AGREEMENT FOR SERVICES #8091
Adult Residential Facility

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and Psynergy Programs, Inc., a California Stock Corporation, duly qualified to conduct business in the State of California, whose principal place of business is 18225 Hale Avenue, Morgan Hill, California 95037, and whose mailing address is 2433 Mariner Square Loop Ste #208, Alameda, California 94501 (hereinafter referred to as "Provider");

RECITALS

WHEREAS, County is under contract with the State of California to serve as the Mental Health Plan (MHP) for the County of El Dorado. As the MHP, County may provide or arrange for the provision of certain mandated services, including the provision of an Adult Residential Facility (ARF) for eligible Medi-Cal beneficiaries served by the County;

WHEREAS, County has determined that it is necessary to obtain a provider for residential treatment services at a licensed ARF for adults identified as eligible for Full Service Partnership services, with serious mental illness (hereinafter referred to as “Client” or “Clients”) in licensed community care facilities on an “as requested” basis for the Health and Human Services Agency (HHSA), Behavioral Health Division;

WHEREAS, Adult Residential Facilities are facilities licensed to provide augmented services beyond living and care services for Clients who are unable to provide for their own daily needs;

WHEREAS, the residential treatment services provided at the ARF are intended to facilitate the movement of Clients from a restricted environment to independent living in the community;

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws; and

WHEREAS, County has determined that the provision of such services provided by Provider are in the public's best interest and that there are specialty skills, qualifications, and equipment not expressly identified in County classifications involved in the performance of the work in accordance with El Dorado County Ordinance Code, Chapter 3.13.030(b), El Dorado County Charter, Section 210(b)(6), and/or Government Code Section 31000;

NOW, THEREFORE, County and Provider mutually agree as follows:

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EXHIBITS

ARTICLE 1. DEFINITIONS

1. BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and providers of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

2. BENEFICIARY OR CLIENT: "Beneficiary" or "client" means the individual(s) receiving services.

3. DHCS: "DHCS" means the California Department of Health Care Services.

4. DIRECTOR: "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.

ARTICLE 2. GENERAL PROVISIONS

1. TERM

   This Agreement shall become effective upon final execution by both parties hereto and shall cover the period July 1, 2023 through June 30, 2026. The parties shall have the option to extend the term for one (1) additional one (1) year term after the initial expiration date. Each option shall be on the same terms and conditions as provided for herein for the initial term. The option to renew shall be subject to HHSA Director approval.

2. SCOPE OF WORK

   Provider agrees to furnish the facility, personnel, services and equipment necessary to provide ARF services and inpatient residential Specialty Mental Health Services (SHMS) for Clients on an "as requested" basis for the HHSA, Behavioral Health Division. Provider agrees to comply with all applicable Federal and State laws and regulations required of the licensed ARF facility and program. Provider shall maintain all requirements in accordance with California Code of Regulations (CCR) Title 22, Division 6, Chapter 6, and CCR Title 9, Division 1, Chapter 11. Provider agrees to provide the services set forth in Exhibit A, marked "Scope of Work," incorporated herein and made by reference a part hereof.

3. COMPENSATION FOR SERVICES

   A. **Rates**: For the purposes of this Agreement, the billing rates shall be as defined in Exhibit B, marked "Provider Rates," incorporated herein and made by reference a part hereof. The County is responsible for payment of ARF residential services (the Day Rate). For Clients who receive Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits, in accordance with Exhibit B, or have sufficient alternative income, Client/Client's payee may be required to pay a residential share of cost to Provider. For Clients who do not receive SSI/SSDI benefits and do not have other income, County may be required to pay the residential share of cost until the Client begins to receive SSI/SSDI benefits or income from an alternative source. At that time, the responsibility for this additional payment will return to the Client's payee. Should retroactive SSI/SSDI benefits or other income be received on behalf of Client for any period during which County paid this residential share of cost, County will be reimbursed for such payments, to the extent funds are available. County may provide

retroactive authorization when special circumstances exist, as determined by the HHSA Director, or designee.

I. **Residential Rates**: Residential Rates are set forth in Exhibit B. Notice of rate changes shall be submitted, in writing, to the address noted in ARTICLE 2, General Provisions, 6. Notice to Parties. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change does not conflict with any other provisions of this Agreement. Said notice shall be provided at least thirty (30) days in advance of a rate change. Upon County HHSA's written confirmation of acceptance of the rate change, the revised rates shall be incorporated by reference as if fully set forth herein.

II. **Enhanced Support and Supervision**: Enhanced Support and Supervision examples are individual stand by assistance for medical treatment or physical therapy, bereavement support, or other one-on-one support necessary to reduce risk of escalation of symptoms and behaviors. These rates are set forth in Exhibit B.

B. **Prior Authorization for Services**: It is expressly understood and agreed between the parties hereto that the County shall make no payment for County Clients and have no obligation to make payment to Provider unless the Provider receives prior written authorization from the HHSA Behavior Health Division. County will provide Provider with written confirmation of the authorization within twenty-four (24) hours of a Client's admission into Provider's facility for Clients referred by County to Provider.

If County Clients need services that are not included in Exhibit B of this Agreement, Provider shall obtain prior written authorization from the HHSA Behavior Health Division before the services are provided.

Under no circumstances shall the Provider make unilateral direct placements to Institutions for Mental Disease, or other facilities, without prior written authorization from County.

C. **Re-Authorizations for Services**: Placements of non-Medi-Cal Clients must be re-authorized every thirty (30) days by the HHSA Behavior Health Division. Placements of Medi-Cal Clients must be re-authorized every three (3) months by the HHSA Behavior Health Division. Re-authorization will be the responsibility of the County, and a thirty (30) day notice will be provided to Provider if County Client is no longer going to be re-authorized for services at Provider's facility.

D. **Bed Holds**: Holding a bed while a Client is absent from the contracted facility shall require written pre-authorization by the County Contract Administrator, or HHSA Behavior Health Division staff member, utilizing the form Exhibit C, marked "Bed Hold Authorization" attached hereto, incorporated herein and made by reference a part hereof. The Bed Hold rate shall be in accordance with Exhibit B.

E. **Invoices:** It is a requirement of this Agreement that Provider shall submit an original itemized invoice, similar in content and format with Exhibit D, marked "HHSA Invoice Template," attached hereto and incorporated by reference herein, to be compensated for services. Itemized invoices shall follow the format specified by County and shall reference this Agreement

number on their faces and on any enclosures or backup documentation. Copies of Service Authorizations and back-up documentation must be attached to invoices shall reflect Provider's charges for the specific services billed on those invoices.

Invoices shall be sent as follows, or as otherwise directed in writing by County:

Email (preferred method):	*U.S. Mail:*
BHinvoice@edcgov.us Please include in the subject line: "Contract #, Service Month, Description / Program	County of El Dorado Health and Human Services Agency Attn: Finance Unit 3057 Briw Road, Suite B Placerville, CA 95667-5321

or to such other location as County directs.

For services provided herein, including any deliverables that may be identified herein, Provider shall submit invoices for services thirty (30) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE 2. GENERAL PROVISIONS, 2. Scope of Work. For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of invoice(s) identifying services rendered.

Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services, previously disallowed services, or inadvertently not submitted services rendered during a month for which a prior invoice has already been submitted to County. Supplemental invoices should include the standard invoice format with description of services rendered. Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement and received by County after July 31st of the subsequent fiscal year, shall be neither accepted nor paid by the County. Requests for exceptions to pay an invoice received after July 31st of the subsequent year, must be submitted in writing, and must be approved by the Health and Human Services Agency's Chief Fiscal Officer.

Upon request from County's Contract Administrator, Provider shall submit audited financial reports specific to this Agreement within forty-five (45) days of County request. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

In the event that Provider fails to deliver, in the format specified, the deliverables and financial reports required by this Agreement, County at its sole option may delay the payment for the period of time of the delay, cease all payments until such time as the required deliverables or financial reports are received, or proceed as set forth below in ARTICLE 2. General Provisions, 12. Default, Termination and Cancellation.

I. **Denied Invoices**: ARF and SMHS service payments shall be made in the amount of the Provider's total claim, minus the amount of denied services. County will submit to Provider the amount of denials received for the prior months' services, as identified on documents received from the State. Provider shall make adjustment for denials on Provider's next submitted invoice.

4. MAXIMUM OBLIGATION

The maximum obligation for services and deliverables provided under this Agreement shall not exceed **$3,600,000.00**, inclusive of all costs and expenses for the term of the Agreement.

A. This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this Agreement.
B. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Provider to discuss renegotiating the services required by this Agreement.

5. FEDERAL FUNDING NOTIFICATION

An award/subaward or contract associated with a covered transaction may not be made to a subrecipient or provider who has been identified as suspended or debarred from receiving federal funds. Additionally, counties must annually verify that the subrecipient and/or provider remains in good standing with the federal government throughout the life of the agreement/contract.

Provider agrees to comply with Federal procedures in accordance with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Any costs for which payment has been made to Provider that are determined by subsequent audit to be unallowable under 48 CFR Part 31 or 2 CFR Part 200 are subject to repayment by Provider to County.

Consistent with 2 CFR 180.300(a), County has elected to verify whether Provider has been suspended or using the federal System for Award Management (SAM). The federal SAM is an official website of the federal government through which counties can perform queries to identify if a subrecipient or contractor is listed on the federal SAM excluded list and thus suspended or debarred from receiving federal funds.

A. System for Award Management: Provider is required to obtain and maintain an active Universal Entity Identifier (UEI) No. in the System for Award Management (SAM) system at https://sam.gov/content/home. Noncompliance with this requirement shall result in corrective action, up to and including termination pursuant to the provisions contained herein this Agreement under detailed in ARTICLE 2. General Provisions, 12. Default, Termination and Cancellation.
B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Assistance Listing Numbers (ALN) number at the time the

contract is awarded. The following are ALN numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Health Care Services that may apply to this contract:

Federal Funding Information			
Provider:	Psynergy Programs, Inc.		**UEI #:** DNAJT47U5XH6
Award Term:	7/1/23-6/30/26		**EIN #:**
Total Federal Funds Obligated: $3,600,000			
Federal Award Information			
ALN Number	**Federal Award Date / Amount**	**Program Title**	
93.778		Medi-Cal Assistance Program	
Project Description:	Adult Residential Facility and Specialty Mental Health Services for referred clients by County of El Dorado, Health and Human Services Agency		
Awarding Agency:	California Department of Health Care Services		
Pass-through Entity	County of El Dorado, Health and Human Services Agency		
Indirect Cost Rate or de minimus	Indirect Cost Rate: _____	**De minimus ☒**	
Yes ☐ **No ☒**	Award is for Research and development.		

6. NOTICE TO PARTIES

All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to County shall be addressed as follows:

COUNTY OF EL DORADO
Health and Human Services Agency
3057 Briw Road, Suite B
Placerville, CA 95667
ATTN: Contracts Unit
HHSA-contracts@edcgov.us

or to such other location as the County directs.

with a copy to

COUNTY OF EL DORADO
Chief Administrative Office
Procurement and Contracts Division
330 Fair Lane
Placerville, CA 95667
ATTN: Purchasing Agent

Notices to Provider shall be addressed as follows:

PSYNERGY PROGRAMS, INC.
2433 Mariner Square Loop, Ste #208
Alameda, California 94501
ATTN: Arturo Uribe, President, or successor
auribe@psynergy.org

or to such other location as the Provider directs.

7. CHANGE OF ADDRESS

In the event of a change in in organizational name, Head of Service, address for Provider's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing at least 15 business days in advance of the change, pursuant to the provisions contained in this Agreement under ARTICLE 2, General Provisions, 6. Notice to Parties. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

A. Provider cannot reduce or relocate without first receiving approval by DHCS. A Drug Medi-Cal (DMC) certification application shall be submitted to the DHCS Provider Enrollment Division (PED) 60 days prior to the desired effective date of the reduction of covered services or relocation. Provider shall be subject to continuing certification requirements at least once every five (5) years. Said notice shall become part of this Agreement upon acknowledgment in writing by the County, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.
B. Provider must immediately notify County of a change in ownership, organizational status, licensure, or ability of Provider to provide the quantity or quality of the contracted services in a timely fashion.

8. INDEPENDENT PROVIDER

The parties intend that an Independent Provider relationship will be created by this contract. Provider is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by the terms of this Agreement. Provider exclusively assumes responsibility for acts of its employees, agents, affiliates, and subcontractors, if any are authorized herein, as they relate to the services or work to be performed under this Agreement during the course and scope of their employment by Provider. Those persons will be entirely and exclusively under the direction, supervision, and control of Provider.

County may designate the tasks to be performed and the results to be accomplished under this Agreement, provide information concerning the work or services, approve or disapprove the final work product and/or services provided, and set deadlines for the completion of the work or services, but County will not control or direct the manner, means, methods, or sequence in which Provider performs the work or services for accomplishing the results. Provider understands and agrees that Provider lacks the authority to bind County or incur any obligations on behalf of County.

Provider, including any subcontractors or employees of Provider, shall not receive, nor be eligible for, any benefits County provides for its employees, including, but not limited to, vacation pay, paid holidays, life insurance, health insurance, social security, disability insurance, pension, or 457 plans. Provider shall not receive, nor be eligible for, workers' compensation, including medical and indemnity payments. County is not responsible for withholding, and shall not withhold, Federal Income Contribution Act amounts or taxes of any kind from any payments which it owes Provider. Provider shall not be subject to the work schedules or vacation periods that apply to County employees.

Provider shall be solely responsible for paying its employees, and for withholding Federal Income Contribution Act amounts and other taxes, workers' compensation, unemployment compensation, medical insurance, life insurance, or any other benefit that Provider provides for its employees.

Provider acknowledges that it has no authority to bind the County or incur any obligations on behalf of the County with regard to any matter, and Provider shall not make any agreements or representations on the County's behalf.

9. ASSIGNMENT AND DELEGATION

Provider is engaged by County for its unique qualifications and skills as well as those of its personnel. Provider shall not subcontract, delegate, or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of County.

In the event Provider receives written consent to subcontract services under this Agreement, Provider is required to ensure subcontractor remains in compliance with the terms and conditions of this Agreement. In addition, Provider is required to monitor subcontractor's compliance with said terms and conditions and provide written evidence of monitoring to County upon request.

10. SUBCONTRACTS

A. Provider shall obtain prior written approval from the County Contract Administrator before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the County Contract Administrator but shall not be unreasonably withheld. Provider shall ensure that all subcontracts are subject to the applicable terms and conditions of this Agreement, including, without limitation, the licensing, certification, privacy, data security and confidentiality requirements set forth herein, and include the applicable provisions of 42 Code of Federal Regulations (CFR) 438.230.
B. Provider shall remain legally responsible for the performance of all terms and conditions of this Agreement, including, without limitation, all ARF or SMHS services provided by third parties under subcontracts, whether approved by the County or not.
C. Provider shall not subcontract, assign or delegate services to providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. (42 CFR Section 438.214(d).)
D. Any work or services specified in this Agreement which will be performed by other than the Provider shall be evidenced by a written Agreement and contain:
    I. The activities and obligations, including services provided, and related reporting responsibilities. (42 CFR Section 438.230(c)(1)(i).)

II. The delegated activities and reporting responsibilities in compliance with the Provider's obligations in this Agreement. (42 CFR Section 438.230(c)(1)(ii).)
III. Subcontractor's agreement to submit reports as required by the Provider and/or the County.
IV. The method and amount of compensation or other consideration to be received by the subcontractor from the Provider.
V. Requirement that the subcontract be governed by, and construed in accordance with, all laws and regulations, and all contractual obligations of the Provider under this contract.
VI. Requirement that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. (42 CFR Section 438.230(c)(2).)
VII. Terms of the subcontract including the beginning and ending dates, as well as methods for amendment and, if applicable, extension of the subcontract.
VIII. Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies permitted by State or federal law when the County or the Provider determine that the subcontractor has not performed satisfactorily. (42 CFR Section 438.230(c)(1)(iii).)
IX. The nondiscrimination and compliance provisions of this Agreement.
X. A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the County, DHCS, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and State agencies. (42 CFR Section 438.3(h).) This audit right will exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. (42 CFR Section 438.230(c)(3)(iii).) The County, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk. (42 CFR Section 438.230(c)(3)(iv).)
XI. Inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least ten (10) years from the close of the State fiscal year in which the subcontract was in effect. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the County.
XII. A requirement that the Provider monitor the subcontractor's compliance with the provisions of the subcontract and this contract, and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified as set forth in ARTICLE 5, Chart Auditing And Reasons For Recoupment, 4. Internal Auditing, Compliance, and Monitoring, of this Agreement.
XIII. Subcontractor's agreement to hold harmless the State, County and Clients in the event the Provider cannot or does not pay for services performed by the subcontractor pursuant to the subcontract.
XIV. Subcontractor's agreement to comply with the County and Provider's policies and procedures on advance directives.

