your letter say why you disagree with our decision. If you want to continue the services your child is getting now, say that in your letter. Please supply all pertinent documentation that supports your appeal.

* Is there a deadline?

Yes. We must receive your appeal within 30 calendar days of the date on the attached NOA letter.

* Can CCS help me with my appeal?

Yes. If you have questions or need help, contact your county's CCS office:

Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110
(805) 681-5360

Your local Family Resource Center can also provide information and support regarding the CCS appeal process.

For information on how to contact the nearest Family Resource Center, call 1-800-515-BABY or go to the Family Voices of California website at www.familyvoicesofca.org.

Parent Training and Information Centers may also be able to provide support (www.cde.ca.gov/sp/se/qa/caprntorg.asp).

Appeal Rights

* Where can I learn about the laws for appeals?

See the California Code of Regulations, Title 22, Sections 42140 and 42160.

You can read the law at: http://ccr.oal.ca.gov

* Where do I send my appeal?

Mail or deliver your appeal to:

Santa Barbara County CCS Office
345 Camino Del Remedio, 3rd Fl
Santa Barbara, CA 93110

Keep a copy of the appeal for your records.

* When will my appeal be decided?

We will send you a copy of the decision on your appeal within 20 days.

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children Services
345 Camino del Remedio, Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

MEDICAL THERAPY PROGRAM (MTP)
THERAPY ASSESSMENT PLAN

☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY

NAME: _____ BIRTHDATE: _____ CCS# _____

Your child has been referred to the CCS Medical Therapy Program for a physical and/or occupational therapy assessment for medically necessary therapy services. The following assessment tools will be used to allow the therapist to develop a proposed therapy plan.

- ☐ CLINICAL OBSERVATIONS: The therapist's observations of the child during the assessment.
- ☐ ACTIVITIES OF DAILY LIVING: Functional skills such as mobility, transfers, ambulation, gait, eating, dressing, bathing, grooming, toileting, home skills and use of adaptive equipment.
- ☐ MOBILITY: Manner in which the child moves about his/her environment.
- ☐ RANGE OF MOTION: Standardized testing of passive and active joint range.
- ☐ SENSORY: Response to position in space, object identification, 2-point discrimination, and tactile (sharp/dull).
- ☐ FINE MOTOR: Motor maturity through age appropriate responses.
- ☐ GROSS MOTOR: Motor maturity through age appropriate responses.
- ☐ REFLEXES: Postural responses, balance and equilibrium reactions.
- ☐ POSTURAL ALIGNMENT: Posture as it relates to the skeletal system and functional abilities.
- ☐ ORAL MOTOR: Examination of the oral cavity, oral/facial reflexes and muscles.
- ☐ PERCEPTION: Standardized testing of child's ability to receive, interpret and use sensory impressions.
- ☐ RESPIRATORY: Standardized testing of vital capacity.
- ☐ OTHER:

_____ _____

Therapist date Therapist date

Santa Barbara MTU, 4400 Cathedral Oaks, Santa Barbara, CA 93110

PLEASE SIGN BELOW AND RETURN TO THE ABOVE ADDRESS AS SOON AS POSSIBLE. SIGNED CONSENT MUST BE GIVEN PRIOR TO THE INITIATION OF THE ABOVE ASSESSMENT.

I hereby give consent for my child to be evaluated in any of the above marked areas.

_____ _____

Parent/Guardian Date

RR5 cc: ___ parent/guardian ___ LEA ___ MTU file

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children Services
345 Camino del Remedio, Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

PROGRAMA DE TERAPIA MÉDICA (MTP)
PLAN DE ASESORAMIENTO DE TERAPIA

☐ TERAPIA FÍSICA ☐ TERAPIA OCUPACIONAL

NOMBRE: _____ FDN: _____ CCS #: _____

Su niño ha sido referido al programa de terapia médica de CCS para un asesoramiento físico y/o ocupacional de terapia necesarios. Los instrumentos siguientes del asesoramiento serán utilizados para permitir que el terapeuta desarrolle un plan preestablecido de terapia.

☐OBSERVACIONES CLINICOS: Las observaciones del terapeuta del niño durante el asesoramiento.

☐ACTIVIDADES DE LA VIDA DIARIA: Habilidades funcionales tales como la movilidad, las transferencias, movimiento, paso, el comer, vestirse, bañarse, asearse, las necesidades, habilidades caseras y uso de equipo adaptado.

☐MOVILIDAD: Manera de la cual el niño se mueve en su medio ambiente.

☐AMPLITUD DE MOVIMIENTO: Prueba estandardizada del alcance pasivo y activo de las coyunturas.

☐SENSORIAL: Reacción a la posición en espacio, la identificación del objeto, discriminación de 2 puntos, y táctil (afilado/no afilado).

☐ MOTOR FINO: Madurez del motor con respuestas apropiadas para la edad.

☐ MOTOR GRUESO: Madurez del motor con respuestas apropiadas para la edad.

☐ REFLEJOS: Reacciones de postura, equilibrio y reacciones al equilibrio.

☐ ALINEAMIENTO POSTURAL: Postura como se relaciona con el sistema esquelético y las capacidades funcionales.

☐ MOTOR ORAL: Examen de la cavidad bucal, de los reflejos orales/faciales y de los músculos.

☐ PERCEPCION: Prueba estandardizada de la capacidad del niño en recibir, interpretar y utilizar impresiones sensoriales.

☐ RESPIRATORIO: Prueba estandardizada de la capacidad vital.

☐ OTRO:

Terapeuta	Fecha	Terapeuta	Fecha
_____ MTU		Dirección: _____	

POR FAVOR FIRME ABAJO Y DEVUELVA ESTE FORMULARIO LO MAS PRONTO POSIBLE A LA DIRECCION QUE SE ENCUENTRA EN EL CABEZAL DE LA HOJA. EL CONSENTIMIENTO FIRMADO SE DEBE DAR ANTES DE INICIAR EL ASESORAMIENTO ANTEDICHO.

Doy por este medio el consentimiento para que mi niño sea evaluado en cualesquiera de las áreas marcadas arriba.

_____ _____
Padre/Guardián Fecha

RR5 cc: ___ parent/guardian ___ LEA ___ MTU file

Santa Barbara County
PUBLIC Health
DEPARTMENT

Lompoc Medical Therapy Unit: CCS

991 Mountain View Blvd. Suite 2 Vandenberg AFB, CA 93437
805-734-2005 - FAX 805-734-0694

To the Parents of:

Jose has an appointment with:

Dr. Sean Early – Wednesday,

At the Lompoc Medical Therapy Unit 991 Mountain View Blvd, Suite 2, Vandenberg AFB, CA 93437

Please call us at 734-2005 when you receive this letter to confirm or cancel the appointment; You can leave a message or send an email.

Appointments are limited and if we do not heard from your family, the appointment will be canceled. This may affect consults with the school, receiving/repair to equipment, physical and occupational therapy.

Feel free to invite your Early Start or Tri-Counties Regional Center Service Coordinator or your child's teacher to attend this appointment with you. The Medical Therapy Conference/Clinic is a free CCS program benefit that does not require financial eligibility. The occupational and physical therapy services prescribed by the Medical Therapy Conference team are also free of charge. Any X-rays, bracing, durable medical equipment, or other medical services or surgeries recommended by the team will require financial eligibility to be authorized by the CCS program.

Since it may be necessary to undress your child for examination purposes, he/she may feel more comfortable in shorts or a bathing suit worn underneath regular clothing. Please bring a list of current medication, any bracing, splints, or assistive devices (walker, crutches, wheelchair) currently being used by your child.

Your questions and concerns regarding your child and their therapy program are important, so please list them below and bring this letter with you to this clinic.

1. _____
2. _____
3. _____

Sincerely,

Monica V. Santana
Monica.Santana@SBCPHD.org
Administrative Office Professional
California Children Services - Lompoc MTU

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children Services
Santa Maria Medical Therapy Unit
601 W. Alvin, Bldg. 160 • Santa Maria, CA 93454
805/928-0662 • FAX 805/739-0430

Sobre:

Estimados Padre:

Nuestra oficina de "Terapia" ha hecho una cita para nuestra próxima Conferencia/Clínica de Medico:

Fecha:	Miércoles –
Hora:	9:00 am
Doctor (es):	Dr. Michael Maguire - Ortopédico
Lugar:	Santa Maria Medical Therapy Unit c/o Robert Bruce School 601 West Alvin Avenue Santa Maria, CA 93454

La Clínica/Conferencia de Terapia Medica es un beneficio gratuito del programa de CCS que no requiere elegibilidad financial. Los servicios de la terapia ocupacional y terapia física prescriptos por la conferencia de Terapia Medica son también gratuitos. Cualquier Rayos-X, aparatos, equipo durable medico u otros servicios médicos o cirugías recomendadas por el equipo se requerirán una elegibilidad finánciale con el CCS para poder ser autorizados por el programa de CCS.

Sus preguntas o preocupaciones acerca a su hija son importantes para nuestro programa, favor de apuntarlos en esta hoja, y traerla con usted el día de la clínica.

1. _____
2. _____
3. _____

Como resultado de esta Conferencia/Clínica de Terapia Medica el plan del tratamiento de su hija de las terapia ocupacional y/o terapia física del CCS puede ser modificada.

Favor de llamar **928-0662 no mas tarde de 05/08/14** para informarnos si usted va poder asistir a esta cita. Como las citas son limitadas, favor de hacer cualquier intento de asistir. Pedir una nueva cita resultara en demora de los servicios.

Sinceramente,

Annabel G. Dollinger
Office Assistant Senior

Physical/ Occupational Therapy Initial/ Progress Assessment
CCS MEDICAL THERAPY PLAN/PRESCRIPTION

Child's Name:	DOB:	Chronological Age:	CCS#:	Referral Date:
Primary Care Physician:	MD Directing Therapy Services:		MTP Medically Eligible Condition:	
Therapist:	School:	Treatment Diagnosis:	Date of Report:	

I. Current Functional Status:(DEPendent, MAXimum assist, MODerate assist, MINimum assist, Contact Guard Assist (CGA), Stand By Assist (SBA), SUPervised, Modified Independent (Mod I), Independent) * = with adaptive equipment N/T=Not Tested # = Age Appropriate

Ambulation:	Bathing:	Community Skills:	Dressing:
Feeding:	Home Skills:	Mobility:	Play/Vocational:
Prewriting:	Toileting:	Transfers:	Other:

II. Benefits of Previous Therapy Services:

III. Short Term Functional Goal(s):

A. (Goal)
1. (Objective)
2. (Objective)
3. (Objective)

B.
1. (Objective)
2. (Objective)
3. (Objective)

IV. Recommended Therapy Services: (Subject to staff availability)

	Frequency	Duration	Location
A. Monitor/Periodic Checks: ☐30 min ☐ 45 min ☐ 60 min sessions			
B. Direct Treatment: ☐30 min ☐ 45 min ☐ 60 min sessions			MTU

C. Treatment Plan:
☐ Gait Training ☐ Functional Activities of Daily Living(ADL) ☐ Splinting ☐ Modalities ☐ School Program
☐ Transfer Training ☐ Oral Motor ☐ Community Skills ☐ Consultation
☐ Functional Mobility ☐ Therapeutic Exercise ☐ Home Program ☐ Home Skills ☐ Evaluation ☐ Other

D. ☐ No therapy indicated. Follow in MTU Conference/Clinic only ☐ Close MTP Services

V. Change from previous Plan/Prescription: ☐ yes ☐ no VI. Proposed date of Initiation of Therapy Plan: _____

VII. Proposed date of medical (re)evaluation: ☐ 6 months from date of report; ☐ 1 year from date of report; ☐ Other

_____ _____ (805) _____
Therapist Name, PT Date Telephone #

I have participated in the development of this treatment plan for my child and consent to its implementation. I also agree to periodic reassessment of my child's needs.

_____ _____
Parent Signature Date

Physician: Please review the above treatment plan and indicate any needed changes or additions and sign below.

Comments/Changes or Additions to Plan: _____

Precautions: _____ *Rehab Potential:* ____*Good* ____*Fair* ____*Limited*

I agree with the above therapy treatment plan with noted changes or additions. My signature will act as prescription for treatment as designated above, as well as for periodic reassessment.

_____ _____ _____
, MD License Number Date

*Physician's and therapist's signature are required in order for CCS MTP services to be provided and to signify an approved therapy plan.
Please return signed Plan/Prescription to: MTU ADDRESS

Distribution: PCP: ____ MTU: _____ Parent/ Guardian: _____ TCRC: ____ LEA: ____ *RR8 (07/01)*

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

Takashi M. Wada, MD, MPH Director
Anne M. Fearon Deputy Director
Suzanne Jacobson, CPA Chief Financial Officer
Susan Klein-Rothschild, MSW Deputy Director
Daniel Reid, MPA Deputy Director Interim
Peter Hesler, MD Medical Director
Charity Thoman, MD, MPH Health Officer

LEA NOTIFICATION OF MEDICAL THERAPY PROGRAM STATUS

Date:

To: (LEA)

Re: _____ Birthdate: _____

CCS has received a referral from this child's Local Education Agency (LEA) for CCS Medical Therapy Program (MTP) services. This notice is to inform the LEA that this child is medically eligible for the MTP and the following has been completed thus far:

( ) The Therapy Assessment Plan has been signed by parent/caregiver and LEA notified.

( ) The MTP Consent for Participation in the CCS Medical Therapy Program (Consent for Treatment) has been signed by parent/caregiver.

( ) Therapy assessment report and proposed therapy plan have been reviewed with parent/caregiver.

( ) Notice of Medical Therapy Conference (MTC) has been sent to parent/caregiver and to the LEA *or* the child will be seen by a private CCS panel physician.

( ) Child has been examined by the physician.

( ) Therapy Plan/Prescription has been signed by the physician and approved by the MTC team and a copy has been sent to the parent/caregiver and LEA.