XV. The “Smoke-Free Workplace Certification” will be inserted into any subcontracts entered into that provide for children's services as described in the Pro-Children Act of 1994.

E. The Provider shall maintain and adhere to an appropriate system, consistent with federal, State and local law, for the award and monitoring of contracts that contain acceptable standards for insuring accountability.

F. The system for awarding contracts will contain safeguards to ensure that the Provider does not contract with any entity whose officers have been convicted of fraud or misappropriation of funds; or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency.

G. Subcontractors shall comply with the confidentiality requirements set forth set forth herein and include the applicable provisions of 42 Code of Federal Regulations (CFR) 438.230.

H. Provider shall monitor any subcontractor’s compliance with the provisions of this Agreement, and shall provide a corrective action plan if deficiencies are identified.

I. No subcontract terminates the legal responsibility of the Provider to the County to assure that all activities under this contract are carried out.

J. Provider shall take positive efforts to use small businesses, minority-owned firms and women's business enterprises, to the fullest extent practicable, including if the Provider subcontracts services pursuant to ARTICLE 2, General Provisions, 9. Assignment and Delegation. Provider shall:

I. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

II. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

III. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

IV. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

11. CHANGES TO AGREEMENT

This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

12. DEFAULT, TERMINATION AND CANCELLATION

A. Termination by Default: If either party becomes aware of an event of default, that party shall give written notice of said default to the party in default that shall state the following:

I. The alleged default and the applicable Agreement provision.

II. That the party in default has ten (10) days upon receiving the notice to cure the default (Time to Cure).

If the party in default does not cure the default within ten (10) days of the Time to Cure, then such party shall be in default and the party giving notice may terminate the Agreement by issuing a Notice of Termination. The party giving notice may extend the Time to Cure at their discretion. Any extension of Time to Cure must be in writing, prepared by the party in default for signature by the party giving notice, and must specify the reason(s) for the extension and the date in which the extension of Time to Cure expires.

If County terminates this Agreement, in whole or in part, for default:

I. County reserves the right to procure the goods or services, or both, similar to those terminated, from other sources and Provider shall be liable to County for any excess costs for those goods or services. County may deduct from any payment due, or that may thereafter become due to Provider, the excess costs to procure from an alternate source.

II. County shall pay Provider the sum due to Provider under this Agreement prior to termination, unless the cost of completion to County exceeds the funds remaining in the Agreement. In which case the overage shall be deducted from any sum due Provider under this Agreement and the balance, if any, shall be paid to Provider upon demand.

III. County may require Provider to transfer title and deliver to County any completed work under the Agreement.

The following shall be events of default under this Agreement:

IV. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.

V. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.

VI. Provider fails to observe and perform any covenant, condition or agreement on its part to be observed or performed under this Agreement, unless County agrees, in writing, to an extension of the time to perform before that time period expires.

VII. A violation of ARTICLE 2, General Provisions, 16. Conflict of Interest.

B. Bankruptcy: County may terminate this Agreement immediately in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.

C. Ceasing Performance: County may terminate this Agreement immediately in the event Provider ceases to operate as a business or otherwise becomes unable to substantially perform any term or condition of this Agreement.

D. Termination or Cancellation without Cause: County may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination. If such termination is effected, County will pay for satisfactory services rendered before the effective date of termination, as set forth in the Notice of Termination provided to Provider, and for any other services that County agrees, in writing, to be necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the Agreement. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.

13. INTERPRETATION; VENUE

A. The headings used herein are for reference only. The terms of the Agreement are set out in the text under the headings.

B. This Agreement shall be governed by the laws of the State of California without regard to the choice of law or conflicts.

C. This Agreement is made in El Dorado County, California. The venue for any legal action in state court filed by either party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement shall be in the Superior Court of California, County of El Dorado. The venue for any legal action in federal court filed by either Party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement lying withing the jurisdiction of the federal courts shall be the Eastern District of California.

14. SEVERABILITY

If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

15. INSURANCE

Provider shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that Provider maintains insurance that meets the following requirements:

A. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.

B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a $2,000,000.00 aggregate limit.

C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.

D. In the event Provider is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than $1,000,000.00 per occurrence.

E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.

G. Provider agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Provider agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider fails to keep in effect at all times insurance coverage as herein provided,

County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

H. The certificate of insurance must include the following provisions stating that:
   1. The insurer will not cancel the insured's coverage without prior written notice to County, and;
   2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

I. The Provider's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Provider's insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.

M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Provider cannot provide an occurrence policy, Provider shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

16. CONFLICT OF INTEREST

The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and the Political Reform Act of 1974 (Section 87100 et seq.), relating to conflict of interest of public officers and employees. Individuals who are working for Provider and performing work for County and who are considered to be a Consultant within the meaning of Title 2, California Code of Regulations (CCR), Section 18700.3, as it now reads or may thereafter be amended, are required to file a statement of economic interest in accordance with County's Conflict of Interest Code. County's Contract Administrator shall at the time this Agreement is executed make an initial determination whether or not the individuals who will provide services or perform work pursuant to this Agreement are Consultants within the meaning of the Political Reform Act and County's Conflict of Interest Code. Statements of economic interests are public records subject to disclosure under the California Public Records Act.

Provider covenants that during the term of this Agreement neither it, or any officer or employee of the Provider, has or shall acquire any interest, directly or indirectly, in any of the following:

A. Any other contract connected with, or directly affected by, the services to be performed by this Agreement.
B. Any other entities connected with, or directly affected by, the services to be performed by this Agreement.
C. Any officer or employee of County that are involved in this Agreement.

If Provider becomes aware of a conflict of interest related to this Agreement, Provider shall promptly notify County of the existence of that conflict, and County may, in its sole discretion, immediately terminate this Agreement by giving written notice as detailed in ARTICLE 2, General Provisions, 9. Assignment and Delegation.

Pursuant to Government Code section 84308 (SB 1439, the Levine Act), Provider shall complete and sign the attached Exhibit F, marked "California Levine Act Statement," incorporated herein and made by reference a part hereof, regarding campaign contributions by Provider, if any, to any officer of County.

17. FORCE MAJEURE

Neither party will be liable for any delay, failure to perform, or omission under this Agreement that is due to any cause that it is beyond its control, not due to its own negligence, and cannot be overcome by the exercise of due diligence. In that event, the affected party will:

A. Promptly give written notice to the other of the fact that it is unable to so perform and the cause(s) that is beyond its control; and
B. Once the cause(s) has ceased, provide written notice to the other party and immediately resume its performance under this Agreement.

For purposes of this section, "cause that is beyond its control" includes labor disturbances, riots, fires, earthquakes, floods, storms, lightning, epidemics, war, disorders, hostilities, expropriation or confiscation of properties, failure of and delays by carriers, interference by civil or military authorities, whether legal or de facto, and whether purporting to act under some constitution, decree, or law, or otherwise, or acts of God.

18. SEVERABILITY

If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

19. AUTHORITY TO CONTRACT

County and Provider warrant that they are legally permitted and otherwise have the authority to enter into this Agreement, the signatories to this Agreement are authorized to execute this Agreement on behalf of their respective entities, and that any action necessary to bind each Party has been taken prior to execution of this Agreement.

20. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

A. Provider shall provide services in conformance with all applicable state and federal statues, regulations and sub-regulatory guidance, as from time to time amended, including but not limited to:
   I. Title 9, CCR;
   II. Title 22, CCR;
   III. California Welfare and Institutions Code, Division 5;
   IV. United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;
   V. United States Code of Federal Regulations, Title 45;
   VI. United States Code, Title 42 (The Public Health and Welfare), as applicable;
   VII. Balanced Budget Act of 1997;
   VIII. **Americans With Disabilities Act**: Provider agrees to ensure that services provided, and deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 USC Section 794(d)), and regulations implementing that Act as set forth in Part 1194 of Title 36 of the CFR. In 1998, Congress amended the Rehabilitation Act of 1973 to require federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California GC Section 11135 codifies Section 508 of the Act requiring accessibility of electronic and information technology;
   IX. **Child Support Compliance Act:** For any Agreement in excess of $100,000, the Provider acknowledges in accordance with PCC 7110, that:
      a. The Provider recognizes the importance of child and family support obligations and shall fully comply with all applicable State and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code;
      b. The Provider, to the best of its knowledge is fully complying with the earnings assignment orders of all employees and is providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department.
      c. Provider agrees to furnish to Contract Administrator within thirty (30) calendar days of the award of this Agreement:
         i. In the case of an individual Provider, his/her name, date of birth, social security number and address of residence.
         ii. In the case of a Provider doing business in a form other than as an individual, the name, date of birth, social security number, and residence address of each individual who owns an interest of ten percent (10%) or more in the contracting entity.
      d. Provider is responsible to be knowledgeable of all current federal and State Regulations regarding Child Support Enforcement. Failure of Provider to timely submit the data required under this section, or to comply with all federal and State reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Agreement. Failure to cure such breach within sixty (60) calendar days of notice from County shall constitute grounds for termination of this Agreement.

X. Client Liability for Payment: The Provider or an affiliate, vendor, contractor, or subcontractor of the Provider shall not submit a claim to, or demand or otherwise collect reimbursement from, the Client or persons acting on behalf of the Client for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments (CCR, Title 9, Section 1810.365 (a)).

The Provider or an affiliate, vendor, contractor, or sub-subcontractor of the Provider shall not hold Clients liable for debts in the event that the Provider becomes insolvent; for costs of covered services for which the County does not pay the Provider; for costs of covered services for which the County or the Provider does not pay the Contractor's network providers; for costs of covered services provided under a contract, referral or other arrangement rather than from the Provider; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary. (42 CFR Section 438.106 and CCR Title 9, Section 1810.365(c).)

The Provider shall ensure any subcontractors and providers do not bill Clients for covered services, any amount greater than would be owed if the Provider provided the services directly (42 CFR Section 483.106(c)).

XI. Health Insurance Portability and Accountability Act (HIPAA);

XII. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.

XIII. Drug-Free Workplace Requirements: Provider shall comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
b. Establish a Drug-Free Awareness Program to inform employees about:
    1. The dangers of drug abuse in the workplace;
    2. The person's or organization's policy of maintaining a drug-free workplace;
    3. Any available counseling, rehabilitation and employee assistance programs; and,
    4. Penalties that may be imposed upon employees for drug abuse violations.
c. Every employee who provides services under the terms of this Agreement will:
    1. Receive a copy of Provider's drug-free workplace policy statement; and,
    2. Agree to abide by the terms of the Provider's statement as a condition of employment under the terms of the Agreement.

XIV. **Mandated Reporter Requirements**: California law requires that certain persons are mandated to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence. Provider acknowledges and agrees to comply with the following state-required mandated reporter regulations as they apply to the services being rendered by Provider: California Penal Code Sections 11160-11163, which covers suspected domestic violence; California Penal Code, Article 2.5 (commencing with Section 11164) of Chapter 2 of Title I of Part 4, also known as the Child Abuse and Neglect Reporting Act; and Welfare and Institutions Code Section 15630, which covers suspected dependent adult abuse.

Failure to comply with these reporting requirements may lead to a fine of up to $1,000 and/or up to six months in jail. A person who makes a report in accordance with these mandates shall not incur civil or criminal liability as a result of any report required or authorized by the above regulations.

XV. **Lobbying Prohibition:** United States Code Title 31, Section 1352 prohibits the use of any federal funds for lobbying activities. Provider shall not use any funds paid from this agreement for any lobbying activities as defined in said code. Any lobbying activities performed by the Provider that are funded through other, non-federal sources must be accurately tracked and properly allocated to ensure compliance with this provision.

B. In the event any law, regulation, or guidance referred to above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

C. Provider acknowledges and agrees that this Agreement is intended to implement the following programs and agreements:

I. Agreement 21-10079, and as amended, by and between the County of El Dorado and California Department of Health Care Services (known as the Performance Agreement), available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx;

II. Agreement 22-20100, and as amended by and between the County of El Dorado and California Department of Health Care Services (known as the Mental Health Plan or MHP), available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx;

III. Proposition 63, otherwise known and the Mental Health Services Act (MHSA), was passed by California voters on November 2004, and is available at http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx;

IV. MHSA Plan, and any Annual Updates, for the County of El Dorado that are currently in effect during the term of this Agreement, available at https://www.edcgov.us/government/mentalhealth/mhsa/pages/mhsa_plans.aspx.

Provider certifies that they have read and understand the four (4) documents identified above, and shall comply with their provisions, including any updates hereto, during the term of this Agreement.

ARTICLE 3. SERVICES AND ACCESS PROVISIONS

1. FACILITIES MEDI-CAL SITE CERTIFICATION:

A. Medi-Cal Site Certification: County shall audit Provider's facilities for Medi-Cal site certification, in accordance with DHCS protocol.

B. Certification of Provider as an organizational provider of SMHS shall be in conformance with Short Doyle/Medi-Cal (SD/MC) "Provider Re/Certification Protocol" requirements available at https://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx.

C. Provider shall maintain at least the following Medi-Cal Site certified and appropriate facility(ies) for the provision of ARF and inpatient residential SMHS services for Clients referred by County who meet the minimum requirements for Medi-Cal eligibility. Any subsequent facilities added or change to the locations listed below, must be approved by the County, in advance and in writing, prior to any relocation, closure, or other change in physical location.

Facility Addresses
Nueva Vista ARF 18225 Hale Avenue Morgan Hill, CA 95037
Cielo Vista ARF 806 Elm Avenue Greenfield, CA 93927
Nueva Vista Sacramento ARF 4604 Roosevelt Avenue Sacramento, CA 95820
Vista Esperanza Residential Care Facility for the Elderly (RCFE) 5240 Jackson Street North Highlands, CA 95660
Vista de Robles, Adult Residential Facility 9847 Folsom Blvd. Sacramento CA 95827
Vista de Robles Crisis Residential Facility 9847 Folsom Blvd. Sacramento CA 95827
Tres Vista Apartments (6 beds) 18217 Apts # (200, 210, 220 and 230) Hale Avenue, Morgan Hill CA 95037

D. Provider shall maintain current written policies and procedures required by the Short Doyle/Medi-Cal (SD/MC) Provider Certification & Re-Certification Protocol issued by the State.

E. Provider shall comply with the provisions of CCR Title 9, Section 1810.435.
   I. Provider shall comply with the requirements of CCR Title 9, Section 1810.435(e) by cooperating with the County for inspection of any site owned, leased, or operated by the Provider and used to deliver covered services to beneficiaries, except that on-site review is not required for a public school or a satellite site.
      a. "Satellite site" means a site owned, leased, or operated by an organizational provider at which SMHS are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which SMHS are delivered by no more than two employees or Providers of the provider.

F. Changes to Site Certified Facilities: Provider shall notify County of any changes that may affect Medi-Cal Site Certification, including but not limited to structural changes, relocation, expansion, closure, identification of staff as ineligible to provide services, or major staffing/organizational structure changes. Such notification shall occur at least forty-five (45) days prior to the change occurring, to the extent possible. If not possible in forty-five (45) days, Provider shall provide County with notification in accordance with ARTICLE 2, General Provisions, 6. Notice to Parties, herein, within one (1) business day of changes.

a. Provider shall not provide Medi-Cal services at any site, other than a satellite site or a public school, prior to receiving authorization from the County to do so, nor may Provider provide services at a site for which the Medi-Cal site certification has expired or otherwise terminated.
b. Provider shall provide CMS, the State Medicaid agency, the County, and their agents, and/or designated Providers with access to provider locations to conduct unannounced on-site inspections of any and all provider locations, with the exception of satellite sites.
c. Correction of Issues Identified During Inspections: Provider shall be responsible to address any issues identified by County during inspections to meet Medi-Cal requirements and shall provide County with a record of corrective action(s).

G. Choice of Provider: Provider shall provide a beneficiary's choice of the person providing services to the extent possible and appropriate consistent with CCR Title 9, Section 1830.225, and 42 CFR part 438.3(I).

H. Utilization Review: Provider shall establish and maintain systems to review the quality and appropriateness of services in accordance with federal and State Program Requirements operative during the term of this Agreement. Contractor shall comply with existing Federal regulations for utilization review pursuant to Title 42, Code of Federal Regulations (CFR), Part 456, Subpart D. These shall include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Provider shall establish a Utilization Review Committee and/or Unit, with the function to determine that admissions and length of stay are appropriate to that level of care and to identify problems with quality of care. Composition of the committee and/or unit shall meet minimum State and Federal requirements. Contractor shall participate in all County-requested Utilization Reviews.

2. **SERVICE PROVIDER REQUIREMENTS:**

A. Staffing Requirements:

I. For the purposes of this Agreement "staff" shall mean any person employed on a part-time, full-time, extra-help, temporary or volunteer basis who works at, for, or with the Provider during the term of this Agreement.