_____	_____	_____
SUPERVISING THERAPIST	DATE	MTU

cc: parent/caregiver

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

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Daniel Reid, MPA Deputy Director Interim
Peter Hesler, MD Medical Director
Charity Thoman, MD, MPH Health Officer

LEA NOTIFICATION OF POSSIBLE DELAY IN DETERMINING MEDICALLY NECESSARY THERAPY SERVICES

Date:

To: (LEA)

Re: _____ Birthdate: _____

There may be a delay in responding to your referral for CCS Medical Therapy Program (MTP) services because of one or more of the following:

( ) The parent/caregiver has not made or kept the appointment for diagnostic evaluation.

( ) No medical reports have been received from the authorized physician in order to review and determine medical eligibility.

( ) Parent/caregiver has not signed the Therapy Assessment Plan.

( ) Parent/caregiver has not signed the Consent for Participation in the CCS Medical Therapy Program (Consent for Treatment).

( ) Parent/caregiver has not made or kept appointment for Therapy Assessment.

( ) Parent/caregiver has not kept appointment for Medical Therapy Conference.

( ) OTHER _____

_____ _____ _____

SUPERVISING THERAPIST DATE MTU

cc: parent/caregiver

RR10

APPENDIX E

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

Rea Goumas, MD
Medical Director

Ana Stenersen
Program Director

MEDICAL THERAPY PROGRAM
SECOND EXPERT OPINION PROCESS

California Children Services (CCS) provides a formal structure for disagreeing with a decision made by the CCS Medical Therapy Conference/Clinic Team. If you disagree with the medical therapy treatment plan developed by the Clinic Team, you can ask for a second expert opinion. The CCS program will provide you with the names of three physicians with experience in the treatment of children with physical disabilities and will pay for an evaluation and second opinion from your choice of the three. The CCS Due Process system delegates the final decision to the expert consultant with no subsequent recourse to further appeal by either party.

If you wish to use this process, the following are the necessary steps to take:

1. If, after reviewing the medical therapy treatment plan with the Medical Therapy Conference/Clinic physician(s), you continue to disagree with their opinion, submit a **written request for a second expert opinion** within five (5) calendar days of the clinic review to:

   Rea Goumas, MD
   Medical Director
   Santa Barbara County CCS
   345 Camino del Remedio
   Santa Barbara, CA 93110

   Your request should include the MTU Conference/Clinic Team decision with which you disagree; the action you want taken; any supportive information or documentation; and whether you wish to have current therapy services continued during the resolution process.

2. Within five (5) calendar days from receipt of your request, CCS will mail you a list of three expert physicians. You may choose one and must inform Dr. Goumas of your choice within 20 calendar days. CCS will authorize and pay for an appointment with the expert physician for a physical evaluation and a second opinion regarding needed therapy services.

The expert physician's findings will be a binding opinion on the type, frequency, and duration of therapy services to be provided through the Medical Therapy Program.

If you would like more information regarding this process, please contact Ana Stenersen, Program Director at (805) 681- 5360.

05/2011

Santa Barbara County
PUBLIC Health
DEPARTMENT

California Children's Services

345 Camino Del Remedio • Santa Barbara, CA 93110
805/681-5360 • FAX 805/681-4763

Rea Goumas, MD
Medical Director
Ana Stenersen
Program Director

PROGRAMA DE TERAPIA MÉDICA
PROCESO DE UNA SEGUNDA OPINION DE UN EXPERTO

El programa de servicios para niños en California (CCS) ofrece un proceso de estructura formal en el caso de no estar de acuerdo con alguna decisión tomada por el equipo de Conferencia Médica de Terapia. Si usted no está de acuerdo con el plan de tratamiento de terapia desarollado por el equipo de clínica medica, usted puede pedir una segunda opinión de un experto médico. El programa de C.C.S. le proveerá con una lista de nombres de tres doctores con experiencia en tratamiento de niños con incapacidades físicas. También pagará por la evaluación del doctor de su elección. El proceso debido legal del CCS delega la decisión final del experto consultante con ningún subsiguiente recurso de futuras apelaciones por cualquiera de las dos partes.

Si usted elije usar este proceso, necesitará seguir los siguentes pasos:

1. Si, despues de discutir/revisar el Plan de Terapia Médico con el doctor (es) de Conferencia de la Clínica Médica, usted continúa en desacuerdo con la opinión provista, **tiene que entregar una petición por escrito para obtener una segunda opinión de un experto médico**, dentro de un período de (5) dias despues de la Conferencia de Clínica Médica a:

   Rea Goumas, MD
   Medical Director
   Santa Barbara Co. CCS
   345 Camino Del Remedio, Bldg. 4
   Santa Barbara, Ca. 93110

   Su petición deberá incluir la decisión tomada por el equipo de Conferencia Clínica Médica con el cual usted no esta de acuerdo; la acción que usted le gustaría tomar; alguna información o documentación que le apoye; y si desea o no que continúen los servicos de terapia actuales durante el proceso de resolución.

2. Dentro de los (5) días calendarios despues de haber recibido su petición, C.C.S. le enviará por correo una lista con los nombres de 3 doctores expertos. Usted tiene que elegir uno e informarle a la Doctor Goumas de su elección, no mas tarde de 20 días calendarios. CCS autorizará y pagará por la cita con el experto médico para una evaluación física y una segunda opinión acerca de servicios de terapia necesarios.

Los hallazgos del experto médico serán una opinion definitiva, en cuanto al tipo de frequencia y duración de los servicios de terapia que serán provistos por el programa de terapia.

Si desea más información acerca de este proceso, por favor de llamar a la programa de CCS a (805) 681-5360.

05/2011

APPENDIX F

DIRECTORY OF AGENCY CONTACTS

CALIFORNIA CHILDREN'S SERVICES	HEATHER BOUVIER Supervising Therapist 345 Camino del Remedio Santa Barbara, CA 93101	681-5362
CARPINTERIA	RUTH RECH Director, Pupil Services Carpinteria Unified School District 1400 North Linden Avenue Carpinteria, CA 93013	684-7657
FAMILY PARTNERSHIP CHARTER SCHOOL	TODD MITCHELL Executive Director PO Box 490 Santa Maria, CA 93454	348-3333 904-0087
GOLETA	MARGARET SALEH Assistant Superintendent, Special Services Goleta Union School District 401 North Fairview Avenue Goleta, CA 93117	681-1220
GUADALUPE	ED CORA Superintendent Guadalupe Union School District 4465 Ninth Street, P.O. Box 788 Guadalupe, CA 93434-0788	343- 2114
HOPE	JESTIN ST.PETER Special Education Coordinator/Psychologist Hope School District 3970 La Colina Road Santa Barbara, CA 93110	455-5885
LOMPOC	TINA CHRISTEN Director, Special Education Lompoc Unified School District P.O. Box 8000 Lompoc, CA 93438-8000	742-3301
LOMPOC MTU & THE JONATA SATELLITE	LOIS KAM, PT, UNIT SUPERVISOR 991 Mountain View Blvd Suite 2 Vandenberg AFB, CA 93437	734-2005