II. Provider agrees to furnish professional personnel in accordance with the regulations, including all amendments thereto, issued by the State or County. Provider shall operate continuously throughout the term of this Agreement with at least the minimum of staff required by law for provision of services hereunder; such personnel shall be qualified in accordance with all applicable laws and regulations.

III. Provider shall at all times have the internal capacity to provide the services called for in this Agreement with personnel that have the requisite cultural and linguistic competence required to provide SMHS under this Agreement.

IV. Provider shall provide clinical supervision or consultation to all treatment staff, licensed, registered, waived, or unlicensed providing services under this Agreement.

V. Staff seeking licensure shall receive clinical supervision in accordance with the appropriate State Licensure Board.

B. Credentialing, Re-Credentialing, and Licensing:

I. Provider shall perform credentialing and re-credentialing activities per CCR Title 9, Sections 1810.435(a) and 1810.435(b), and DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 18-019, (This and subsequent notices can be found at https://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-

Information-Notices.aspx.), shall review its providers for continued compliance with standards at least once every three years, and shall make proof of those credentials upon request.

II. Required Licenses and Credentials: Provider hereby represents and warrants that Provider and any of its staff or subcontractors providing services under this Agreement has all the applicable licenses, permits, and certifications that are legally required for Provider, staff, and its subcontractors to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Provider and its subcontractors shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement. Provider shall submit a copy of any licensing report issued by a licensing agency to HHSA within ten (10) business days of Provider's receipt of any such licensing report.

C. Enrollment, Provider Selection, and Screening:

I. Comply with the provisions of 42 CFR, Sections 455.104, 455.105, 1002.203 and 1002.3, which relate to the provision of information about Provider's business transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the Provider.

II. The Provider shall ensure that all network providers are enrolled with the State as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR part 455, subparts B and E. (42 CFR Section 438.608(b).)

III. The Provider may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected beneficiaries. (42 CFR Section 438.602(b)(2).)

IV. The Provider shall have written policies and procedures for selection and retention of providers. (42 CFR Section 438.214(a).) Provider's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 CFR Section 438.12(a)(2), 438.214(c).)

V. The Provider may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. (42 CFR Section 438.12(a)(1).)

VI. Provider shall only use licensed, registered, or waivered providers acting within their scope of practice for services that require a license, waiver, or registration. (CCR Title 9, Section 1840.314(d).)

VII. The Provider is not located outside of the United States. (42 CFR Section 602(i).)

VIII. A background screening of all employees who may access personal health information (PHI) or personal information (PI) must be conducted. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The

Contractor shall retain each employee's background check documentation for a period of three (3) years.

3. CERTIFICATION OF ELIGIBILITY

Provider will, in cooperation with County, comply with Section 14705.5 of California Welfare and Institutions Code to obtain a certification of a client's eligibility, to obtain a certification of a client's eligibility for Specialty Mental Health Services (SMHS) and licensed Adult Residential Facility services, under Medi-Cal.

4. ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

A. In collaboration with the County, Provider will work to ensure that individuals to whom the Provider provides SMHS meet access criteria, as per DHCS guidance specified in BHIN 21-073. Specifically, the Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision.

5. DEBARMENT AND SUSPENSION CERTIFICATION

A. Federal funds may not be used for any contracted services if Provider is debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any federal department or agency.

I. In accordance with Title 2 CFR Part 376.10, Social Security Act; Title 42 CFR Sections 438.214 and 438.610; and Mental Health Letter No. 10-05 and DHCS MHSUDS Information Notice 18-020, or as subsequently amended or superseded, Contractor will comply with the Federal Health and Human Services, Office of Inspector General's requirement that any provider excluded from participation in federal health care programs, including Medicare or Medicaid/Medi-Cal, may not provide services under this Agreement. Payment will be denied for any services provided by a person identified as excluded from participation in federal health care programs.

II. Consistent with the requirements of 42 CFR part 455.436, the Provider must confirm the identity and determine the exclusion status of all providers (employees and network providers) and any subcontractor, as well as any person with an ownership or control interest through checks of federal and State databases at intervals identified in MHSUDS Information Notice 18-019 as may be amended or replaced. The following identifies these databases:

a. Office of Inspector General List of Excluded Individuals/Entities (LEIE)
b. DHCS Medi-Cal List of Suspended or Ineligible Providers
c. Social Security Administration's Death Master File
d. National Plan and Provider Enumeration System (NPPES)
e. Excluded Parties List System (EPLS)

III. If the Provider finds a party that is excluded, it must promptly notify the County (42 CFR Section 438.608(a)(2),(4)) and the County will notify the State, and take action consistent with 42 CFR Section 438.610(d) and cease billing for any services rendered by the excluded provider as of the effective date of the exclusion. The Provider shall not certify or pay any excluded provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

IV. Allowing staff listed in any State or federal database to provide services performed under this Agreement will result in corrective action.

V. Provider shall not assign or continue the assignment of any employees, agents (including subcontractors), students, or volunteers ("Assigned Personnel") who have been convicted or incarcerated within the prior ten (10) years for any felony as specified in Penal Code Sections 667.5 and/or 1192.7, to provide direct care to clients.

VI. By signing this Agreement, the Provider agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR parts 180 and 417, 2 CFR part 376, 2 CFR part 1532, or 2 CFR part 1485.

VII. The Provider shall not knowingly have any prohibited type of relationship with the following:

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

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

VIII. By signing this Agreement, the Provider certifies to the best of its knowledge and belief, that it and its principals:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

b. Have not within a period of three (3) years preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false Statements, or receiving stolen property;

c. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph h(2) herein; and

d. Have not within a three-year period preceding this agreement had one or more public transactions (federal, State or local) terminated for cause or default.

e. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

f. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

IX. If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to the County Contract Administrator, or successor.

X. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order (FEO) 12549.

XI. The Provider shall provide the County with its System of Award Management Universal Entity Identification (UEI) number, and will be required to register and with the Federal Government's System of Award Management (www.sam.gov); evidence of registration must be provided by the Provider to the County within thirty (30) days of request.

6. ADDITIONAL CLARIFICATIONS
   A. Criteria
      I. A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service listed within Exhibit A of this Agreement can be provided and submitted to the County for reimbursement under any of the following circumstances:
         a. The services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;
         b. The service was not included in an individual treatment plan; or
         c. The client had a co-occurring substance use disorder.
   B. Diagnosis Not a Prerequisite
      I. Per BHIN 21-073, a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a current Centers for Medicare & Medicaid Services (CMS) approved ICD diagnosis code.

7. MEDICAL NECESSITY
   I. Provider will ensure that services provided are medically necessary in compliance with BHIN 21-073 and pursuant to Welfare and Institutions Code section 14184.402(a). Services provided to a client must be medically necessary and clinically appropriate to address the client's presenting condition. Documentation in each client's chart as a whole will demonstrate medical necessity as defined below, based on the client's age at the time of service provision.
   II. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.
   III. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

8. COORDINATION OF CARE
   A. Provider shall ensure that all care, treatment and services provided pursuant to this Agreement are coordinated among all providers who are serving the client, including all other SMHS providers, as well as providers of Non-Specialty Mental Health Services (NSMHS), substance use disorder treatment services, physical health services, dental services, regional center services and all other services as applicable to ensure a client-centered and whole-person approach to services.
   B. Provider shall ensure that care coordination activities support the monitoring and treatment of comorbid substance use disorder and/or health conditions.

C. Provider shall include in care coordination activities efforts to connect, refer and link clients to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
D. Provider shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
E. To facilitate care coordination, Provider will request a HIPAA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state and federal privacy laws and regulations.

9. CO-OCCURRING TREATMENT AND NO WRONG DOOR
A. As specified in BHIN 22-001**,** Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically appropriate, coordinated, and not duplicative.
B. When a client meets criteria for both NSMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the client has a co-occurring mental health condition and substance use disorder.
C. Under this Agreement, Provider will ensure that clients receive timely mental health services without delay.
D. Services are reimbursable to Provider by County even when:
I. Services are provided prior to determination of a diagnosis, during the assessment or prior to determination of whether SMHS access criteria are met, even if the assessment ultimately indicates the client does not meet criteria for SMHS.
II. If Provider is serving a client receiving both SMHS and NSMHS, Provider holds responsibility for documenting coordination of care and ensuring that services are non-duplicative.

ARTICLE 4. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION
A. Provider will collaborate with County to complete authorization requests in line with County and DHCS policy.
B. Provider shall have in place, and follow, written policies and procedures for completing requests for initial and continuing authorizations of services, as required by County guidance.
C. Provider shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
D. County shall provide Provider with written notice of authorization determinations within the timeframes set forth in BHINs 22-016 and 22-017, or any subsequent DHCS notices.
E. Provider shall alert County when an expedited authorization decision (no later than 72 hours) is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function.

2. DOCUMENTATION REQUIREMENTS

A. Provider will follow all documentation requirements in compliance with federal, state and County requirements.
B. All Provider documentation shall be accurate, complete, and legible, shall list each date of service, and include the face-to-face time for each service. Provider shall document travel and documentation time for each service separately from face-to-face time and provide this information to County upon request. Services must be identified as provided in-person, by telephone, or by telehealth.
C. All services shall be documented utilizing County-approved templates and contain all required elements. Provider agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this section require corrective action plans.

3. ASSESSMENT
   A. Provider shall ensure that all client medical records include an assessment of each client's need for mental health services.
   B. Provider will utilize the seven uniform assessment domains and include other required elements as identified in BHIN 22-019 and document the assessment in the client's medical record.
   C. For clients aged 6 through 20, the Child and Adolescent Needs and Strengths (CANS), and for clients aged 3 through 18, the Pediatric Symptom Checklist-35 (PSC-35) tools are required at intake, every six months during treatment, and at discharge, as specified in DHCS MHSUDS INs 17-052 and 18-048.
   D. The time period for providers to complete an initial assessment and subsequent assessments for SMHS are up to clinical discretion of County; however, Provider's providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

4. ICD-10
   A. Provider shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
   B. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of ICD. Provider shall use the ICD diagnosis code(s) to submit a claim for SMHS services to receive reimbursement from County.
   C. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.
   D. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by CMS.

5. PROBLEM LIST
   A. Provider will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

B. Provider must document a problem list that adheres to industry standards utilizing at minimum International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
C. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
E. The problem list shall include, but is not limited to, all elements specified in BHIN 22-019.
F. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Provider shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

6. TREATMENT AND CARE PLANS
   A. Provider is not required to complete treatment or care plans for clients under this Agreement, except in the circumstances specified in BHIN 22-019 and additional guidance from DHCS that may follow after execution of this Agreement.

7. PROGRESS NOTES
   A. Provider shall create progress notes for the provision of all SMHS services provided under this Agreement.
   B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
   C. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or a group service.
   D. Provider shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
   E. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services, if applicable.

8. TRANSITION OF CARE TOOL
   A. Provider shall use a Transition of Care Tool for any clients whose existing services will be transferred from Provider to an Medi-Cal Managed Care Plan (MCP) provider or when NSMHS will be added to the existing mental health treatment provided by Provider, as specified in BHIN 22-065, in order to ensure continuity of care.
   B. Determinations to transition care or add services from an MCP shall be made in alignment with County policies and via a client-centered, shared decision-making process.
   C. Provider may directly use the DHCS-provided Transition of Care Tool, found at https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx, or obtain a copy of that tool provided by the County. Provider may create the Transition of Care Tool in its Electronic Health Record (EHR). However, the contents of the Transition of Care Tool, including the specific wording and

order of fields, shall remain identical to the DHCS provided form. The only exception **to** this requirement is when the tool is translated into languages other than English.

9. TELEHEALTH
   A. Provider may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
   B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.
   C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
   D. Medical records for clients served by Provider under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Provider. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.
   E. County may at any time audit Provider's telehealth practices, and Provider must allow access to all materials needed to adequately monitor Provider's adherence to telehealth standards and requirements.

ARTICLE 5. CHART AUDITING AND REASONS FOR RECOUPMENT

1. MAINTENANCE OF RECORDS
   Provider shall maintain proper clinical and fiscal records relating to clients served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.

2. ACCESS TO RECORDS
   Provider shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Provider shall allow County, CMS, the Office of the Inspector General, the Controller General of the United States, and any other authorized federal and state agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Provider pertaining to such services at any time and as otherwise required under this Agreement.

3. FEDERAL, STATE AND COUNTY AUDITS
   In accordance with the Title 9, CCR, Chapter 11, Section 1810.380(a), County will conduct monitoring and oversight activities to review Provider's SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to SMHS as established in BHIN 21-073, in compliance with the applicable state and federal laws and regulations, and/or the

terms of the Agreement between Provider and County, and future BHINs which may spell out other specific requirements.

4. INTERNAL AUDITING, COMPLIANCE, AND MONITORING
   A. Providers of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet SHMS definitions and be documented accurately.
   B. Provider shall provide County with notification and a summary of any internal audit within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, including any exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Provider's internal audit process as applicable.
   C. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Provider receiving a Contract Monitoring Survey shall, within sixty (60) days of receipt, complete and return the survey along with all documentation, details, and supporting materials required by the survey or otherwise necessary for the County to verify compliance with the terms and conditions of the Agreement. Failure to return the survey within the specified time period may result in the withholding of payment from the Provider until such time as compliance with the terms of the Agreement can be verified. Verifying compliance may necessitate additional on-site reviews should information submitted by the Provider be deemed insufficient or inaccurate.
   D. State Audits: Provider acknowledges that if total compensation under this agreement is greater than $10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Provider shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.
   E. The State, CMS the Health and Human Services (HHS) Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
   F. The Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
   G. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
   H. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.
   I. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the

notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with ARTICLE 2, General Provisions, 9. Assignment and Delegation.

J. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.

5. CONFIDENTIALITY IN AUDIT PROCESS

A. Provider and County mutually agree to maintain the confidentiality of Provider's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA and California Welfare and Institutions Code 5328, to the extent that these requirements are applicable. Provider shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.

B. Provider's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.

C. Provider's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County. All statistical data or information requested by the Director shall be provided by the Provider in a complete and timely manner.

6. REASONS FOR RECOUPMENT

A. County will conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.

B. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:

I. Identification of Fraud, Waste or Abuse as defined in federal regulation.

a. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).

b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.

II. Overpayment of Provider by County due to errors in claiming or documentation.

III. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.

C. Provider shall reimburse County for all overpayments identified by Provider, County and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

7. COOPERATION WITH AUDITS

A. Provider shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.

B. In addition, Provider shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.

C. Provider shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
D. Provider shall allow inspection, evaluation and audit of its records, documents and facilities for ten (10) years from the term end date of this Agreement or in the event Provider has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

8. INDEMINITY

To the fullest extent permitted by law, Provider shall defend at its own expense, indemnify, and hold the County harmless, its officers, employees, agents, and volunteers, against and from any and all liability, claims, suits, losses, damages, or expenses of every name, kind and description, including attorney's fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the acts or omissions of Provider or its officers, agents, or employees in rendering the services, operations, or performance hereunder, except for liability, claims, suits, losses, damages or expenses arising from the sole negligence or willful acts of the County, its officers and employees, or as expressly prescribed by statute. This duty of Provider to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

The insurance obligations of Provider are separate, independent obligations under the Agreement, and the provisions of this defense and indemnity are not intended to modify nor should they be construed as modifying or in any way limiting the insurance obligations set forth in the Agreement.

Nothing herein shall be construed to seek indemnity in excess of that permitted by Civil Code section 2782, et seq. In the event any portion of this Article is found invalid, the Parties agree that this Article shall survive and be interpreted consistent with the provisions of Civil Code section 2782, et seq.

ARTICLE 6. CLIENT PROTECTIONS

1. GRIEVANCES AND APPEALS

A. All grievances (as defined by 42 C.F.R. §438.400) and complaints received by Provider must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
B. Provider shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
C. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).

D. Provider must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
E. Provider must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2. ADVANCED DIRECTIVES

Provider must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. §438.600(b)). For Clients aged eighteen (18) and older, Provider shall provide adult Clients with the written information on advance directives and shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Contractor shall educate its staff concerning the County and Provider's policies and procedures on advance directives. Any written materials prepared by the Contractor shall be updated to reflect changes in State laws governing advance directives as soon as possible, but no later than ninety (90) days after the effective date of the change.

ARTICLE 7. PROGRAM INTEGRITY

1. GENERAL

As a condition of receiving payment under a Medi-Cal managed care program, the Provider shall comply with the provisions of 42 C.F.R. §§438.604, 438.606, 438.608 and 438.610. (42 C.F.R. §438.600 (b)).

2. CREDENTIALING AND RECREDENTIALING OF PROVIDERS

A. Providers must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
B. Upon request, the Provider must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.
C. Provider must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. See relevant section below regarding specific requirements for exclusion monitoring.
D. Providers shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
    I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
    II. A history of loss of license or felony convictions;
    III. A history of loss or limitation of privileges or disciplinary activity;
    IV. A lack of present illegal drug use; and
    V. The application's accuracy and completeness

E. Provider must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
F. Provider is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
G. Provider is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up to date, updated information should be obtained from network providers to complete the re-credentialing process.

3. SCREENING AND ENROLLMENT REQUIREMENTS
A. County shall ensure that all Provider providers are enrolled with the State as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. §438.608(b)).
B. County may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of Provider, of up to 120 days but must terminate this Agreement immediately upon determination that Provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the Provider, and notify affected clients (42 C.F.R. § 438.602(b)(2)).
C. Provider shall ensure that all Providers and/or subcontracted providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. §455.434(a). Provider shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

4. COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS
A. Provider shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. §438.608 (a)(1), that must include:
I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.
II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.
III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
V. Effective lines of communication between the Compliance Officer and the organization's employees.

VI. Enforcement of standards through well-publicized disciplinary guidelines.
VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.
VIII. The requirement for prompt reporting and repayment of any overpayments identified.

B. Provider must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Provider must report fraud and abuse information to the County including but not limited to:
I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),
II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).
III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).
IV. Information about a change in the Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Provider as per 42 C.F.R. § 438.608 (a)(6).

C. Provider shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
D. Provider shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.
E. County may suspend payments to Provider if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).
F. Provider shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Provider shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

5. <u>INTEGRITY DISCLOSURES</u>

A. Provider shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Provider. (42 C.F.R. §§ 455.104, 455.105, and 455.106)
B. Upon the execution of this Agreement, Provider shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. § 455.104).
C. Provider must disclose the following information as requested in the Provider Disclosure Statement:

I. Disclosure of 5% or More Ownership Interest:
   a. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
   b. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
   c. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
   d. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)

II. Disclosures Related to Business Transactions:
   a. The ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
   b. Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

III. Disclosures Related to Persons Convicted of Crimes:
   a. The identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
   b. County shall terminate the enrollment of Provider if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

D. Provider must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Provider ownership or upon request of County. County may refuse to enter into an Agreement or terminate an existing Agreement with a Provider if the Provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the Provider did not fully and accurately make the disclosure as required.

E. Provider must provide the County with written disclosure of any prohibited affiliations under 42 C.F.R. §438.610. Provider must not employ or subcontract with providers or have other relationships with providers Excluded from participating in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610.

6. <u>CERTIFICATION OF NON-EXCLUSION OR SUSPENSION FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM</u>

A. Prior to the effective date of this Agreement, the Provider must certify that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.
B. Provider shall certify, prior to the execution of the Contract, that the Provider does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
    I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
    II. www.sam.gov/portal/SAM - GSA Exclusions Extract
    III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
    IV. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
    V. any other database required by DHCS or DHHS.
C. Provider shall certify, prior to the execution of the Agreement, that Provider does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
    I. https://www.ssdmf.com/ - Social Security Death Master File
D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.
E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
F. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
G. If a Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

ARTICLE 8. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION
    A. Provider shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
    B. Provider shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in

relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Provider shall measure, monitor, and annually report to the County its performance.

C. Provider shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Provider shall assess client/family satisfaction by:
   I. Surveying client/family satisfaction with the Provider's services at least annually.
   II. Evaluating client grievances, appeals and State Hearings at least annually.
   III. Evaluating requests to change persons providing services at least annually.
   IV. Informing the County and clients of the results of client/family satisfaction activities.

D. Provider, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.

E. Provider shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Provider shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Provider at least annually and shared with the County.

F. Provider shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.

G. Provider shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Provider shall ensure that there is active participation by the Provider's practitioners and providers in the QIC.

H. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.

I. Provider shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

2. <u>NETWORK ADEQUACY</u>

A. Provider shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a),(c)).

B. Provider shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.

C. Provider shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.

3. TIMELY ACCESS
   A. Provider shall comply with the requirements set forth in Title 9, CCR, §1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Provider to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
   B. Timely access standards include:
      I. Providers must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Provider offers services to non-Medi-Cal clients. If the Provider's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the Provider makes available for Medi-Cal services that are not covered by the Agreement or another county.
      II. Appointment data, including wait times for requested services, must be recorded and tracked by Provider, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.
      III. Urgent care appointments for services that do not require prior authorization must be provided to clients within 48 hours of a request. Urgent appointments for services that do require prior authorization must be provided to clients within 96 hours of request
      IV. Non-urgent non-psychiatry mental health services, including, but not limited to Assessment, Targeted Case Management, and Individual and Group Therapy appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 10 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service. Non-urgent psychiatry appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 15 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service
      V. Applicable appointment time standards may be extended if the referring or treating provider has determined and noted in the client's record that a longer waiting period will not have a detrimental impact on the health of the client.
      VI. Periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.

4. PRACTICE GUIDELINES
   A. Provider shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements:
      I. They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;
      II. They consider the needs of the clients;
      III. They are adopted in consultation with contracting health care professionals; and
      IV. They are reviewed and updated periodically as appropriate (42 C.F.R.§ 438.236(b) and Title 9, CCR, Section 1810.326).

V. Provider shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients (42 C.F.R. § 438.236(c)).

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)
   A. Provider shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal clients on behalf of Provider, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to BHIN 20-071 requirements, the 21st Century Cures Act, and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.
   B. SMHS licensed individuals required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e., PAVE application package) available through the DHCS PED Pave Portal, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Psychologist, Licensed Educational Psychologist, Physician (MD and DO), Physician Assistant, Registered Pharmacist/Pharmacist, Certified Pediatric/Family Nurse Practitioner, Nurse Practitioner, Occupational Therapist, and Speech-Language Pathologist.
   C. Interns, trainees, and associates are not eligible for enrollment.

6. REPORTING UNUSUAL OCCURRENCES
   A. Provider shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.
   B. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
      I. Complete written description of event including outcome;
      II. Written report of Provider's investigation and conclusions;
      III. List of persons directly involved and/or with direct knowledge of the event.
   C. County and DHCS retain the right to independently investigate unusual occurrences and the Provider will cooperate in the conduct of such independent investigations.

ARTICLE 9. FINANCIAL TERMS

1. CLAIMING
   A. Provider shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Provider shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, as from time to time amended.
   B. Claims shall be complete and accurate and must include all required information regarding the claimed services.
   C. Provider shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.

2. ADDITIONAL FINANCIAL REQUIREMENTS

A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
B. Provider must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.
C. Provider agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.
D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. §1396b(i)(2)).

3. FISCAL CONSIDERATIONS

The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, County is subject to the provisions of Article XVI, section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment, or services not budgeted in a given fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products, or equipment subject herein. Such notice shall become effective upon the adoption of a final budget, which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated, and County released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce or order a reduction in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

4. PROVIDER PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS [IF APPLICABLE]

A. Provider may not redirect or transfer funds from one funded program to another funded program under which Provider provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.
B. Provider may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

5. FINANCIAL AUDIT REPORT REQUIREMENTS FOR PASS-THROUGH ENTITIES
   A. If County determines that Provider is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Provider represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Provider shall observe and comply with all applicable financial audit report requirements and standards.
   B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.
   C. Provider will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the Director. The Director is responsible for providing the audit report to the County Auditor.
   D. Provider must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

ARTICLE 10. ADDITIONAL FINAL RULE PROVISIONS

1. NON-DISCRIMINATION
   A. Provider shall not discriminate against Medi-Cal eligible individuals in its County who require an assessment or meet medical necessity criteria for SMHS services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and State law.
   B. Provider shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.
   C. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
   D. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (Title 2, CCR,

Sections 11100 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I, Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.

E. Where applicable, Provider shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.
F. Provider's signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, CCR, Section 11102.
G. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
H. Provider shall comply with Exhibit G, marked "Vendor Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs," incorporated herein and made by reference a part hereof. Provider shall acknowledge compliance by signing and returning Exhibit G upon request by County.

2. PHYSICAL ACCESSIBILITY

In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Provider must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities.

3. APPLICABLE FEES

A. Provider shall not charge any clients or third-party payers any fee for service unless directed to do so by the County at the time the client is referred for services. When directed to charge for services, Provider shall use the uniform billing and collection guidelines prescribed by DHCS.
B. Provider will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.
C. Provider shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (Title 9, CCR, § 1810.365(c)).

D. The Provider must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

4. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Provider must participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Provider shall participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

5. CLIENT INFORMING MATERIALS

A. Basic Information Requirements

I. Provider shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. §438.10(c)(1)). Provider shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Provider shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

II. Provider shall provide the required information in this section to each client receiving SMHS under this Agreement and upon request. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26., attachments 3, 4; Tit. 9, CCR, § 1810.360(e).)

III. Provider shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. §438.10.

IV. Provider shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).

V. Client information required in this section may only be provided electronically by the Provider if all of the following conditions are met:

a. The format is readily accessible;
b. The information is placed in a location on the Provider's website that is prominent and readily accessible;
c. The information is provided in an electronic form which can be electronically retained and printed;
d. The information is consistent with the content and language requirements of this Agreement;
e. The client is informed that the information is available in paper form without charge upon request and the Provider provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).

B. Language and Format

I. Provider shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)

II. Provider shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.

III. Provider shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Provider's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(d)(3).)
   a. Provider shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); Title 9, CCR, § 1810.410, subd. (e), para. (4))

IV. Provider shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)-(4).)

V. Provider shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Beneficiary Informing Materials

I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
   a. Guide to Medi-Cal Mental Health Services
   b. County Beneficiary Handbook (BHIN 22-060)
   c. Provider Directory
   d. Advance Health Care Directive Form (required for adult clients only)
   e. Notice of Language Assistance Services available upon request at no cost to the client
   f. Language Taglines
   g. Grievance/Appeal Process and Form
   h. Notice of Privacy Practices
   i. Early & Periodic Screening, Diagnostic and Treatment (EPSDT) poster (if serving clients under the age of 21)

II. Provider shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.

III. Provider shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.

IV. Required informing materials must be electronically available on the Provider's website and must be physically available at the Provider agency facility lobby for clients' access.

V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS)

711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

VI. Informing materials will be considered provided to the client if Provider does one or more of the following:
   a. Mails a printed copy of the information to the client's mailing address before the client first receives a SMHS;
   b. Mails a printed copy of the information upon the client's request to the client's mailing address;
   c. Provides the information by email after obtaining the client's agreement to receive the information by email;
   d. Posts the information on the Provider's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
   e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Provider provides informing materials in person, when the client first receives SMHS, the date and method of delivery shall be documented in the client's file.

D. Provider Directory
   I. Provider must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
   II. Provider must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).
   III. Any changes to information published in the provider directory must be reported to the County within two (2) weeks of the change.
   IV. Provider will only need to report changes/updates to the provider directory for licensed, waivered, or registered mental health providers.

ARTICLE 11. DATA, PRIVACY AND SECURITY REQUIREMENTS

1. CONFIDENTIALITY AND SECURE COMMUNICATIONS

A. Provider shall comply with all applicable Federal and State laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records and all relevant County policies and procedures.

B. Provider will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.

C. Provider shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.

D. Provider shall not use or disclose PHI or PII other than as permitted or required by law.

2. ELECTRONIC PRIVACY AND SECURITY
   A. Provider shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Provider's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.
   B. Provider shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and safeguarding passwords. Provider shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.
   C. Any Electronic Health Records (EHRs) maintained by Provider that contain any PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Provider that utilize an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.
   D. Provider entering data into any County electronic systems shall ensure that staff are trained to enter and maintain data within this system.

3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE BUSINESS ASSOCIATE AGREEMENT (BAA)
   A. Provider may perform or assist County in the performance of certain health care administrative duties that involve the use and/or disclosure of client identifying information as defined by HIPAA. For these duties, the Provider shall be a Business Associate of the County and shall comply with the applicable provisions set forth in Exhibit H, marked "HIPAA Business Associate Agreement," incorporated herein and made by reference a part hereof.
   B. Provider shall follow all requirements listed within the BAA and shall comply with all applicable County policies, state laws and regulations and federal laws pertaining to breaches of confidentiality. Provider agrees to hold the County harmless for any breaches or violations.

ARTICLE 12. CLIENT RIGHTS

Provider shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code § 5325 et seq; Title 9, CCR, §§ 862, 883, 884; Title 22 CCR, §72453 and § 72527; and 42 C.F.R. §438.100.

ARTICLE 13. RIGHT TO MONITOR

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

2. Provider shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the Provider has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(I)-(ii)).
3. The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Provider's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).
4. Provider shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Provider to ensure compliance with laws, regulations, and requirements, as applicable.
5. County reserves the right to place Provider on probationary status, should Provider fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Provider may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.
6. Provider shall retain all records and documents originated or prepared pursuant to Provider's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Provider's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
7. Provider shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200,

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
9. Provider shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
10. Provider shall comply with ARTICLE 11. Data, Privacy And Security Requirements regarding relinquishing or maintaining medical records.
11. Provider shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. Provider shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or Provider ceases operation of its business, Provider shall deliver or make available to County all financial records that may have been accumulated by Provider or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
14. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Provider.
15. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Provider has not performed satisfactorily.

ARTICLE 14. SITE INSPECTION

Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Provider shall permit authorized County, state, and/or federal agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Provider shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

ARTICLE 15. EXECUTIVE ORDER N-6-22 – RUSSIA SANCTIONS

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, if this Agreement is funded by state funds and County determines Provider is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The County shall provide Provider advance written notice of such termination, allowing Provider at least

thirty (30) calendar days to provide a written response. Termination shall be at the sole discretion of the County.

ARTICLE 16. CONTRACT ADMINISTRATOR
The County Officer or employee with responsibility for administering this Agreement is Christianne Kernes, LMFT, Deputy Director, Health and Human Services Agency, Behavioral Health Division, or successor.

ARTICLE 17. ELECTRONIC SIGNATURES
Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement, are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic Signature means any electronic visual symbol or signature attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including facsimile or email electronic signatures, pursuant to the California Uniform Electronic Transactions Act (Cal. Civ. Code §§ 1633.1 to 1633.17) as amended from time to time.

ARTICLE 18. COUNTERPARTS
This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

ARTICLE 19. ENTIRE AGREEMENT
This Agreement, including all schedules, addenda, exhibits and attachments, contains the entire understanding of the Parties in regard to Provider's provision of the services specified in Exhibit A ("Scope of Work") and supersedes all prior representations in regard to the same subject matter, whether written or oral.

Requesting Contract Administrator Concurrence:

By: ChristianneKernes
ChristianneKernes (Nov 17, 2023 10:59 PST)
Christianne Kernes, LMFT
Deputy Director
Health and Human Services Agency, Behavioral Health Division

Dated: 11/17/2023

Requesting Department Head Concurrence:

By: Olivia Byron-Cooper
Olivia Byron-Cooper (Nov 17, 2023 11:02 PST)
Olivia Byron-Cooper,MPH
Director
Health and Human Services Agency

Dated: 11/17/2023

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates indicated below.

-- COUNTY OF EL DORADO --

Dated: _____

By: _____
Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: _____
Deputy Clerk

-- PSYNERGY PROGRAMS, INC --

By: Arturo Uribe
Arturo Uribe (Nov 20, 2023 09:44 PST) Dated: 11/20/2023
Arturo Uribe
President, CEO
"Provider"

By: Jean Edwards
Jean Edwards (Nov 20, 2023 09:52 PST) Dated: 11/20/2023
Jean Edwards
CCO/Partner
"Provider"

Psynergy Programs, Inc.
Exhibit A
Scope Of Work

A. Provider/Program Overview:
Provider shall provide licensed Adult Residential Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), and Intensive Outpatient Mental Health Services in Provider's outpatient mental health clinics in close proximity to the County of El Dorado (County) Clients. Provider shall provide reliable adult residential home care in combination with intensive outpatient mental health services to help individuals with mental illness avoid the unnecessary expense and emotional trauma often associated with incarceration and hospitalization. Provider shall provide both residential services and mental health services to people with serious mental illnesses ages 18 and above.

Provider's program shall utilize tenets of the Wellness and Recovery, Integrated Dual Diagnosis Treatment and Modified Therapeutic Community (MTC) treatment models, (Phase One, Two and Four). Provider's programs serve as an alternative to locked institutional settings such as a State Hospital, Psychiatric Hospital, an Institutions for Mental Disease (IMD), a Psychiatric Health Facility (PHF) and Jail. The intent and goal of the Provider services is to improve each Client's quality of life, to help individuals gain the skills and ability necessary to stay out of locked hospital settings and to move into a less restrictive living arrangement in the community.