ORCUTT	LANA THOMAS Director, Pupil Services Orcutt Union School District 500 Dyer Street Santa Maria, CA 93455	938-8960
SANTA BARBARA COUNTY EDUCATION OFFICE	CATHY BREEN Assistant Superintendent, Special Education Santa Barbara County Schools Office 4400 Cathedral Oaks Road Santa Barbara, CA 93111	964-4711
SANTA BARBARA MTU & THE CANALINO SATELLITE	JEANINE JOHNSON-CALOUDES OT, UNIT SUPERVISOR 4400 Cathedral Oaks Road Santa Barbara, CA 93110	967-7758
SANTA BARBARA SCHOOL DISTRICT	HELEN RODRIGUEZ Assistant Superintendent Santa Barbara School District 720 Santa Barbara Street Santa Barbara, CA 93011	963-4338 x254
SANTA MARIA-BONITA SCHOOL DISTRICT	KAREN ANDERSON Director, Special Education Santa Maria-Bonita School District 708 South Miller Santa Maria, CA 93454	928-1783 x8180
SANTA MARIA HIGH SCHOOL DISTRICT	FRANCES EVANS Director, Special Education Santa Maria Jt. Union High School District 2560 Skyway Drive Santa Maria, CA 93455	922-4573 x4221
SANTA MARIA MTU & THE BATTLES SATELLITE	ISABEL TELLEZ, PT UNIT SUPV. 601 W. Alvin Avenue Santa Maria, CA 93454	928-0662
SANTA YNEZ VALLEY CONSORTIUM	CLAUDIA ECHAVARRIA Director of Santa Ynez Valley Special Education Consortium Jonata School 301 Second Street Buellton, CA 93427-9476	688-4222 x2121

SBCSELPA COORDINATOR	STACY TOLKIN Santa Barbara County SELPA 401 N. Fairview Avenue Goleta, CA 93117	683-1424
SBCSELPA DIRECTOR	JARICE BUTTERFIELD Santa Barbara County SELPA 401 N. Fairview Avenue Goleta, CA 93117	683-1424

CHDP Administrative Budget Summary for FY 2014-15
No County/City Match
County/City Name: _____Santa Barbara_____

Column	1	2	3	4	5
Category/Line Item	Total Budget (2 + 3)	Total CHDP Budget	Total Medi-Cal Budget (4 + 5)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	$ 432,450	$ 1,806	$ 430,645	$ 223,111	$ 207,533
II. Total Operating Expenses	$ 40,800	$ 483	$ 40,317	$ 5,475	$ 34,842
III. Total Capital Expenses	$ -	$ -	$ -		$ -
IV. Total Indirect Expenses	$ 77,195	$ 318	$ 76,877		$ 76,877
V. Total Other Expenses	$ -	$ -	$ -		$ -
Budget Grand Total	$ 550,446	$ 2,607	$ 547,839	$ 228,586	$ 319,252
		$ 3,152			

Column	1	2	3	4	5
Source of Funds	Total Funds	Total CHDP Budget	Total Medi-Cal Budget	Enhanced State/Federal	Nonenhanced State/Federal
State General Funds	$ 2,607	$ 2,607			
Medi-Cal Funds:	$ 547,839		$ 547,839		
State	$ 216,773		$ 216,773	$ 57,147	$ 159,626
Federal (Title XIX)	$ 331,066		$ 331,066	$ 171,440	$ 159,626

219,380

Nancy Leidelmeijer
Prepared By

10/15/2014
Date Prepared

(805) 681-5188
Phone Number

CHDP Director or Deputy Director (Signature)

10-15-14
Date

(805) 681-5476
Phone Number

CHDP Administrative Budget Worksheet
No County/City Match
State and State/Federal

County/City Name: _ Santa Barbara

Fiscal Year 2014-15

Column	1A	1B	1	2A	2	3A	3	4A	4	5A	5
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	CHDP % or FTE	Total CHDP Budget	Total Medi-Cal %	Total Medi-Cal Budget (4 + 5)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
Personnel Expenses											
1. PH Prog Mgr S Copley	25%	$ 105,500	$ 26,375	0.71%	$ 187	99.29%	$ 26,188	50%	$ 13,094	50%	$ 13,094
2. PHN Lmarshall	100%	$ 95,500	$ 95,500	0.71%	$ 678	99.29%	$ 94,822	80%	$ 75,858	20%	$ 18,964
3. Staff Phys. Dr. Goumas	10%	$ 192,000	$ 19,200	0.92%	$ 177	99.08%	$ 19,023	80%	$ 15,219	20%	$ 3,805
4.Health Educator J Waite	50%	$ 75,500	$ 37,750	0.11%	$ 42	99.89%	$ 37,708	75%	$ 28,281	25%	$ 9,427
5. AOP I	75%	$ 72,477	$ 54,358	0.11%	$ 60	99.89%	$ 54,298	30%	$ 16,289	70%	$ 38,009
6. AOP II	75%	$ 73,490	$ 55,118	0.11%	$ 61	99.89%	$ 55,057	0%	$ -	100%	$ 55,057
7. AOP III	5%	$ 75,500	$ 3,775								
Total Salaries and Wages			$ 292,075		$ 1,204		$ 287,096		$ 148,741		$ 138,355
Less Salary Savings			$ -		$ -		$ -		$ -		$ -
Net Salaries and Wages			$ 292,075		$ 1,204		$ 287,096		$ 148,741		$ 138,355
Staff Benefits (Specify %) 50.00%			$ 146,038		$ 602		$ 143,548		$ 74,370		$ 69,178
I. Total Personnel Expenses			$ 438,113		$ 1,806		$ 430,645		$ 223,111		$ 207,533
II. Operating Expenses											
1. Travel			$ 3,500		$ 21		$ 3,479		$ 2,783		$ 696
2. Training			$ 3,500		$ 135		$ 3,365		$ 2,692		$ 673
3. Office expense			$ 11,000		$ 200		$ 10,800				$ 10,800
4.Printing/Duplicating			$ 3,000		$ 40		$ 2,960				$ 2,960
5. Communications			$ 3,000		$ 6		$ 2,994				$ 2,994
6. Motorpool			$ 5,000		$ -		$ 5,000				$ 5,000
7. Utilities			$ 7,300		$ 66		$ 7,234				$ 7,234
8.Data Processing			$ 4,500		$ 15		$ 4,485				$ 4,485
II. Total Operating Expenses			$ 40,800		$ 483		$ 40,317		$ 5,475		$ 34,842
III. Capital Expenses											
1.											
2.											
3.											
4.											
5.											
II. Total Capital Expenses			$ -		$ -		$ -				$ -
IV. Indirect Expenses											
1. Internal (Specify %) 12.45%			$ 54,545		$ 225		$ 54,320				$ 54,320
2. External (Specify %) 5.17%			$ 22,650		$ 93		$ 22,557				$ 22,557
IV. Total Indirect Expenses			$ 77,195		$ 318		$ 76,877				$ 76,877
V. Other Expenses											
1.											
2.											
3.											
4.											
5.											
V. Total Other Expenses			$ -		$ -		$ -				$ -
Budget Grand Total			$ 556,108		$ 2,607		$ 547,839		$ 228,586		$ 319,252