B. Provider's Residential Facilities:
Provider agrees to furnish the facility, personnel, services and equipment necessary to provide Residential Treatment Services for Clients on an "as requested" basis for the Health and Human Services Agency (HHSA), Behavioral Health Division. Provider agrees to comply with all applicable Federal and State laws and regulations required of the licensed facilities and programs. Provider shall maintain all requirements in accordance with California Code of Regulations (CCR) Title 22, Division 6, Chapter 6, and CCR Title 9, Division 1, Chapter 11.

C. Provider's Medi-Cal Certified Residential Facilities/Programs:
Provider shall provide Residential Services at six (6) Medi-Cal certified sites, which are used in a step-down manner from locked settings, with a high level of support and services offered at all sites. Provider shall provide an array of services that ensure client safety and that help individuals meet their basic needs in the least restrictive home-like setting possible. Provider shall foster community reintegration for many individuals that have previously resided in locked mental health facilities for extended periods of time.

Provider's residential facilities serving El Dorado County Clients (hereinafter referred to as Clients) are as follows:

1. Nueva Vista Adult Residential Facility (72 beds)
   18225 Hale Avenue, Morgan Hill CA 95037

2. Nueva Vista Sacramento (60 beds)
   4604 Roosevelt Avenue, Sacramento CA 95820

3. Cielo Vista Adult Residential Facility (40 beds)
   806 Elm Avenue, Greenfield CA 93927

4. Vista Esperanza Residential Care Facility for the Elderly (RCFE) – 54 beds)
   5240 Jackson Street, North Highlands CA 95660

5. Vista de Robles, Adult Residential Facility (80 beds)
   9847 Folsom Blvd., Sacramento CA 95827

6. Vista de Robles Crisis Residential Facility (10 beds – pending proposal)
   9847 Folsom Blvd., Sacramento CA 95827

7. Tres Vista Apartments (6 beds)
   18217 Apts # (200, 210, 220 and 230)
   Hale Avenue, Morgan Hill CA 95037

D. Program Intent and Goals:

The Provider shall provide residential and Intensive Outpatient Specialty Mental Health Services (SMHS) services to individuals diagnosed with Serious Mental Illness (SMI) and Serious Persistent Mental Illness (SPMI) whose level of functioning, symptoms, and psychiatric history necessitate service intervention to maintain the individual in community settings. The goal is to assist individuals in Institutions for Mental Disease (IMD) levels of care to step-down and transition back into the community with the support that has been demonstrated to be the most effective, using tenets of the Wellness and Recovery, Integrated Dual Diagnosis Treatment, and Modified Therapeutic Community (MTC) models (Phases One, Two, and Four). Provider shall provide both residential services and mental health services to people with serious mental illnesses ages 18 and above. The intent and goal of Provider's services is to improve each individual's quality of life, to help individuals gain the skills and ability necessary to stay out of locked hospital settings and to move into a less restrictive living arrangement in the community.

E. Residential Program Description and Services:

Provider shall provide Clients with the following Residential Services:

1. **Client Development Services**: Provider shall provide Client Development Services to Clients residing in locked hospital settings. Prior to enrollment in Psynergy Programs, Provider's Client Development Specialists work in partnership with Clients, counties, hospitals and IMDs to help individuals become motivated and prepared to move into residential programs. Motivational interviewing techniques are utilized to engage clients and to foster a treatment alliance that can be further developed in the therapeutic community. This multifaceted process facilitates community re-integration.
2. **General Client Services**: Provider shall provide a broad range of services in an enriched, structured environment focused on each Client's individual needs and interests. Services shall be designed to enhance basic living skills, improve social functioning, allow for training opportunities within the community, and for participation in out-of-home activities, in an effort to normalize each Client's lifestyle. Such services are intended to

help each Client reach and maintain their highest level of functioning resulting in integration into the community.

3. **Care and Supervision**: Provider shall provide 24/7 staffing at the facilities to adequately address the needs of Clients, in accordance with Title 22 of the CCR Section 85065.6(d). Night supervisory staff shall be awake in compliance to CCR 85065.6(d).
4. **Room and Board**: Provider shall ensure Clients are provided with clean, comfortable, functional, and non-institutional living quarters, as well as attractive living areas, which contribute to the improvement of their mental and physical health and functioning.
5. **Basic Services**: Provider's facility's Administrators and staff shall be actively involved in developing opportunities for residents to learn and practice independent living skills and responsibilities. This includes group activities and classes, "Leisure" and "Recreational", as well as opportunities to learn vocational skills. The primary goal is to assist residents to obtain skills needed to move to a less restrictive, more independent setting.
6. **General Residential Program Services:** Provider services shall include the following general residential services as appropriate for the Client's individual needs:
    i. Orientation by staff and/or peer shall be provided to each resident within three days of arrival.
    ii. Provision of three (3) nutritious and well-balanced meals and three (3) snacks to Clients daily.
    iii. Provision of bed linens and towels.
    iv. Weekly, and as needed, cleaning of the resident's room and bathroom by onsite housekeeping staff. Daily cleaning is provided for all incontinent individuals
    v. Limited individual storage space consisting of a closet and small dresser in resident's room for resident's own private use.
    vi. Provision of all personal hygiene needs from dental floss to shampoo.
    vii. Provision of recreational, leisure and social activities.
    viii. Help with planning and arranging for transportation to local functions, churches and educational classes within a nearby radius.
    ix. Observance of resident's general health.
    x. Updating of resident's Needs and Services Plan as frequently to ensure the Plan's accuracy and to document significant occurrences that result in changes in the resident's physical, mental, emotional and/or social needs.
    xi. Consultation as needed with resident's doctors about resident's general mental and physical health.
    xii. Assistance as needed with obtaining linkage to medical care.
    xiii. Assistance as needed with taking prescribed medications in accordance with doctor's instructions unless prohibited by law or regulation.
7. **Daily Activities Program**: Provider shall provide a Daily Activities Program designed to help Clients improve their well-being and functioning to include the following:
    i. Provide daily program activities to Clients seven (7) days a week, featuring recreational and leisure activities.
    ii. Provider's program activities shall promote the development of personal interests and help residents to practice healthy lifestyles, social skills, positive coping strategies, accessing community resources and money management. The daily schedule of activities is developed and implemented by the facility's Program

Manager. The facility Administrator, residential counselors, and Clients shall assist with some of the planned activities at times for all-facility engagement

8. **Holistic Health Programs**: Provider shall provide Holistic Health Programs focused on Nutrition, Smoking Cessation, Medication Education, Sexual Health Education, Diabetes Awareness and Management, and Healthy Habits Coaching including personal hygiene, good eating habits, and weather appropriate care and dress.
    i. For diabetic clients and other clients whose health can be enhanced by following special diets, they will be assisted in special meal procurement and preparation. In addition, snacks will be available to meet their dietary needs. The Provider's facility shall be prepared and capable of offering vegetarian and allergy sensitive options.
9. **Recreational and Leisure Activities**: Recreation is a vital aspect of maintaining a stable and healthy lifestyle. Provider shall invite Clients' families to join the residence at holiday events and residential celebrations. Recreational opportunities shall be offered by Provider on a daily basis. As Clients recover and benefit from the Provider's programs, Provider shall encourage them to access some of the community resources available to them. Provider shall promote participation in daily outings in the community, including walks in the surrounding neighborhoods, bike rides, visits to local festivals, visits to the library and outings to local restaurants with the aim of enhancing self-esteem, building social skills and instilling optimism about the future.
10. **Physical Fitness Programs**: Provider shall provide daily exercise groups to residents and may make available local gym memberships while providing support to access facilities.
11. **Vocational Readiness Training**: Provider shall provide a variety of vocational opportunities to Clients as part of the Daily Activities Program.
    i. The types of vocational job opportunities offered include administrative work (i.e., constructing and making copies of fliers and distributing them, janitorial work, assisting in landscape maintenance and meal service.) Residents shall be given a detailed description of the job and the skills it requires they apply and participate in an interview with the Provider's staff to be awarded the job.
    ii. Provider shall give Clients a stipend once they complete the job. Provider shall explain to Clients the correlation between the task they performed and the associated job in the real world. This helps Clients develop skills in an informal way and helps them develop a resume of marketable skills.
12. **Peer and Family Support:** Provider shall provide Peer Counseling and Leadership to allow individuals to take a proactive role within the facility as well as in the lives of each other. This aspect of the program develops a sense of empowerment and leadership skills within the Client.
    i. Provider shall establish a Resident Council to allow the residents as a whole to give voice to their opinions and ideas of the program and their needs.
    ii. Provider shall develop a volunteer sign-up for those willing to provide assistance with leading groups, assist individuals to access community resources, or to provide assistance to those Clients with a lower functioning capability.
    iii. Provider shall provide education and support to Clients through recreational activities, family support groups, and facilitating linkages with the National Alliance on Mental Illness.

iv. Provider shall enact visiting hours for Client's friends and family seven (7) days a week.

13. **Linkage to Community Resources:** Provider shall provide Clients linkage to community resources to help individuals who have just been discharged from locked settings integrate into the community.
    i. Linkage shall also be provided to those individuals that have progressed further in the recovery process and that are working toward more independence.
    ii. Providers shall provide linkage to Clients for referrals as needed to include schools, colleges, and other institutions for education; vocational programs; public transit; medical and dental services; cultural organizations; churches and places of worship; financial institutions; and government agencies.
14. **Provider's Older Adult Residential Program - Residential Care Facility for Elderly (RCFE):** Clients 60 years and older may be placed at Provider's Residential Care Facility for the Elderly (RCFE), Vista Esperanza.
    i. Vista Esperanza is an all-inclusive full service, whole person care, program providing services to adults 60+ years, or younger if determined as needed, who have a serious and persistent mental illness with a co-occurring physical disorder that are risk of losing their community placement due to an ongoing chronic co-existing physical impairment.
    ii. Older adult Clients whom have had extensive histories of institutionalization or at high risk for a higher level of care, hospitalizations, unplanned emergency services and at high risk for skilled nursing care, are the target population to be served at the Provider's RCFE.
    iii. Younger Clients may utilize this RCFE if determined as needed, who have a serious and persistent mental illness with a cooccurring physical disorder that are risk of losing their community placement due to an ongoing chronic co-existing physical impairment.
    iv. Clients admitted to Provider's RCFE will benefit from intensive case management preventing further deterioration of their condition and enhancing their capacity to remain in the least restrictive environment. The services are designed to maximize Client's participation in their recovery and enhance their quality of life while living in their community.
    v. If appropriate, Provider will provide the setting for hospice care and end-of-life services in a dignified, safe, and supportive environment.
    vi. Provider shall provide Outpatient Specialty Mental Health services to eligible Clients, anticipated to be eight (8) to ten (10) hours a month provided onsite the Provider's RCFE.
    vii. Provider's RCFE, Vista Esperanza, will may accept or retain persons with the following allowable health conditions provided all requirements in CCR, Title 22, Chapter 8 are met. The facility will make an assessment of its ability to comply with each specific requirement prior to accepting or retaining a client:
        a) Individuals diagnosed with diabetes and requiring regular insulin-injections.
        b) Individuals with stage 1 or 2 dermal ulcers.

c) Individuals with respiratory disorders requiring inhalers and other inhalation-assistive devices including C-PAP and BiPAP machines, humidifiers, dehumidifiers and nebulizers.
d) Individuals requiring Colostomy / ileostomy care.
e) Individuals with fecal impaction requiring digital removal, enemas, or suppositories.
f) Individuals with indwelling urinary catheter and requiring outpatient level catheter care.
g) Individuals with wounds that are unhealed, surgically closed and expected to heal.
h) Individuals with bowel and bladder incontinence
i) Limited beds for Non-ambulatory clients

15. **Provider's Older Adult Residential Program <u>Accommodations and Amenities</u>**: <u>Provider shall provide the following accommodations and amenities at the RCFE,</u> Vista Esperanza:
    - **i.** Provision of 24-hour residential care, 24-hour nursing, full activities of daily living (ADL) support for stable yet medically fragile older adults as well as adults at the RCFE.
    - **ii.** clean and comfortable lodging to Clients
    - iii. Three (3) nutritious and well-balanced meals and three (3) snacks daily
    - iv. Weekly, and as needed, cleaning of the resident's room and bathroom by onsite housekeeping staff. Daily cleaning is provided for all incontinent individuals
    - v. Bed linens and towels.
    - vi. A phone available for resident's incoming personal and outgoing local personal calls.
    - vii. Limited individual storage space consisting of a closet and small dresser in resident's room for resident's own private use.
    - viii. Provider shall provide all personal hygiene products including but not limited to dental floss, shampoo, feminine hygiene products. etc. When recommended by our Dental Hygienist electric toothbrushes are provided at no cost.
    - ix. Provider shall provide Over-The-Counter (OTC) medicines to all residents, at no cost to the individual or County.
    - x. Provider shall provide the following medicines to Clients based on their symptoms:
        - Headache – acetaminophen; aspirin; or Motrin.
        - Constipation - acetaminophen, ibuprofen, or acetylsalicylic acid.
        - Diarrhea - Pepto Bismol or Imodium.
        - Nausea and Upset Stomach - Tums, Maalox, or Pepto Bismol
16. **Provider's Assertive Community Treatment (ACT) & Supported Accommodations Program**: **Tres Vista Apartments**
    Provider shall provide Assertive Community Treatment (ACT) & Supported Accommodations Program at Provider's Tres Vista Apartments, and shall:
    - i. Provide the right combination of Services and Supports to Clients based on their individualized needs. Provider shall incorporate evidence-based practices as well as draws from therapeutic community and psychosocial rehabilitation models.

ii. Align with the Modified Therapeutic Community (MTC) model to specifically address acute psychiatric symptoms, cognitive impairments, and reduced level of functioning of individuals struggling with the debilitating effects of mental illness, dual substance use disorders and co-morbid health conditions. In partnership with the MTC model, Provider has adapted an ACT model that reflects individuals being supported in the community, and also by creating community.

iii. Provider, working in partnership with Clients, shall deliver MTC Three (3)-Program Phases to help individuals move into community settings and culminate with a "Live Out" re-entry program called Tres Vista Apartments. The Provider's Three (3)-Program Phases are as follows.

Provider's Modified Therapeutic Community: Three Program Phases

	ONE	**TWO**	**THREE**
PHASE	**Admission:** Client Development Services	**Primary Treatment:** Nueva Vista	**Live Out Re-entry:** Tres Vista Apartments
FOCUS	Assessment, Engagement, Orientation	Awareness, Change	Adjustment, Productivity

iv. Provider's Services and Supports delivered by professional staff shall help individuals learn to meet basic needs, develop new skills, increase social support, become a responsible member of the community and live a healthy and productive lifestyle.

v. Provider's emphasis of "Living Out" within the community is based on a Client experiencing enjoyment and satisfaction in the "here and now," independent problem solving, and taking action to achieve personal goals.

17. **Provider's Tres Vista Apartments and Housing Description of Living Accommodations**

i. **Shared Living Unit**: Individuals are provided with a completely furnished and equipped apartment in a shared apartment, house, or studio. Amenities include all furnishings, refrigerator, microwave, stove, cable television, kitchenware, cooking utensils, and linens.

ii. **Meals and Snacks**: Individuals are invited to the community kitchen and given the option to enjoy a nutritious breakfast, lunch, and dinner. Individuals may elect to customize their meal service by preparing certain meals and eating privately in their own living unit if preferred. Tenants are required to attend at least one of the main meal services per day of their own choosing in the main residential facility (lunch or dinner.) This ongoing engagement demonstrates community inclusiveness.

iii. **Utilities**: the cost of all utilities are included as part of the base rent.

iv. **Weekly Housekeeping**: Tenants are required to keep their living quarters in a sanitary and orderly condition. Provider shall provide a housekeeper once per week to assist with maintaining the living unit in a clean and sanitary condition.

v. **Laundry Facility**: Tenants are required to maintain their clothing in a neat and clean condition. Tenants may use the clothes washer and dryer provided on site free of charge. Tenants must purchase their own laundry detergents and other laundry supplies.

vi. **Services and Support**: Provider's staff members are available to conduct "check-ins" with clients on a daily basis to monitor the client's condition and to provide appropriate support to ensure the client's safety and stability.

18. **Provider's Tres Vista Apartments Description of Clinical Services and Supports:**

i. **Recreational Activities:** Tenants are encouraged to participate in recreational activities occurring on a daily basis within the main residential facility. Activities are designed to promote development of social skills, interest in hobbies and enjoyment of leisure time, while decreasing stigmatization and social isolation. Activities include staff supervised outings to the library, movies, parks, recreational sites and community events.

ii. **Psychosocial Rehabilitation Classes:** Our psycho-educational classes are wellness and recovery oriented and are designed to promote adoption of a healthy lifestyle through the development of life skills. Areas of focus include positive coping skills, effective communication, symptom management, relapse prevention, medication management and social skills

iii. **Independent Living Skills Group Training:** Tenants are encouraged to participate in independent living skills group training, which occurs daily within the main residential facility. Topics of independent living skills group training include money management, budgeting, shopping, cooking, personal health, nutrition, exercise, personal hygiene, and grooming.

iv. **Psychiatric and Medication Services:** Psychiatric services are provided at Psynergy's outpatient clinic, which is located on campus adjacent to the main facility. The regularly scheduled frequency of psychiatric visits is either two times per month or once per month, depending on client need and stage of treatment. Unscheduled emergency visits with the psychiatrist may occur as needed. The duration of each regular psychiatric visit is typically 30 minutes, depending on the nature and purpose of the visit.