Nancy Leidelmeijer
Prepared By

10/13/2014
Date Prepared

805-681-5188
Phone Number

CHDP Director or Deputy

10-13-2014
Date

(805) 681-5476
Phone Number

CHDP No County Match Budget Narrative
Santa Barbara County
Fiscal Year 2014-15

I. PERSONNEL EXPENSE		
Total Salaries	292,075.25	
Total Benefits	146,037.63	
Total Personnel Expense	**438,112.88**	
II. OPERATING EXPENSE		
1. Travel	3,500.00	Estimate of travel necessary to perform program activities
2. Training	3,500.00	Estimate of training needed for current and new staff
3. Office expense	11,000.00	Estimate of office expense based on CY usage
4. Printing/Duplicating	3,000.00	Copying and printing for program activities and newsletter
5. Communications	3,000.00	Telephone charges
6. Motorpool	5,000.00	County Carpool attibutable to CHDP
7. Utilities	7,300.00	pro-rated CHDP share of utilities
8. Data Processing	4,500.00	Charges by county's DP department
TOTAL OPERATING EXPENSE	40,800.00	
III. CAPITAL EXPENSE		
	-	
TOTAL CAPITAL EXPENSE	-	
IV. INDIRECT EXPENSE		
1. Internal	$ 54,545	Program share of internal overhead, per PHD cost plan
2. External	$ 22,650	Program share of external overhead, per PHD cost plan
TOTAL INDIRECT EXPENSE	$ 77,195	
V. OTHER EXPENSE		
	$ -	
TOTAL OTHER EXPENSE	$ -	
TOTAL BUDGET	**$ 556,108**	

HCPCFC Administrative Budget Summary Fiscal Year 2013-14

County/City Name: Santa Barbara County

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	$143,498	$143,498	$0
II. Total Operating Expenses	$1,800	$1,800	$0
III. Total Capital Expenses			
IV. Total Indirect Expenses	$25,284		$25,284
V. Total Other Expenses			
Budget Grand Total	$170,582	$145,298	$25,284

Column	1	2	3
Source of Funds	Total Funds	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds	48,967	36,324	12,642
Federal Funds (Title XIX)	121,615	108,973	12,642
Budget Grand Total	170,582		

Prepared By (Signature)	10/17/2014 Date Prepared	805-681-5188 Phone Number	nleidel@sbcphd.org Email Address
CHDP Director or Deputy Director (Signature)	10/17/14 Date	805-681-5476 Phone Number	scopley@sbcphd.org Email Address

HCPCFC Administrative Budget Worksheet Fiscal Year 2013-14

County/City Name: Santa Barbara County

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
I. Personnel Expenses							
1. PHN, I. Lopez	100%	$95,500	$92,500	100%	$92,500		
2. Program Mgr, S Copley	3%	$105,500	$3,165	100%	$3,165		
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages			$95,665		$95,665		
Less Salary Savings							
Net Salaries and Wages			$95,665	100%	$95,665		
Staff Benefits (Specify %) 50.00%			$47,833		$47,833		
I. Total Personnel Expenses			$143,498		$143,498		
II. Operating Expenses							
1. Travel			$200	**100%**	$200		
2. Training			$1,600	**100%**	$1,600		
3. Licenses			$150	**100%**	$150		
II. Total Operating Expenses			$1,800		$1,800		
III. Capital Expenses							
1.							
2.							
II. Total Capital Expenses							
IV. Indirect Expenses							
1. Internal (Specify %) 17.62%			$25,284				$25,284
2. External 5.79%							
IV. Total Indirect Expenses			$25,284				$25,284
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total			$170,582		$145,298		$25,284

Prepared By (Signature)	Date prepared	Phone Number	Email Address
Nancy Leidel Meyer	10/13/2014	805-681-5188	nleidel@sbcphd.org

CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address
	10-13-2014	805-681-5476	sandra.copley@sbcphd.org

HCPCFC No County Match Budget Narrative
Santa Barbara County
Fiscal Year 2013-14

I. PERSONNEL EXPENSE		
Total Salaries	95,665	
Total Benefits	47,833	
Total Personnel Expense	**143,498**	
II. OPERATING EXPENSE		
1. Travel	200	Estimate of travel necessary to perform program activities
2. Training	1,600	Estimate of training needed for current
TOTAL OPERATING EXPENSE	1,800	
III. CAPITAL EXPENSE		
	-	
TOTAL CAPITAL EXPENSE	-	
IV. INDIRECT EXPENSE		
1. Internal	25,284	Program share of internal overhead, per PHD cost plan
2. External		Program share of external overhead, per PHD cost plan
TOTAL INDIRECT EXPENSE	25,284	
V. OTHER EXPENSE		
	-	
TOTAL OTHER EXPENSE	-	
TOTAL BUDGET	**170,582**	

CCS CASELOAD	Actual Caseload	Percent of Total CCS Caseload
STRAIGHT CCS - Total Cases of Open (Active) Straight CCS Children	160	8.21%
HEALTHY FAMILIES - Total Cases of Open (Active) Healthy Families Children	0	0.00%
MEDI-CAL/OTLICP (TITLE XXI) - Total Cases of Open (Active) MC/TLICP Children	322	16.52%
MEDI-CAL (TITLE XIX) - Total Cases of Open (Active) Medi-Cal Children	1467	75.27%
TOTAL CCS CASELOAD	**1949**	**100%**

CCS Administrative Budget Worksheet

Fiscal Year: 2014-15

County: Santa Barbara

	Col 1 = Col 2+3+4+5	Straight CCS	Title XXI - HF	Title XXI Medi-Cal/OTLICP	Title XIX Medi-Cal (Column 5 = Columns 6 + 7)		
Column	1	2	3	4	5	6	7
Category/Line Item	**Total Budget**	**Straight CCS County/State (50/50)**	**Healthy Families County/State/Fed (17.5/17.5/65)**	**Medi-Cal/Optional Targeted Low Income Children's Program (OTLICP) County/State/Fed (17.5/17.5/65)**	**Title XIX Medi-Cal State/Federal**	**Enhanced Title XIX Medi-Cal State/Federal (25/75)**	**Non-Enhanced Title XIX Medi-Cal State/Federal (50/50)**
I. Total Personnel Expense	1,960,056	160,908	0	323,826	1,475,319	0	1,475,319
II. Total Operating Expense	110,000	9,030	0	18,173	82,796	0	82,796
III. Total Capital Expense	0	0	0	0	0		0
IV. Total Indirect Expense	345,362	28,352	0	57,058	259,952		259,952
V. Total Other Expense	0	0	0	0	0		0
Budget Grand Total	2,415,418	198,290	0	399,057	1,818,067	0	1,818,067

	Col 1 = Col 2+3+4+5	Straight CCS	Title XXI - HF	Title XXI Medi-Cal/OTLICP	Title XIX Medi-Cal (Column 5 = Columns 6 + 7)		
Column	1	2	3	4	5	6	7
Source of Funds	**Total Budget**	**Straight CCS County/State (50/50)**	**Healthy Families County/State/Fed (17.5/17.5/65)**	**Medi-Cal/Optional Targeted Low Income Children's Program (OTLICP) County/State/Fed (17.5/17.5/65)**	**Title XIX Medi-Cal State/Federal**	**Enhanced Title XIX Medi-Cal State/Federal (25/75)**	**Non-Enhanced Title XIX Medi-Cal State/Federal (50/50)**
Straight CCS							
State	99,145	99,145					
County	99,145	99,145					
Healthy Families							
State	0		0				
County	0		0				
Federal (Title XXI)	0		0				
Title XXI - Medi-Cal/TLICP							
State	69,835			69,835			
County	69,835			69,835			
Federal (Title XXI)	259,387			259,387			
Title XIX - Medi-Cal							
State	909,034				909,034	0	909,034
Federal (Title XIX)	909,033				909,033	0	909,033

Prepared By (Signature)

Nancy Leidelmeijer
Prepared By (Printed Name)

nleidel@sbcphd.org
Email Address

CCS Administrator (Signature)

10-16-2014

Ana Stenersen
CCS Administrator (Printed Name)

a.stenersen@sbcphd.org
Email Address

CCS CASELOAD	Actual Caseload	Percent of Total CCS Caseload
STRAIGHT CCS - Total Cases of Open (Active) Straight CCS Children	160	8.21%
HEALTHY FAMILIES - Total Cases of Open (Active) Healthy Families Children	0	0.00%
MEDI-CAL/OTLICP (TITLE XXI) - Total Cases of Open (Active) MC/TLICP Children	322	16.52%
MEDI-CAL (TITLE XIX) - Total Cases of Open (Active) Medi-Cal Children	1467	75.27%
TOTAL CCS CASELOAD	1949	100%

CCS Administrative Budget Worksheet

Fiscal Year: 2014-15

County: Santa Barbara

				Straight CCS		Title XXI - Healthy Families		Title XXI - Medi-Cal/Optional Targeted Low Income Children Program (OTLICP)	
Column	1	2	3	4A	4	5A	5	6A	6
Category/Line Item	% FTE	Annual Salary	Total Budget (1 x 2 or 4 + 5 +6 + 7)	Caseload %	Straight CCS County/State (50/50)	Caseload %	Healthy Families County/State/Fed (17.5/17.5/65)	Caseload %	Medi-Cal/ Optional Targeted Low Income Children's Program (OTLICP) Co/State/Fed (17.5/17.5/65)
I. Personnel Expense									
Program Administration									
1. Stenersen, Ana, Program Manager	100.00%	111,370	111,370	8.21%	9,143	0.00%	0	16.52%	18,400
2. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
3. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
4. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
5. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
Subtotal		111,370	111,370		9,143		0		18,400
Medical Case Management									
1. Blasing, Dorothy, RN	100.00%	76,692	76,692	8.21%	6,296	0.00%	0	16.52%	12,671
2. Acosta, Nicole, RN	75.00%	93,922	70,442	8.21%	5,783	0.00%	0	16.52%	11,638
3. Cheng, Linda PHN	100.00%	93,922	93,922	8.21%	7,710	0.00%	0	16.52%	15,517
4. Chu, Kimberly, RN	100.00%	81,084	81,084	8.21%	6,656	0.00%	0	16.52%	13,396
5. Petrini, Carol PHN	75.00%	93,922	70,442	8.21%	5,783	0.00%	0	16.52%	11,638
6. Strunin, Maxyne PHN	100.00%	93,922	93,922	8.21%	7,710	0.00%	0	16.52%	15,517
7. Goumas, Staff Physician	50.00%	190,911	95,455	8.21%	7,836	0.00%	0	16.52%	15,770
8. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
Subtotal		724,376	581,959		47,774		0		96,147
Other Health Care Professionals									
1. Barr, Shereen MSW	75.00%	56,500	42,375	8.21%	3,479	0.00%	0	16.52%	7,001
2. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
3. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
Subtotal		56,500	42,375		3,479		0		7,001
Ancillary Support									
1. Bayquen, Case Worker	100.00%	56,000	56,000	8.21%	4,597	0.00%	0	16.52%	9,252
2. Connor, Case Worker	100.00%	56,000	56,000	8.21%	4,597	0.00%	0	16.52%	9,252
3. Escobedo, Case Worker	100.00%	56,000	56,000	8.21%	4,597	0.00%	0	16.52%	9,252
4. Ramos, Case Worker	100.00%	56,000	56,000	8.21%	4,597	0.00%	0	16.52%	9,252
5. Guendulain Ordaz and Barvie, Case Worker	150.00%	56,000	84,000	8.21%	6,896	0.00%	0	16.52%	13,878
Subtotal		280,000	308,000		25,284		0		50,886
Clerical and Claims Support									
1. Castaneda, Admin Office Professional	100.00%	75,000	75,000	8.21%	6,157	0.00%	0	16.52%	12,391
2. Zacapa, Admin Office Professional	100.00%	56,500	56,500	8.21%	4,638	0.00%	0	16.52%	9,335
3. Quezada, Admin Office Professional	100.00%	56,500	56,500	8.21%	4,638	0.00%	0	16.52%	9,335
4. Emmens, Admin Office Professional	100.00%	75,000	75,000	8.21%	6,157	0.00%	0	16.52%	12,391
5. Employee Name, Position	0.00%	0	0	8.21%	0	0.00%	0	16.52%	0
Subtotal		263,000	263,000		21,590		0		43,452

10-16-2014

CCS CASELOAD	Actual Caseload	Percent of Total CCS Caseload
STRAIGHT CCS - Total Cases of Open (Active) Straight CCS Children	160	8.21%
HEALTHY FAMILIES - Total Cases of Open (Active) Healthy Families Children	0	0.00%
MEDI-CAL/OTLICP (TITLE XXI) - Total Cases of Open (Active) MC/TLICP Children	322	16.52%
MEDI-CAL (TITLE XIX) - Total Cases of Open (Active) Medi-Cal Children	1467	75.27%
TOTAL CCS CASELOAD	1949	100%