F. <u>Provider's Intensive Support Services (ISS) Program</u>

1. Provider's ISS Program provides a higher level of care to transitional clients, including but not limited to, higher levels of supervision, separate smaller residential wing, more intensive clinical and medication management leading to symptom stabilization, and supervised integration with other facility residents.
2. Provider's ISS Program is intended for County clients who are discharged to Contractor from Psychiatric Health Facilities, Psychiatric Hospitals, State Hospitals, Crisis Stabilization Units, and Behavioral Health Units. Program may also be beneficial to County clients who are not thriving, relapsing or decompensating while admitted to Contractor residential programs.

G. Provider's Comprehensive Whole Health Management Program

Provider shall provide a Comprehensive Whole Health Management Program, designed to provide Clients with medical and health support services not covered under traditional models, yet essential for persons to thrive in community settings, to include:

1. 24 Hour nursing giving clients ability to move into an open community setting
2. Onsite Geriatric Nurse Practitioner
3. Services for medically fragile individuals
4. Individual therapy
5. Full ADL support
6. Comprehensive psychiatric services
7. Fulltime Occupational Therapist

H. Provider Outpatient Specialty Mental Health Services:

Provider shall provide Clients with Intensive Outpatient Mental Health Service while Clients are a resident of one of the Provider's Facilities identified in this Agreement. Provider shall provide outpatient SMHS to Clients to include:

1. Each of Provider's Outpatient Mental Health Clinics will be Medi-Cal certified by each individual contracting county to ensure their specific conditions are met.
2. Provider Programs: Provider's Outpatient Mental Health Clinics will maintain an active Medicare Certification and Provider is responsible for updating its Medicare re-certification as require by Noridian.
3. Provider will collaborate with counties in regard to Medicare billing for when a Client has both Medicare and MediCal coverage (referred to as Medi-Medi Clients.) This includes counties in Northern, Central, and Southern California. The outpatient mental health clinics currently have thirty-two (32) full-time & part-time clinical Providers who provide SHMS to individuals living in the adult residential facilities and supported accommodations/independent living. This number of professionals is subject to change depending upon Clients served.
4. Provider shall provide intensive outpatient Specialty Mental Health Services (SMHS) in accordance with Short-Doyle Medi-Cal and Medicare services standards and billing practices. Provider specific SMHS services shall include:
    i. **Assessment**: A service activity which may include a clinical analysis of the history and current status of a client's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures. This will be completed within thirty days and includes, Medical Doctor Assessment and Initial Clinical Intake Assessment.
    ii. **Plan Development**: Involves the development and approval of client plans and monitoring client progress.
    iii. **Therapy:** A service activity that focuses primarily on symptom reduction as a means to improve functional impairments. This service activity may be delivered to an individual or group of Clients, and may also include family therapy with or without the beneficiary present.
    iv. **Collateral:** Contact with one or more significant support persons in the life of the beneficiary with the intent of improving or maintaining the mental health status of the beneficiary. Collateral services include, but are not limited to, helping significant support persons to understand and accept the beneficiary's

condition and involving them in service planning and implementation of the service plan(s). Family counseling or therapy provided on behalf of the client, when this person is not present, is considered collateral.

v. Rehabilitation: Assistance improving, maintaining, or restoring:
- Functional and daily living skills
- Social and leisure skills
- Grooming and personal hygiene skills
- Obtaining support resources and/or medical education

vi. **Group Rehabilitation**: Psycho-education and/or rehabilitation services administered in a group setting, allowing for emotional and mental growth that support therapeutic goals.

vii. **Targeted Case Management**: Services provided to assist a consumer with accessing medical, educational, social, prevocational, or rehabilitative services. The service activities include: interagency and intra-agency consultation; communication coordination and referral; monitoring service delivery to ensure client access to services and service delivery system; and monitoring of the client's progress and any plan development regarding referrals and linkage to services.

viii. **Crisis Intervention**: Crisis Intervention means a service lasting less than 24 hours, to or on behalf of a clinic for a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an immediate emergency response that is intended to help the client cope with a crisis (e.g., potential danger to self or others, potentially life altering event; severe reaction that is above the client's normal baseline).

ix. **Medication Support**: Services that include the administering, dispensing, and monitoring of psychiatric medications provided by staff person within the scope of his/her profession; services are necessary to alleviate the symptoms of mental illness. Specific service may include the following:
- Plan development related to the delivery of this service and/or to the status of the client's functioning in the community.
- Prescribing, dispensing, and administering of psychiatric medications.
- Obtaining medical consents and provide psycho-education
- Documentation Requirements: Response, compliance, side effects

I. Outpatient Mental Health Clinics Intent and Goals**:**

The overall goal of Provider's Outpatient Mental Health Clinics is to provide Intensive Outpatient Mental Health Services (i.e., medication support, Individual therapy, Group therapy, family therapy, rehabilitation services, group rehabilitation, and targeted case management) to ensure that Client's living in an adult residential facility or independent/supportive accommodation successfully maintain their community placement by avoiding inpatient and high utilization of psychiatric hospitalizations.

1. Provider's clinical staff shall support and encourage Client's successfully transition back to their county of origin, to a boarding care home, independent living situation, or back to a family's home when appropriate.
2. Upon admission to Provider's Programs, Provider's clinical staff will complete an Medical Doctor's assessment and an initial clinical assessment. Within 30 days in

collaboration with Client, family members (if available and appropriate) and County case manager, Provider's clinical staff shall complete a Client's treatment plan.

3. By providing intensive outpatient Specialty Mental Health Services, Provider shall allow individuals the ability to:
    - **i.** Cope effectively with life challenges and attain greater autonomy in community living.
    - ii. Experience a growing sense of trust, self-confidence and self-control in their lives and relationships.
    - iii. Develop innate capabilities and practical skills necessary to create and sustain a healthy lifestyle.
    - iv. Utilize capabilities and skills to move in a positive direction in life and to satisfy basic needs.
4. Success at each clinical site is measured by the number of days that individuals remain in their residences and out of locked settings as well as helping individuals successfully transition back to their counties. Improvement in quality of life is also measured and tracked through our MTC (Modified Therapeutic Community) level system. Individuals are rated each week by our Status Review committee on their ability to demonstrate a set of pro-social abilities and life skills specified by our Program Agreements and Steps to Recovery.
5. Individuals advance in their recovery from "Orientation" to "Peer Leader" and earn rewards and privileges on the basis of clinical staff observation and reports from residential staff. Success is also measured by ability and responsibility of attending their own psychiatric and individual therapy appointments at the clinic on their own without prompts or reminders. Other objectives we measure and track as part of our level system include:
    - i. Reduction in intensity and frequency of psychiatric symptoms, as observed and reported by the residential staff to clinical staff.
    - ii. Total days of abstinence and reduction in frequency of substance use as observed and reported by residential staff to clinical staff and indicated by toxicology reports.
    - iii. Improvement in functioning in various life domains, including health, daily activities, social relationships, and living arrangement as observed and reported by residential staff to clinical staff.
    - iv. Program participation and group attendance, as observed and reported by residential staff to clinical staff.

J. Integrated Dual Recovery Treatment

Provider's integrated dual recovery outpatient clinics providing mental health, substance abuse, and physical health treatments shall be integrated within one comprehensive program that is designed to enable individuals to actively participate in their recovery process by developing the skills and capabilities necessary to maintain a healthy lifestyle. In Provider's integrated dual recovery model, mental illness, substance abuse, and physical illnesses are not regarded as separate problems, but rather are holistically viewed as the primary focus. The Provider's clinical team at Provider's Dual Recovery Treatment clinics is designed to enable Clients to satisfy a wide range of needs. Each participant is encouraged to engage in

meaningful work, education, recreation and leisure activities and to develop a capacity for independent living.

1. Comprehensive Clinical Services: Provider's integrated dual recovery program includes the following services:
    i. Assertive Community Treatment
    ii. Coping Skills Training
    iii. Healthy Lifestyle Training
    iv. Social Skills Training
    v. Supported Employment
    vi. Specialty Mental Health Services
2. Harm Reduction: Provider's Outpatient Mental Health Services are aimed at reducing the harmful effects and negative consequences of co-occurring substance abuse and physical and mental illness. Provider's clinical staff members work closely and collaboratively with Clients, family and county case managers and residential staff to provide the care and attention necessary to safeguard them against the risk of harm.
3. Practice Evidence Based Treatment Approaches:
    i. CBT/DBT—focuses on teaching client skills, increasing understanding of illness and creating relapse prevention plans/strategies.
    ii. CBTp – for Clients with a psychosis related diagnosis this is an evidenced based treatment to reduce the emotional distress and behavioral disturbance in relation to individual psychotic symptoms
    iii. Motivational Interviewing (MI)—uses empathic listening to explore attitudes and to build on strengths.
    iv. Modified Therapeutic Community—use of peers and counselors as positive role models. Focuses on building self-awareness, social skills and social support.
    v. Psychopharmacology—use of medication to stabilize symptoms.
    vi. Case Management—focuses on helping individuals meet basic needs.
    vii. Matrix—integrates mutual self-help, CBT and Motivational therapy. Focuses on fostering strong therapeutic relationship, coping skills, social skills, abstinence from substance use and relapse prevention.
4. General Goals of Dual Recovery Treatment
    i. Help individual achieve abstinence/self-control.
    ii. Foster behavioral changes that support abstinence/self-control.
    iii. Improve problem solving and coping skills.
    iv. Identify and address a wide range psychosocial problems (housing, employment, education, social/family relationships).
    v. Develop a positive family/social support network.
    vi. Facilitate active participation in mutual self-help, 12-step programs.

K. Provider and County Responsibilities: Client Admission and Discharge

1. **Admissions**: HHSA BHD will refer Clients to Provider and will send Provider a referral packet for Clients stepping down from state hospitals, IMDs, PHF, Jails, or other sub-acute crisis programs.
    i. The Provider shall review the packet, which includes records from current placement and items listed in Exhibit E, marked "Complex Care Level of Treatment Evaluation," incorporated herein and made by reference a part hereof.

ii. HHSA BHD shall send Provider copies of Client's benefits and insurance information prior to admission.
iii. Provider will work in collaboration with the HHSA BHD Case Manager to determine a Client's Level of Complexity (with the appropriate level as listed in item 4 below, Levels of Treatment Complexity) for each referred Client.
iv. Clients will be transported by County Personnel unless prior arrangements are made, (see Exhibit B for transportation rates.)
v. HHSA BHD will provide Provider a Client's initial assessment and most recent assessment, with supporting documentation to the best of their ability.
vi. Clients should arrive to Provider's facility with two (2) weeks of medication, Physicians Report (LIC612), and results of a tuberculosis test completed within six (6) months of the date of admission.

1) **Discharges**: Provider shall provide two (2) weeks-notice to HHSA BHD prior to Client discharge to ensure all supporting documentation is prepared in a timely manner with a safe medical, psychiatric, and therapeutic transition plan. Clients are discharged or transferred from Contractor's Facilities when: the Client has successfully completed a treatment plan and no longer needs this level of residential care, the Client or their conservator requests a transfer or discharge, or the Client needs a higher level of medical or psychiatric care.

2. **Discharge Criteria**: Criteria for Client discharge is as follows:
   i. The Client has demonstrated that they meet one or more of the following criteria listed below:
      a. Client has met the criteria for discharge listed in their treatment plan;
      b. Client has alleviated all crisis and/or other symptoms; or
      c. Client has demonstrated ability to function in a less-restrictive environment.
      d. Client has demonstrated need for a higher level of medical or psychiatric care;
      e. Client has demonstrated an uncooperative attitude toward treatment and is actively engaged in counter-productive behavior;
      f. Client has demonstrated threats and/or other dangerous behavior to other residents or staff;
      g. Client has engaged in property damage or theft;
      h. Client has brought contraband articles or material into Contractor's Facilities and/or onto the Contractor's property;
      i. Client has engaged in drinking alcohol or using illicit drugs while residing at Contractor's Facilities; or
      j. Client has expired.
3. **Client Eligibility:** Clients served under this Agreement must be age eighteen (18) years or older, and eligible for mental health services in conformance with all applicable Federal and State statutes.
4. **Levels of Treatment Complexity:** Provider shall work in collaboration with the HHSA BHD Case Manager to determine a Client's Level of Treatment for each referred Client. A Client's complexity level will be assessed upon admission, discharge, and at the request of the HHSA BHD Case Manager, using the Exhibit E as an assessment tool. A daily patch rate, included in Exhibit B will be determined based on an individual's level of treatment complexity. As is consistent with Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Levels of Treatment Complexity include:

i. Level I
ii. Level II
iii. Intensive Support Services
iv. Inclusive Whole Person Care

Daily patch rates will be compatible with these levels of treatment. Provider will utilize the Complex Care Level of Services Evaluation as shown in Exhibit C as an assessment tool prior to Client admission. County and Provider will both provide input to determine the Client's level of treatment complexity prior to admission. Provider shall work in collaboration with County to determine the daily patch rate for each referred Client.

Examples of some Level I and Level II complex care coincide with the specialized needs, reporting, and treatment requirements of the following Client populations:

i. Individuals who have severe psychiatric conditions that require additional temporary assistance in monitoring medical issues or that need continued support and education to manage chronic medical conditions such as diabetes and COPD.
ii. Individuals with co-occurring disorders such as substance abuse, developmental delays or physical impairments that require linkage to specialized community resources or that may need various behavioral supports, including specialized health care, frequent one-to-one supervision and prompting to maintain a community placement.
iii. Individuals requiring Restricted Health Care Plans, incontinent care (urinary and fecal), Diabetes and Insulin management, Colostomy care, Vitals, Oncology treatment and support, etc. significant medication management, crushed medication orders, medication adherence precautions, treatment supports, multiple medications, and supporting refusals with medication room staff interventions.
iv. Individuals released from jail requiring additional supports and reporting. Mental Health Diversion, PC1001.36, Registered Sex Offenders, Court Ordered Treatment (AOT, Laura's Law), Arsonists, Electronic monitoring devices, and Probation.

5. **Levels of Treatment Complexity Re-assessment**: Client's level of treatment complexity will be mutually reassessed by Provider and HHSA BHD Case Manager and every six (6) months. If there is a significant change in the level of functioning prior to six (6) months, Provide shall work with HHSA BHD Case Manager to establish a new benchmark assessment using Exhibit C and adjust the daily patch rate accordingly.

L. Outcome Reporting: **P**rovider shall provide the County quarterly progress reports, summarizing the Clients' overall progress to individual treatment goals, medication compliance, engagement in treatment, etc. Quarterly reports must be received within fifteen (15) days after the completion of each quarter (Quarters are defined as: April 15th, July 15th, Oct 15th, and Jan 15th) or upon special request.
Measurable Outcomes:
1. County's Clients admitted to the program from higher level placements will move to a lower level of care based on their progress in treatment and review of reported treatment

goals and outcomes. The primary goal is for each Client to progress toward lower levels of care and return to the County of El Dorado.

2. The number of County's Clients re-admitted to higher level placements will be reported to County to assess the long-term effectiveness of Provider's programs.

M. Role of Client's Conservator: In the event Client is conserved, Conservator shall have the power, if specified in the court order, to approve the care, maintenance and support of the Conservatee, to require the Conservatee to receive mental health and medical treatment related to remedying the recurrence of the Conservatee being gravely disabled, including the administration of medication. The Conservator shall have such general powers as provided by law together with the powers set forth in Section 5358 of the California Welfare and Institutions Code (WIC) to place Conservatee in the least restrictive residential placement available and necessary to achieve the purpose of treatment. This section shall not supersede any powers assigned to the Conservator or maintained by the Conservatee by court order.

N. Documentation and Information Requirements:

All documentation must be completed in compliance with Medi-Cal requirements.