				Title XIX - Medi-Cal					
Column	1	2	3	7A	7	8A	8	9A	9
Category/Line Item	% FTE	Annual Salary	Total Budget (1 x 2 or 4 + 5 +6 + 7)	Caseload %	Title XIX Medi-Cal State/Federal	Enhanced % FTE	Enhanced Title XIX Medi-Cal State/Federal (25/75)	Non-Enhanced % FTE	Non-Enhanced Title XIX Medi-Cal State/Federal (50/50)
I. Personnel Expense									
Program Administration									
1. Stenersen, Ana, Program Manager	100.00%	111,370	111,370	75.27%	83,827			100.00%	83,827
2. Employee Name, Position	0.00%	0	0	75.27%	0			100.00%	0
3. Employee Name, Position	0.00%	0	0	75.27%	0			100.00%	0
4. Employee Name, Position	0.00%	0	0	75.27%	0			100.00%	0
5. Employee Name, Position	0.00%	0	0	75.27%	0			100.00%	0
Subtotal		111,370	111,370		83,827				83,827
Medical Case Management									
1. Blasing, Dorothy, RN	100.00%	76,692	76,692	75.27%	57,726	0.00%	0	100.00%	57,726
2. Acosta, Nicole, RN	75.00%	93,922	70,442	75.27%	53,021	0.00%	0	100.00%	53,021
3. Cheng, Linda PHN	100.00%	93,922	93,922	75.27%	70,694	0.00%	0	100.00%	70,694
4. Chu, Kimberly, RN	100.00%	81,084	81,084	75.27%	61,031	0.00%	0	100.00%	61,031
5. Petrini, Carol PHN	75.00%	93,922	70,442	75.27%	53,021	0.00%	0	100.00%	53,021
6. Strunin, Maxyne PHN	100.00%	93,922	93,922	75.27%	70,694	0.00%	0	100.00%	70,694
7. Goumas, Staff Physician	50.00%	190,911	95,455	75.27%	71,848	0.00%	0	100.00%	71,848
8. Employee Name, Position	0.00%	0	0	75.27%	0	0.00%	0	100.00%	0
Subtotal		724,376	581,959		438,035		0		438,035
Other Health Care Professionals									
1. Barr, Shereen MSW	75.00%	56,500	42,375	75.27%	31,895	0.00%	0	100.00%	31,895
2. Employee Name, Position	0.00%	0	0	75.27%	0	0.00%	0	100.00%	0
3. Employee Name, Position	0.00%	0	0	75.27%	0	0.00%	0	100.00%	0
Subtotal		56,500	42,375		31,895		0		31,895
Ancillary Support									
1. Bayquen, Case Worker	100.00%	56,000	56,000	75.27%	42,151			100.00%	42,151
2. Connor, Case Worker	100.00%	56,000	56,000	75.27%	42,151			100.00%	42,151
3. Escobedo, Case Worker	100.00%	56,000	56,000	75.27%	42,151			100.00%	42,151
4. Ramos, Case Worker	100.00%	56,000	56,000	75.27%	42,151			100.00%	42,151
5. Guendulain Ordaz and Barvie, Case Worker	150.00%	56,000	84,000	75.27%	63,226			100.00%	63,226
Subtotal		280,000	308,000		231,830				231,830
Clerical and Claims Support									
1. Castaneda, Admin Office Professional	100.00%	75,000	75,000	75.27%	56,452	0.00%	0	100.00%	56,452
2. Zacapa, Admin Office Professional	100.00%	56,500	56,500	75.27%	42,527	0.00%	0	100.00%	42,527
3. Quezada, Admin Office Professional	100.00%	56,500	56,500	75.27%	42,527	0.00%	0	100.00%	42,527
4. Emmens, Admin Office Professional	100.00%	75,000	75,000	75.27%	56,452	0.00%	0	100.00%	56,452
5. Employee Name, Position	0.00%	0	0	75.27%	0	0.00%	0	100.00%	0
Subtotal		263,000	263,000		197,958		100 0		197,958

10-16-2014

CCS CASELOAD	Actual Caseload	Percent of Total CCS Caseload
STRAIGHT CCS - Total Cases of Open (Active) Straight CCS Children	160	8.21%
HEALTHY FAMILIES - Total Cases of Open (Active) Healthy Families Children	0	0.00%
MEDI-CAL/OTLICP (TITLE XXI) - Total Cases of Open (Active) MC/TLICP Children	322	16.52%
MEDI-CAL (TITLE XIX) - Total Cases of Open (Active) Medi-Cal Children	1467	75.27%
TOTAL CCS CASELOAD	**1949**	**100%**

CCS Administrative Budget Worksheet

Fiscal Year: 2014-15

County: Santa Barbara

					Straight CCS		Title XXI - Healthy Families		Title XXI - Medi-Cal/Optional Targeted Low Income Children Program (OTLICP)	
Column		1	2	3	4A	4	5A	5	6A	6
Category/Line Item		**% FTE**	**Annual Salary**	**Total Budget (1 x 2 or 4 + 5 +6 + 7)**	**Caseload %**	**Straight CCS County/State (50/50)**	**Caseload %**	**Healthy Families County/State/Fed (17.5/17.5/65)**	**Caseload %**	**Medi-Cal/ Optional Targeted Low Income Children's Program (OTLICP) Co/State/Fed (17.5/17.5/65)**
Total Salaries and Wages				1,306,704	8.21%	107,272	0.00%	0	16.52%	215,884
Staff Benefits (Specify %)	50.00%			653,352	8.21%	53,636	0.00%	0	16.52%	107,942
I. Total Personnel Expense				1,960,056	8.21%	160,908	0.00%	0	16.52%	323,826
II. Operating Expense										
1. Travel				2,500	8.21%	205	0.00%	0	16.52%	413
2. Training				7,500	8.21%	616	0.00%	0	16.52%	1,239
3. Other Expenditures				100,000	8.21%	8,209	0.00%	0	16.52%	16,521
4.					8.21%	0	0.00%	0	16.52%	0
5.					8.21%	0	0.00%	0	16.52%	0
6.					8.21%	0	0.00%	0	16.52%	0
7.					8.21%	0	0.00%	0	16.52%	0
II. Total Operating Expense				110,000		9,030		0		18,173
III. Capital Expense										
1.					8.21%	0	0.00%	0	16.52%	0
2.					8.21%	0	0.00%	0	16.52%	0
3.					8.21%	0	0.00%	0	16.52%	0
III. Total Capital Expense				0		0		0		0
IV. Indirect Expense										
1. Internal	12.45%			244,027	8.21%	20,033	0.00%	0	16.52%	40,316
2. External	5.17%			101,335	8.21%	8,319	0.00%	0	16.52%	16,742
IV. Total Indirect Expense				345,362		28,352		0		57,058
V. Other Expense										
1. Maintenance & Transportation				0	8.21%	0	0.00%	0	16.52%	0
2.					8.21%	0	0.00%	0	16.52%	0
3.					8.21%	0	0.00%	0	16.52%	0
4.					8.21%	0	0.00%	0	16.52%	0
5.					8.21%	0	0.00%	0	16.52%	0
V. Total Other Expense				0		0		0		0
Budget Grand Total				2,415,418		198,290		0		399,057

Prepared By (Signature)	Nancy Leidelmeijer	10/13/2014	805-681-5188
	Prepared By (Printed Name)	Date Prepared	Phone Number
CCS Administrator (Signature)	Ana Stenersen	10/20/14	805-681-4026
	CCS Administrator (Printed Name)	Date Signed	Phone Number

10-16-2014

CCS CASELOAD	Actual Caseload	Percent of Total CCS Caseload
STRAIGHT CCS - Total Cases of Open (Active) Straight CCS Children	160	8.21%
HEALTHY FAMILIES - Total Cases of Open (Active) Healthy Families Children	0	0.00%
MEDI-CAL/OTLICP (TITLE XXI) - Total Cases of Open (Active) MC/TLICP Children	322	16.52%
MEDI-CAL (TITLE XIX) - Total Cases of Open (Active) Medi-Cal Children	1467	75.27%
TOTAL CCS CASELOAD	**1949**	**100%**

					Title XIX - Medi-Cal					
Column		**1**	**2**	**3**	**7A**	**7**	**8A**	**8**	**9A**	**9**
Category/Line Item		**% FTE**	**Annual Salary**	**Total Budget (1 x 2 or 4 + 5 +6 + 7)**	**Caseload %**	**Title XIX Medi-Cal State/Federal**	**Enhanced % FTE**	**Enhanced Title XIX Medi-Cal State/Federal (25/75)**	**Non-Enhanced % FTE**	**Non-Enhanced Title XIX Medi-Cal State/Federal (50/50)**
Total Salaries and Wages				1,306,704	75.27%	983,545	0.00%	0	100.00%	983,545
Staff Benefits (Specify %)	50.00%			653,352	75.27%	491,774		0		491,774
I. Total Personnel Expense				1,960,056	75.27%	1,475,319		0		1,475,319
II. Operating Expense										
1. Travel				2,500	75.27%	1,882	0.00%	0	100.00%	1,882
2. Training				7,500	75.27%	5,645	0.00%	0	100.00%	5,645
3. Other Expenditures				100,000	75.27%	75,269			100.00%	75,269
4.					75.27%	0			100.00%	0
5.					75.27%	0			100.00%	0
6.					75.27%	0			100.00%	0
7.					75.27%	0			100.00%	0
II. Total Operating Expense				110,000		82,796		0		82,796
III. Capital Expense										
1.					75.27%	0				0
2.					75.27%	0				0
3.					75.27%	0				0
III. Total Capital Expense				0		0				0
IV. Indirect Expense										
1. Internal	12.45%			244,027	75.27%	183,678			100.00%	183,678
2. External	5.17%			101,335	75.27%	76,274			100.00%	76,274
IV. Total Indirect Expense				345,362		259,952				259,952
V. Other Expense										
1. Maintenance & Transportation				0	75.27%	0			100.00%	0
2.					75.27%	0			100.00%	0
3.					75.27%	0			100.00%	0
4.					75.27%	0			100.00%	0
5.					75.27%	0			100.00%	0
V. Total Other Expense				0		0				0
Budget Grand Total				2,415,418		1,818,067		0		1,818,067

Prepared By (Signature)

Nancy Leidelmeijer

Prepared By (Printed Name)

CCS Administrator (Signature)

Ana Stenersen

CCS Administrator (Printed Name)

10-16-2014

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County/City Name: Santa Barbara County
Date of Report: 9/4/14
Complete Address: 345 Camino Del Remedio, Santa Barbara, CA 93110
CMS Administrative Consultant: Sandra Copley, RN, PHN
Consultant's Address: 345 Camino Del Remedio, Santa Barbara, CA 93110
Program Name: CHDP
Consultant's Telephone No.: 805-681-4026
Program Contract Telephone No.: 805-681- 5476
Program Contract E-Mail Address: Sandra.Copley@sbcphd.org

DHCS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./(type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHCS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, list VIN No.)
	1	MDF HP Laser Jet 1200n printer	$ 598.00		8/25/2001	CNBR124527
	1	MDN HP Laser Jet 1200 printer	$ 428.85		9/26/2002	CNCO330893
	1	725 HP Cpq dc5700 SFF P4 541 HT/1GB/80GB/Combo	$ 829.17		1/19/2007	MXM65205NG
	1	725 HP Cpq dc5700 SFF P4 541 HT/1GB/80GB/Combo	$ 829.17		1/19/2007	MXM65205N7
	1	753 HP LP1965 Flat Paner Monitor	$ 297.00		6/25/2007	CNN71039PK
	1	753 HP LP1965 Flat Paner Monitor	$ 340.94		8/22/2007	CNN72802V
	1	753 HP LP1965 Flat Paner Monitor	$ 340.95		11/18/2007	CNN7371XON
	1	788 HP Laser Jet CP1518ni	$ 754.52		5/20/2008	CNAC82P1MD
	1	820 LCD TFT-24" Widescreen -1920 - 1200/60HZ Monitor	$ 428.16		9/30/2009	3C09190VT9
	1	818 HP Laser jet P2035	$ 333.16		7/28/2010	CNB9k29861
	1	876 HP Compaq 8200 Elite Small Form Factor PC-XL510	$ 865.93		6/28/2011	MCL124125M
	1	879 HP Compaq 8200 Elite Small From Factor PC-Xl510 CPU	$ 865.93		6/28/2011	MXL124125F

Revised: March 2008
CMSB A-2 (7/01)

State of California - Health and Human Services
Department of Health Care Services

Systems of Care
Children's Medical Services Branch

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County/City Name: Santa Barbara County

Date of Report: 9/4/14

Complete Address: 345 Camino Del Remedio, Santa Barbara, CA 93110

CMS Administrative Consultant: Sandra Copley, RN, PHN

Consultant's Address: 345 Camino Del Remedio, Santa Barbara, CA 93110

Program Name: CHDP

Consultant's Telephone No.: 805-681-4026

Program Contract Telephone No.: 805-681- 5476

Program Contract E-Mail Address: Sandra.Copley@sbcphd.org

DHCS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./(type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHCS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, list VIN No.)
	1	876 HP Compaq 8200 Elite Small Form Factor PC XL510	$ 863.50		6/28/2011	MCL124121J
	1	826 LA 1951g 19-inch LCD Monitor	$ 181.48		7/22/2011	CNC115R392
	1	Fujtsu LIFEBOOK T730 Tablet -	$ 1,685.70		10/10/2012	A4VEE3E902LE1A05
	1	Fujtsu Port Replicator FPCPR94AP	$ 145.35		10/10/2012	
	1	Fujitsu Notebook Carrying case - black FPCCC16	$ 52.85		10/10/2012	
	1	HP Compaq Elite 8300	$ 699.00		3/5/2013	CCNN7282Q2V
	1	HP Compaq LA 2405x LED Monitor	$ 272.00		4/7/2014	N440108Q7

Revised: March 2008
CMSB A-2 (7/01)

State of California - Health and Human Services
Department of Health Care Services

Systems of Care
Children's Medical Services Branch

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County/City Name: Santa Barbara County CCCS
Date of Report: 10/10/2014

Complete Address: 345 Camino del Remedio
CMS Administrative Consultant: Ana Stenersen, RN, PHN

Santa Barbara, CA 93110
Consultant's Address: 345 Camino del Remedio, Santa Barbara, CA 93110

Program Name: CCS
Consultant's Telephone No.: 805-681-4026

Program Contract Telephone No.: 805-681-5360

Program Contract E-Mail Address: ana.stenersen@sbcphd.org

DHCS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./(type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHCS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, list VIN No.)
	1	HLP LaserJet Enterprise Printer M601DN	$ 843.00		1/18/2013	CNCCDDK0PX
	1	Jabra PRO 9450 Headset	$ 339.98		4/24/2013	0Z5D05FK2DA
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Revised: March 2008
CMSB A-2 (7/01)