1. **Clinical Record**:
   - i. Provider shall maintain adequate Client records, with a preference for an electronic clinical record, on each individual Client, which shall include diagnostic studies, records of Client interviews, treatment plans, progress notes, and records of services provided by various professional and paraprofessional personnel, in sufficient detail to permit an evaluation of services. Such records shall comply with all applicable federal, State, and county record maintenance requirements. Provider shall ensure all written "Service Authorizations" documents shall become a part of the Client's clinical record.
   - ii. Provider shall provide Clients with, and document in the Clients' clinical record the provision of the "Guide to Medi-Cal Mental Health Services," "Notice of Privacy Practices," and "Informed Consent" at the first appointment after receiving the Initial Authorization, at the time of re-assessment, and upon Client request. The "Guide to Medi-Cal Mental Health Services" can be accessed on the County Mental Health website, currently located at https://www.edcgov.us/Government/MentalHealth.
   - iii. Provider shall inform Clients who are Medi-Cal Beneficiaries about grievance, appeal, expedited appeal, fair hearing, and expedited fair hearing procedures and timeframes as specified in 42 Code of Federal Regulations (CFR) Part 438 and State guidance. Provider shall provide Clients with a copy of the Provider and county case manager will establish a new benchmark assessment, using the Exhibit C as an assessment tool and adjust the daily patch rate accordingly.
   - iv. Services Provided in Language Other Than English
     a. If services are provided to a Client in a language other than English, Provider shall document the use of an alternate language in the Clients' clinical record and identify the language in which services were provided.
     b. In the event of the use of an interpreter service in the provision of SMHS, Provider shall document in the Clients' clinical record the name of the interpreter service and the language utilized.

2. **Client Progress Notes**: Provider shall document Client progress notes that minimally contain the required elements to be an allowable Medi-Cal billable service, including but not limited to the following elements: the date and time the services were provided; the date and time the documentation was entered into the medical record; the amount of time taken to provide the services; the location of the intervention; the relevant clinical decisions and alternative approaches for future interventions; the specific interventions applied; how the intervention relates to the Client's mental health functional impairment and qualifying diagnosis; identify the Client's response to the intervention; document any referrals to community resources and other agencies (when appropriate); be signed by the person providing the service (or electronic equivalent) with the person's type of professional degree, licensure, or job title. A progress note must be written for every service contact.
3. **Client Assessment and Re-Assessment**: Upon admission to Psynergy Programs, Provider's clinical staff will complete a medical assessment and an initial clinical assessment for each Client.
    i. Treatment Plans:
        a. Within thirty (30) days, in collaboration with the Client, family members (if available and appropriate), and a HHSA BHD Case Manager, a treatment plan will be complete by Provider's clinical staff. Provider shall modify the Treatment Plan when effectiveness or progress is not evident, or to meet the changing needs of the Client.
        b. Provider staff will maintain services for Clients even when difficulties and challenges (e.g., a psychiatric emergency) disrupt the Treatment Plan.
    ii. Re-Authorization of Services:
        a. Provider shall review each Treatment Plan a minimum of once within each Service Authorization Period to assess Client progress and outcomes, and update the Treatment Plan. This process includes a review of the needs and strategies to support movement to the community, independence, the shift from formal to informal services and supports, and the transition to less intensive services or the adult service system.
        b. Provider shall submit requests for reauthorization of a client by completing the process specified in the Outpatient SMHS Protocol.
    iii. Discharge Summary:
        a. Planned Discharge (Graduation): Provider shall provide the County a copy of the written Discharge Summary within fourteen (14) days following a planned discharge (graduation); and
        b. Unplanned Discharge: Provider shall provide the County a copy of the written Discharge Summary within thirty (30) days following the last date of service for unplanned discharges.
    iv. Psychiatric and Medication Support Services:
        a. Psychiatric and Medication Support Services shall be provided and documented in accordance with CCR, Title 9, Division 1 and Medi-Cal billing requirements.
        b. Provider shall notify the County in writing when the waiting time to see a Psychiatrist exceeds twenty (20) days.
        c. Lanterman-Petris-Short (LPS) Evaluations and Declarations: Upon request of the County, Provider will provide LPS conservatorship assessments with two of their three psychiatrists. The psychiatrists complete an evaluation of the Clients'

mental status, medication efficacy, and psycho social dynamics; in addition will determine Clients' legal status and provide a recommendation. However, if the county wants to provide the evaluation, or part of it, this would be acceptable as well. Annual evaluations and conservatorship declarations are provided at no cost to the County, evaluations will be billed to Medi-Cal.

4. **Requirements Regarding Information Provided to Clients**:
    i. The Provider shall provide information in a manner and format that is easily understood and readily accessible to beneficiaries. (42 CFR Section 438.10(c)(1).)
        a. The Provider shall provide all written materials for Clients in easily understood language, format, and alternative formats that take into consideration the special needs of beneficiaries. (42 CFR Section 438.10(d)(6).)
            1) Language: Provider shall make its materials that are critical to obtaining services, including, at a minimum, Provider directories, beneficiary handbooks, appeal and grievance notices, denial and termination notices, and Provider's mental health education materials, available in the prevalent non-English languages in the County. (42 CFR Section 438.10(d)(3).
            2) Font: Provider shall provide all written materials for potential Clients and Clients in a font size no smaller than 12 point (42 CFR Section 438.10(d)(6)(ii)). "Large print" means printed in a font size no smaller than 18 point (42 CFR Section 438.10(d)(3).
            3) Alternate Formats: The Provider shall ensure its informational materials are available in alternative formats, including large print, audio and/or braille depending upon the needs of the Clients, upon request of the potential Clients or Clients at no cost.
            4) Auxiliary Aids: The Provider shall make auxiliary aids and services, such as TTY/TDY, available upon request and free of charge to each Client. (42 CFR Section 438.10(d)(3)-(4).) Provider shall also notify Clients how to access these services. (42 CFR Section 438.10(d) (5)(ii)-(iii).)
            5) Interpretation: The Provider shall make interpreter services, including American Sign Language (ASL), available and free of charge for any language. (42 CFR Section 438.10(d)(2), (4)-(5).) Provider shall notify Clients that the service is available and how to access those services. (42 CFR Section 438.10(d)(5)(i), (iii).)
        b. The Provider shall inform beneficiaries that information is available in alternate formats and how to access those formats. (42 CFR Section 438.10.)
5. **Cultural Competency Plan**: Upon request, Provider shall provide each Client with a copy of its Cultural Competency/Linguistic Policy and Procedure. Provider shall provide its Cultural Competency/Linguistic Policy to County, upon request.

O. Operation and Administration:
1. Provider agrees to furnish all space, facilities, equipment, and supplies necessary for its proper operation and maintenance.
2. Provider, if incorporated, shall be in good standing and operate according to the provisions of its Articles of Incorporation and By-Laws. Said documents and any

amendments thereto shall be maintained and retained by Provider and made available for review or inspection by County at reasonable times during normal business hours.

3. Provider shall notify the County of any/all changes in leadership staff within ten (10) days of change. Leadership staff includes but is not limited to Executive Director, Clinical/Program Director, Chief Fiscal Officer, Psychiatrist, and Chairperson of the Board of Directors.
4. If Provider becomes aware that a Client becomes ineligible for Medi-Cal, Provider shall notify the County, and Client's Conservator if the Client is conserved, in writing within 24 hours, and refer the Client, or Client's Conservator if the Client is conserved, to the Client's Medi-Cal Eligibility Worker.
5. All program-related written materials must be provided, minimally, in English and in the County's Medi-Cal threshold language.
6. In the event that Provider is required by subpoena to testify in any matter arising out of or concerning this Agreement by any party other than County, Provider shall not be entitled to any compensation from County for time spent or expense incurred in giving or preparing for such testimony, including travel time. Provider must seek compensation from the subpoenaing party, and County shall not be liable if Provider fails to receive compensation.
7. Provider shall have representative staff attend County-sponsored Provider Meetings and other work groups as established and scheduled.
    i. Notification of Events:
        a. Occurrences of a Serious Nature: Provider shall notify Contract Administrator, in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature. For the purpose of this Agreement an occurrence of a serious nature shall include, but is not be limited to, accidents, injuries, acts of negligence, acts that are reportable to a governing body, hospitalizations, any event that impacts delivery of services to Client(s), events that are usually or reasonably preventable, and of a nature such that the risk impacts the provision of services and/or this Agreement for Services or loss or damage to any County property in possession of Provider.
        b. Notification of Death: Provider shall notify Contract Administrator immediately by telephone upon becoming aware of the death of any Client served under this Agreement due to any cause. The Provider shall follow up with a written report faxed or hand-delivered within twenty-four (24) hours of the telephone notification.
    ii. Notification Content: The Notification of Death shall contain the name of the deceased, the date and time of death, the nature, and circumstances of the death, and the name(s) of Provider's officers or employees with knowledge of the incident.

Psynergy Programs, Inc.
Exhibit B
Provider Rates

Provider shall observe and comply with all lockout and non-reimbursable service rules, as outlined in the Drug Medi-Cal Billing Manual.

A. Supplemental Day Rate Patch

A single per person per day rate to be billed daily dependent on the Level of Complexity assessed by provider staff per Exhibit A.

Level of Treatment Complexity	Unit	Rate
Level I	Per day/per client	$172.10
Level II	Per day/per client	$143.61
Intensive Support Services	Per day/per client	$284.86
Inclusive Whole Person Care	Per day/per client	$242.00

B. Specialty Mental Health Services (SMHS)

Rates for SMHS outpatient services are to be billed to County of El Dorado (County) at the following rates per provider taxonomy.

Taxonomy	Unit	Rate
Psychiatrist/MD	15 minutes	$260.98
Psychiatrist/MD (Group Rate)	15 minutes	$58.00
Licensed Practitioner of the Healing Arts (LPHA)	15 minutes	$68.11
Licensed Practitioner of the Healing Arts (LPHA) (Group Rate)	15 minutes	$15.14
Mental Health Rehab Specialist (MHRS)	15 minutes	$51.24
Mental Health Rehab Specialist (MHRS) (Group Rate)	15 minutes	$11.37
Psychiatric Technician	15 minutes	$47.88
Psychiatric Technician (Group Rate)	15 minutes	$10.64
Licensed Vocational Nurse (LVN)	15 minutes	$55.84
Licensed Vocational Nurse (LVN) (Group Rate)	15 minutes	$12.41

New Patient Evaluation - Psychiatrist/MD	15-29 Minutes	$382.77
New Patient Evaluation - Psychiatrist/MD	30-44 Minutes	$643.75
New Patient Evaluation - Psychiatrist/MD	45-59 Minutes	$904.73
New Patient Evaluation - Psychiatrist/MD	60-74 Minutes	$1,165.71
Established Patient Evaluation - Psychiatrist/MD	10-19 Minutes	$260.98
Established Patient Evaluation - Psychiatrist/MD	20-29 Minutes	$434.97
Established Patient Evaluation - Psychiatrist/MD	30-39 Minutes	$608.95
Established Patient Evaluation - Psychiatrist/MD	40-54 Minutes	$817.74
Family Psychotherapy (with patient present) - Psychiatrist/MD	50 Minutes	$869.93
Family Psychotherapy (with patient present) - LPHA	50 Minutes	$227.03
Individual Counseling 1341 (90832) - LPHA	30 minutes	$122.60
Individual Counseling 1341 (90832) - Psychiatrist/MD	30 minutes	$469.76
Individual Counseling 1341 (90834) - LPHA	45 minutes	$204.33
Individual Counseling 1341 (90834) - Psychiatrist/MD	45 minutes	$782.94
Individual Counseling 1341 (90837) - LPHA	60 Minutes	$272.44
Individual Counseling 1341 (90837) - Psychiatrist/MD	60 Minutes	$1,043.92
Interpretation Services	15 minutes	$30.00
Interactive Complexity	Flat Rate	$16.50

C. Unbenefited Clients without SSI.

If the client does not yet receive SSI or SSI/SSA benefits, or those benefits have been diminished due to back payments owed to other entities, or do not reflect standard residential care rates, County will provide payment to cover the delinquent and/or amount owed. Monthly residential board and care rate is currently $1,324.80 per month and is updated and increased every January 1st on an annual basis. Additionally, the County will pay $3.00 per day for Personal Needs for the client. It is the responsibility of the client's conservator to reimburse the county funds paid for on behalf of the client.

County will advise Provider if there is a change in payee or representative payee.

D. Rates for Tres Vista, Supported Accommodations / Independent Living

General community services and supports for individuals living in an unlicensed, independent setting experiencing mental distress, substance abuse and co-occurring medical diagnoses. All

meals, groups and recreational activities are included. Application and Program Agreements must be reviewed with County prior to admission.

Day Rate for Individuals with Benefits	**$54.60 per client day.**

E. Transportation

Admission, Conservatorship Hearings, Discharge to Lower Level of Care Transportation

Upon request from County , when possible with available staffing, Provider will pick-up new Client's admitted for residential placement into facility. Travel is reimbursable from the Client's residence to their destination, and their return in a Psynergy Program insured car. Provider's driver rate is $50.00 per hour plus mileage.

Beginning on January 1, 2023, the standard mileage rates for the use of a car, van, pickup or panel truck will be: 65.5 cents per mile for business miles driven, and is subject to change as the IRS updates annually.

In the event the Client is being transported to a higher level of care, when safe and appropriate, Provider's additional staff will be charged the same rate of $50.00 per hour. If the roundtrip mileage is 200+ there may be additional costs incurred, such as: hotel for staff, meals, and additional staff to avoid driver fatigue.

For the purpose of travel (transportation), meal, and motel (lodging) costs, the rates shall be in accordance with current County Travel Policy D-1 available at: https://www.edcgov.us/Government/BOS/Policies/Documents/D-1%20Travel%20Policy%20Amended%20-%2010-22-19.pdf

Driver will ensure the safety and supervision of individuals, ensure admission paperwork and medications are in order, meal provided, hydration, cigarette breaks if so required.

F. Enhanced Support and Supervision

Provider will provide individual support and supervision with prior written authorization from County Health and Human Services Agency.

Service	Increment of Service	Rate
Enhanced Support and Supervision	15 minutes	$40.00 per hour, per 15 minute increment

Examples of individual support and supervision, but not exhaustive, are:

1. Stand by assistance for dialysis treatment, including bedside support during treatment and transport to and from treatment. Stand by assistance for chemotherapy treatment, including bedside support during treatment, and transport to and from treatment.

2. Individual support (1:1) for clients diagnosed with Serious and Persistent Mental Illness (SPMI) and Intellectual Disabilities that without this individual support are placing their housing at risk with the escalation of symptoms and behaviors. Extra support for hygiene and Assistance with Daily Living (ADL) if required.

3. Bereavement support for individuals attending funeral or memorial of a loved one, including the transportation.

G. Isolation Support Services

If a County Client (resident) has been ordered to stay in their room due to COVID-19, or other transmissible disease or diagnosis, precautions, or exposure, Provider shall be reimbursed at a flat rate of $100.00 per day for room support, bed side support, medication delivery, and 1:1 support as needed. This allows the facility to bring in temporary and on-call staff for support and supervision.

Psynergy Programs, Inc.
Exhibit C
Bed Hold Authorization

County of El Dorado Health And Human Services Agency, Behavioral Health Division:

Resident: _____

Reason for Absence from Facility:

_____
_____
_____
_____

I,_____, authorized representative for County of El Dorado Health and Human Services Agency, Behavioral Health Division (HHSA/BHD) do hereby authorize Contractor to hold the bed of the resident noted above while he/she is away from the facility. Holding the bed is guaranteeing the board and care payment to Contractor for the duration of the client's absence or until notice of discharge.

By:_____ Dated: _____
Authorized Representative
El Dorado County HHSA BHD

Public Guardian / Payee:

Resident: _____

Reason for Absence from Facility:

_____
_____
_____
_____

I,_____, do hereby authorize Provider to hold the bed of the resident noted above while he/she is away from the facility. Holding the bed is guaranteeing the board and care payment to Provider for the duration of the client's absence or until notice of discharge.

By:_____ Dated: _____
Public Guardian / Payee
El Dorado County

Psynergy Programs, Inc.
Exhibit D
HHSA Invoice Template

Vendor Name:	
Vendor Address:	
Phone:	
Fax:	
Email:	
Billing Contact:	

Contract #:	
Program Description:	
EDC HHSA Program Contact Person:	
Invoice #:	
Invoice Date:	
Invoice Total Amount:	0
Service Period/Month:	

DATE OF SERVICE	SERVICE TYPE/ DESCRIPTION	UNITS OF SERVICE (Hours/QTY)	COST PER UNIT (Rate)	AMOUNT
				0
				0
				0
				0
				0
				0
				0
	Subtotal:			0
	Tax:			
	Please Pay this Amount:			**0**

Invoice Backup
Invoice backup for services to include all data listed in your contract. – (if appropriate)
If Authorization of Services is required, the signed Authorization Form must be included with this invoice.

Bill to:	**Email: BHInvoice@edcgov.us (*preferred method*)**
	Mail: County of El Dorado Health and Human Services Agency **3057 Briw Road, Ste. B** **Placerville, CA 95667**

Psynergy Programs, Inc.
Exhibit E
Complex Care Level of Treatment Evaluation

Diagnosis – *Circle all known diagnoses. No points allocated.*

Schizophrenia	ADD/DHD
Schizo-Affective	SUD/Poly-Substance
Bipolar Disorder	Major Depression Disorder
Anxiety Disorder	Impulse Control Disorder
Dissociative	PTSD
Personality D/O	

Symptoms *Check all that apply in the past six months pre-admission and every six months post admission.*

(1) Psychosomatic	(2) Psychosis
(2) Labile	(1) Disorganized
(2) Depression	(2) Mania
(1) Anxiety	(3) Suicidal Ideation
(2) Perseverating	(1) Fearfulness
(1) Delusional	(2) Paranoia
(2) Auditory Hallucinations	(2) Command Hallucinations

Total_____

Behavioral Supports – *Check all that apply in the past six months pre-admission and every six months post admission.*

(2) Intrusive	(2) Labile
(3) Intermittent Explosiveness	(3) Verbally Assaultive
	(1) Victimization
(2) Inappropriate Sexual Bx	(3) Elopement/UAA Bxs
	(2) Disruptive to Milieu
(1) OCD Bxs	(1) Isolation
(2) Threatening Behaviors	(2) Aggressive Behaviors
(2) Impulsive behaviors	(2) Property Destruction

Total_____

Legal Restrictions

2 On Probation
2 Registered Sex Offender
3 Arsonist/Fire-Setting with intent to destroy property
3 Electronic Monitoring Device
4 Mental Health Diversion PC1001.36

Total_____

Restricted Health Care Plans

(2) Urinary Incontinence, Neurosis
(3) Fecal Incontinence
(2) Diabetes, BSL Management
(2) Inhaler/Asthma/Allergy
(2) Hypertension
(2) COPD with Inhaler
(2) Vitals, Blood Pressure, Temperature, Etc.
(2) Pacemaker
(2) Colostomy Care

Total____

Special Diets

(2) Ground/Pureed/Chopped
(2) Vegan, Vegetarian, GERD friendly
(3) Weight management, shakes, dbl portions, etc
(2) Other:
(*must be approved by Food Services Manager prior to admission)*

Total_____

Medication and Medical Management

(3) Clozaril	(2) 1-6 Oral Medications
(3) Lithium	(3) 7-11 Oral Medications
(4) Insulin	(4) 12-18 Oral Medications
(2) 1-2 Treatments	(3) 3+ Treatments

(3) 2 or more Antipsychotics
(3) Crushed Medications Order
(3) Medication adherence precautions / Med Refusals

Total_____

Suicidal Attempt & Self Injurious Bx

(3) Past 30 Days
(2) 30-90 Days
(1) 90-180 Days
(0) 180+ Days & History of SA/SIB

Total_____

Physical Disabilities

(2) Assistive Device, Walker, Knee Scooter, Etc.
(3) Visual Impaired (ex. Blind)
(3) Hearing Impaired

Total_____

Activities of Daily Living Assistance

(4) Bathing, Grooming, Dressing

Dual Recovery Program Support

(MUST BE DIAGNISED- INCLUDES ETOH, POLYSUBSTANCE, AND CAFFEINE)

(1) <1 Test Administered
(2) x1 Test Administered
(3) x2 Tests Administered
(4) x3 Tests Administered

(3) Relapse Prevention Plan – Active

Total_____

Total Level of Service Score

Level I Management	18 +
Level II Management	0 - 17

Total Points: _____

Psynergy Programs Only: CLIENT NAME_____
COUNTY NAME:_____

Completed by Facility Administrator:

Signature:

Date:

Review by Medication Room Mgr.:

Signature:

Date:

County Case Manager or Conservator:

Signature:

Date:

This form must be completed prior to initial admission and/or internal transfer to other Psynergy facility.

Psynergy Programs, Inc.
Exhibit F
California Levine Act Statement

California Government Code section 84308, commonly referred to as the "Levine Act," prohibits any officer of El Dorado County from participating in any action related to a contract if he or she receives any political contributions totaling more than two hundred and fifty dollars ($250) within the previous twelve (12) months, and for twelve (12) months following the date a final decision concerning the contract has been made, from the person or company awarded the contract. The Levine Act also requires disclose of such contribution by a party to be awarded a specific contract. An officer of El Dorado County includes the Board of Supervisors, and any elected official (collectively "Officer"). It is the Contractor's/Consultant's responsibility to confirm the appropriate "officer" and name the individual(s) in their disclosure.

Have you or your company, or any agent on behalf of you or your company, made any political contributions of more than $250 to an Officer of the County of El Dorado in the twelve months preceding the date of the submission of your proposals or the anticipated date of any Officer action related to this contract?

☐ YES ☑ NO
If yes, please identify the person(s) by name:
If no, please type N/A.

Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contribution of more than $250 to an Officer of the County of El Dorado in the twelve months following any Officer action related to this contract?

☐ YES ☑ NO
If yes, please identify the person(s) by name:
If no, please type N/A.

Answering YES to either of the two questions above does not preclude the County of El Dorado from awarding a contract to your firm or any taking any subsequent action related to the contract. It does, however, preclude the identified Officer(s) from participating in any actions related to this contract.

11/20/2023	Arturo Uribe Arturo Uribe (Nov 20, 2023 09:44 PST)
Date	Signature of authorized individual
Psynergy Programs Inc.	Arturo Uribe
Type or write name of company	Type or write name of authorized individual

Psynergy Programs, Inc.
Exhibit G
"Vendor Assurance of Compliance with
Nondiscrimination in State and Federally Assisted Programs"

HEREBY AGREES THAT it will comply with Title VI and VII of the Civil Rights Act of 1964 as amended; Section 504 of the Rehabilitation Act of 1973 as amended; the Age Discrimination Act of 1975 as amended; the Food Stamp Act of 1977, as amended and in particular section 272.6; Title II of the Americans with Disabilities Act of 1990; California Civil Code Section 51 et seq., as amended; California Government Code section 11135-11139.5, as amended; California Government Code section 12940 (c), (h) (1), (i), and (j); California Government Code section 4450; Title 22, California Code of Regulations section 98000 – 98413; Title 24 of the California Code of Regulations, Section 3105A(e); the Dymally-Alatorre Bilingual Services Act (California Government Code Section 7290-7299.8); Section 1808 of the Removal of Barriers to Interethnic Adoption Act of 1996; and other applicable federal and state laws, as well as their implementing regulations [including 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, 7 CFR Part 15, and 28 CFR Part 42], by ensuring that employment practices and the administration of public assistance and social services programs are nondiscriminatory, to the effect that no person shall because of ethnic group identification, age, sex, color, disability, medical condition, national origin, race, ancestry, marital status, religion, religious creed or political belief be excluded from participation in or be denied the benefits of, or be otherwise subject to discrimination under any program or activity receiving federal or state financial assistance; and HEREBY GIVE ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all federal and state assistance; and THE VENDOR/RECIPIENT HEREBY GIVES ASSURANCE THAT administrative methods/procedures which have the effect of subjecting individuals to discrimination or defeating the objectives of the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Chapter 21, will be prohibited.

BY ACCEPTING THIS ASSURANCE, the vendor/recipient agrees to compile data, maintain records and submit reports as required, to permit effective enforcement of the aforementioned laws, rules and regulations and permit authorized CDSS and/or federal government personnel, during normal working hours, to review such records, books and accounts as needed to ascertain compliance. If there are any violations of this assurance, CDSS shall have the right to invoke fiscal sanctions or other legal remedies in accordance with Welfare and Institutions Code section 10605, or Government Code section 11135-11139.5, or any other laws, or the issue may be referred to the appropriate federal agency for further compliance action and enforcement of this assurance.

THIS ASSURANCE is binding on the vendor/recipient directly or through contract, license, or other provider services, as long as it receives federal or state assistance.

11/20/2023
Date

Arturo Uribe
Arturo Uribe (Nov 20, 2023 09:44 PST)
Signature

18225 Hale Avenue Morgan Hill CA 95037
Address of vendor/recipient

Psynergy Programs, Inc.
Exhibit H
HIPAA Business Associate Agreement

This Business Associate Agreement is made part of the base contract ("Underlying Agreement") to which it is attached, as of the date of commencement of the term of the Underlying Agreement (the "Effective Date").

R E C I T A L S

WHEREAS, County and Contractor (hereinafter referred to as Business Associate ("BA") entered into the Underlying Agreement pursuant to which BA provides services to County, and in conjunction with the provision of such services, certain Protected Health Information ("PHI") and Electronic Protected Health Information ("EPHI") may be disclosed to BA for the purposes of carrying out its obligations under the Underlying Agreement;

WHEREAS, the County and BA intend to protect the privacy and provide for the security of PHI and EPHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (the "HITECH" Act), and regulation promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws as may be amended from time to time;

WHEREAS, County is a Covered Entity, as defined in the Privacy Rule and Security Rule, including but not limited to 45 CFR Section 160.103;

WHEREAS, BA, when a recipient of PHI from County, is a Business Associate as defined in the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to 42 USC Section 17938 and 45 CFR Section 160.103;

WHEREAS, "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.202(g);

WHEREAS, "Breach" shall have the meaning given to such term under the HITECH Act under 42 USC Section 17921; and

WHEREAS, "Unsecured PHI" shall have the meaning to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to 42 USC Section 17932(h).

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

I. Definitions. Unless otherwise provided in this Business Associate Agreement, capitalized terms shall have the same meanings as set forth in the Privacy Rule, as may be amended from time to time.

II. Scope of Use and Disclosure by BA of County Disclosed PHI

A. BA shall not disclose PHI except for the purposes of performing BA's obligations under the Underlying Agreement. Further, BA shall not use PHI in any manner that would constitute a violation of the minimum necessary policies and procedures of the County, Privacy Rule, Security Rule, or the HITECH Act.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Business Associate Agreement or required by law, BA may:

1. Use the PHI in its possession for its proper management and administration and to fulfill any legal obligations.
2. disclose the PHI in its possession to a third party for the purpose of BA's proper management and administration or to fulfill any legal responsibilities of BA, or as required by law
3. Disclose PHI as necessary for BA's operations only if:
   a) Prior to making a disclosure to a third party, BA will obtain written assurances from such third party including:
      (1) To hold such PHI in confidence and use or further disclose it only for the purpose of which BA disclosed it to the third party, or as required by law; and
      (2) The third party will immediately notify BA of any breaches of confidentiality of PHI to the extent it has obtained knowledge of such breach.
4. Aggregate the PHI and/or aggregate the PHI with that of other data for the purpose of providing County with data analyses related to the Underlying Agreement, or any other purpose, financial or otherwise, as requested by County.
5. Not disclose PHI disclosed to BA by County not authorized by the Underlying Agreement or this Business Associate Agreement without patient authorization or de-identification of the PHI as authorized in writing by County.
6. De-identify any and all PHI of County received by BA under this Business Associate Agreement provided that the de-identification conforms to the requirements of the Privacy Rule, 45 CFR and does not preclude timely payment and/or claims processing and receipt.

C. BA agrees that it will neither use nor disclose PHI it receives from County, or from another business associate of County, except as permitted or required by this Business Associate Agreement, or as required by law, or as otherwise permitted by law.

III. Obligations of BA. In connection with its use of PHI disclosed by County to BA, BA agrees to:

A. Implement appropriate administrative, technical, and physical safeguards as are necessary to prevent use or disclosure of PHI other than as permitted by the Agreement that reasonably and appropriately protects the confidentiality, integrity, and availability of the PHI in accordance with Title 45 of the Code of Federal Regulations, Part 160 and Part 164, Subparts A and C (the "HIPAA Privacy Rule" and the "HIPAA Security Rule") in effect or as may be amended, including but not limited to 45 CFR 164.308,

164.310, 164.312, and 164.504(e)(2). BA shall comply with the policies, procedures, and documentation requirements of the HIPAA Security Rule.

B. Report to County within 24 hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

C. Report to County in writing of any access, use, or disclosure of PHI not permitted by the Underlying Agreement and this Business Associate Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than five (5) days. To the extent the Breach is solely a result of BA's failure to implement reasonable and appropriate safeguards as required by law, and not due in whole or part to the acts or omissions of the County, BA may be required to reimburse the County for notifications required under 45 CFR 164.404 and CFR 164.406.

D. BA shall not use or disclose PHI for fundraising or marketing purposes. BA shall not disclose PHI to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. BA shall not directly or indirectly receive remuneration in exchange of PHI, except with the prior written consent of the County and as permitted by the HITECH Act, 42 USC Section 17935(d)(2); however, this prohibition shall not affect payment by County to BA for services provided pursuant to the Agreement.

IV. PHI Access, Amendment, and Disclosure Accounting. BA agrees to:

A. Provide access, at the request of County, within five (5) days, to PHI in a Designated Record Set, to the County, or to an Individual as directed by the County. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable County to fulfill its obligations under the HITECH Act, including, but not limited to, 42 USC Section 17935(e).

B. Within ten (10) days of receipt of a request from County, incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in BA's possession constitutes a Designated Record Set.

C. To assist the County in meeting its disclosure accounting under HIPAA:

1. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosure from Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At the minimum, the information collected shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed and; (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

2. Within in 30 days of notice by the County, BA agrees to provide to County information collected in accordance with this section to permit the County to respond to a request by an Individual for an accounting of disclosures of PHI.

D. Make available to the County, or to the Secretary of Health and Human Services (the "Secretary"), BA's internal practices, books and records relating to the use of and disclosure of PHI for purposes of determining BA's compliance with the Privacy Rule, subject to any applicable legal restrictions. BA shall provide County a copy of any PHI that BA provides to the Secretary concurrently with providing such information to the Secretary.

V. Obligations of County.

A. County agrees that it will promptly notify BA in writing of any restrictions on the use and disclosure of PHI agreed to by County that may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

B. County agrees that it will promptly notify BA in writing of any changes in, or revocation of, permission by any Individual to use or disclose PHI, if such changes or revocation may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

C. County agrees that it will promptly notify BA in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect BA's use of disclosure of PHI.

D. County shall not request BA to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by County, except as may be expressly permitted by the Privacy Rule.

E. County will obtain any authorizations necessary for the use or disclosure of PHI, so that BA can perform its obligations under this Business Associate Agreement and/or the Underlying Agreement.

VI. Term and Termination.

A. Term. This Business Associate Agreement shall commence upon the Effective Date and terminate upon the termination of the Underlying Agreement, as provided therein when all PHI provided by the County to BA, or created or received by BA on behalf of the County, is destroyed or returned to the County, or, or if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

B. Termination for Cause. Upon the County's knowledge of a material breach by the BA, the County shall either:

1. Provide an opportunity for the BA to cure the breach or end the violation and terminate this Agreement if the BA does not cure the breach or end the violation within the time specified by the County.
2. Immediately terminate this Agreement if the BA has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cures are feasible, the County shall report the violation to the Secretary.

C. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, the BA shall, at the option of County, return or destroy

all PHI that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI.

2. In the event that the County determines that returning or destroying the PHI is infeasible, BA shall provide to the County notification of the conditions that make return or destruction infeasible, and BA shall extend the protections of this Agreement to such PHI to those purposes that make the return or destruction infeasible, for so long as the BA maintains such PHI. If County elects destruction of the PHI, BA shall certify in writing to County that such PHI has been destroyed.

VII. Indemnity

A. BA shall indemnify and hold harmless all Agencies, Districts, Special Districts and Departments of the County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (collectively "County") from any liability whatsoever, based or asserted upon any services of BA, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to BA's performance under this Business Associate Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever including fines, penalties or any other costs and resulting from any reason whatsoever to the extent arising from the performance of BA, its officers, agents, employees, subcontractors, agents or representatives under this Business Associate Agreement. BA shall defend, at its sole expense, all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards against the County in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by BA, BA shall, at its sole cost, have the right to use counsel of its choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes BA's indemnification of County as set forth herein. BA's obligation to defend, indemnify and hold harmless County shall be subject to County having given BA written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at BA's expense, for the defense or settlement thereof. BA's obligation hereunder shall be satisfied when BA has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Business Associate Agreement shall in no way limit or circumscribe BA's obligations to indemnify and hold harmless the County herein from third party claims arising from the issues of this Business Associate Agreement.

D. In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code Section 2782. Such interpretation shall not relieve the BA from indemnifying the County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Business

Associate Agreement, this indemnification shall only apply to the subject issues included within this Business Associate Agreement.

VIII. Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

IX. Survival. The respective rights and obligations of this Business Associate Agreement shall survive the termination or expiration of this Business Associate Agreement.

X. Regulatory References. A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.

XI. Conflicts. Any ambiguity in this Business Associate Agreement and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

Approval and Signatures

By: Arturo Uribe
Arturo Uribe (Nov 20, 2023 09:44 PST) Dated: 11/20/2023

Name:
"BA Representative"

By: ChristianneKernes
ChristianneKernes (Nov 20, 2023 10:08 PST) Dated: 11/20/2023

Name:
"HHSA Representative"