AGREEMENT FOR SERVICES #7938
AMENDMENT I

This First Amendment to that Agreement for Services #7938, 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 Summitview Child & Family Services, Inc., a California non-profit public benefit corporation, duly qualified to conduct business in the State of California, whose principal place of business is 670 Placerville Drive, Suite 2, Placerville, California 95667; (hereinafter referred to as "Provider");

RECITALS

WHEREAS, Provider has been engaged by County to provide outpatient Specialty Mental Health Services (SMHS) for County-authorized children and young adults ages 21 and under (hereinafter referred to as Clients) who meet the criteria for SMHS set forth in Welfare and Institutions Code Section 5600.3 and California Code of Regulations Title 9, Division 1 on an "as requested" basis, pursuant to Agreement for Services #7938, dated August 15, 2023, incorporated herein and made by reference a part hereof (hereinafter referred to as "Agreement");

WHEREAS, the parties hereto desire to amend the Agreement to update contract provisions, amending **ARTICLE 2, GENERAL PROVISIONS,** 2. SCOPE OF SERVICES and replacing **Exhibit A**, marked "Scope of of Services," with **Amended Exhibit A**, marked, "Amended Scope of Services," incorporated herein and made by reference a part hereof;

WHEREAS, the parties hereto desire to amend the Agreement to update billing rates, amending **ARTICLE 2, GENERAL PROVISIONS,** 3. COMPENSATION FOR SERVICES AND DELIVERABLES, and replacing **Exhibit B**, marked "Provider Rates," with **Amended Exhibit B,** marked "Amended Provider Rates," incorporated herein and made by reference a part hereof;

WHEREAS, the parties hereto desire to amend the Agreement to update contract provisions, amending **ARTICLE 3, SERVICES AND ACCESS PROVISIONS,** 5. ADDITIONAL CLARIFICATIONS, A. Criteria, and **ARTICLE 4, AUTHORIZATION AND DOCUMENT PROVISIONS,** 1. Service Authorization, and 4. ICD-10, B., and **ARTICLE 16, CONTRACT ADMINISTRATOR**; and

WHEREAS, unless otherwise specified herein, the following terms and conditions shall be effective upon final execution of this First Amendment to that Agreement #7938, and shall cover the retroactive period of July 1, 2023 through December 31, 2024.

NOW THEREFORE, in consideration of the foregoing and the mutual promises and covenants hereinafter contained, County and Provider mutually agree to amend the terms of the Agreement in this First Amendment to Agreement #7938 on the following terms and conditions:

Except as herein amended, all other parts and sections of that Agreement #7938 shall remain unchanged and in full force and effect.

1) **ARTICLE 2, GENERAL PROVISIONS, 2**. SCOPE OF SERVICES, of the Agreement is amended in its entirety to read as follows:

ARTICLE 2, GENERAL PROVISIONS,
2. SCOPE OF SERVICES
Provider shall provide the services set forth in Amended Exhibit A, marked "Amended Scope of Work," incorporated herein and made by reference a part hereof.

2) For the purposes of updating contracted services provisions in this Agreement, **Exhibit A**, is hereby replaced in its entirety with **Amended Exhibit A**, marked "Amended Scope of Services."

3) **ARTICLE 2, GENERAL PROVISIONS,** 3. COMPENSATION FOR SERVICES AND DELIVERABLES, of the Agreement is amended in its entirety to read as follows:

ARTICLE 2, GENERAL PROVISIONS
3. COMPENSATION FOR SERVICES AND DELIVERABLES

A. **Rates**: For the purposes of this Agreement, the billing rate shall be as defined in Amended Exhibit B, marked " Amended Provider Rates," incorporated herein and made by reference a part hereof.

B. **Invoices**: It is a requirement of this Agreement that Provider shall submit an original itemized invoice to be compensated for services. Itemized invoices shall follow the format specified by County Behavioral Health and shall reference this Agreement number on their faces and on any enclosures or backup documentation. Copies of 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 Services. 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 itemized invoice(s) identifying services rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

I. **Invoicing** shall be performed in a Two-Step Process *(Drug Medi-Cal Services)*: Provider shall upload to County's Secured File Transfer Protocol (SFTP) server an Excel data file and draft invoice to County for payment.

a. Step 1: Provider shall submit an Excel data file with columns as identified below. To avoid federal and state HIPAA violations, County requires that Providers submit client's protected private health information (PHI) via the County's SFTP server, or by using a secured and encrypted email protocol in compliance with HIPAA security regulations. To gain access the County's SFTP server, please email: HHSA-Billing@edcgov.us.

The Excel data file shall include the following information:

1. First Name
2. Last Name
3. Client Address
4. Date of Birth
5. CIN #
6. Diagnosis
7. Admission Date
8. Date of Service
9. Practitioner Name
10. Units/Duration
11. Billed Amount

b. Step 2: County will perform a review and approval of the submitted Excel data file and notify Provider of services approved for billing. Upon approval by County, Provider shall follow Invoice Submittal/Remittance instructions below detailing services approved for billing.

II. **Invoice Submittal/Remittance *(All Services)*:** Invoices shall be emailed to BHinvoice@edcgov.us, or as otherwise directed in writing by County. Invoices must include the following information:

1. County Issued Agreement Number
2. Provider Name & Address
3. Service Month
4. Invoice Total
5. Service Totals (Units & Cost total per service code)
6. Provider Contact Information

III. **Supplemental Invoices**: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe.

a. For those situations where a service is disallowed by HHSA on an invoice, or inadvertently not submitted on an invoice, and a corrected invoice is

later submitted ("Supplemental Invoice"), Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement and received by HHSA after July 31 of the subsequent fiscal year, shall be neither accepted nor paid by the County. Requests for exceptions to pay an invoice received after July 31 of the subsequent year, must be submitted in writing and must be approved by HHSA's Agency Chief Fiscal Officer.

IV. **Denied Invoices**: SMHS 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.

C. **Incentive Payments for Deliverables**

Provider shall receive a monthly incentive payment for a maximum of 12 months during the first 12-months of the term of this Agreement, contingent upon the Provider meeting the monthly reporting deliverable by submitting a completed Exhibit C, marked "Monthly Incentive Deliverable Data Report," in addition to the monthly invoice to the County Behavioral Health Division.

The data report shall include:

I. For each SMHS service that required travel time, Provider shall report the type of services rendered, the provider type, and the length of travel time.
II. For each SMHS service provided in the threshold language Spanish, Provider shall report the type of the type of service and the provider type.
III. For each Client discharged from an inpatient psychiatric hospital, Provider shall report the length of time from discharge to first outpatient mental health service provided.

Provider's incentive payment will be based on the total number of months in which Provider submitted this report during the first 12 months of this Agreement, even if the data reported is zero.

D. **Compensation for Deliverables**

For deliverables provided herein, Provider shall submit a completed Exhibit C each month for the first twelve (12) months of the Agreement, within fifteen (15) 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 Services. For monthly reports provided herein during the first twelve (12) months of the Agreement, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of the monthly data reports, identifying requested data. County will withhold a deliverable payment if Provider fails to submit the report within this timeframe. Additionally, County may withhold a deliverable payment if Provider fails to comply with any provision of this Agreement.

4) For the purposes of updating rates in the Agreement, **Exhibit B**, is hereby replaced in its entirety with **Amended Exhibit B**, marked **"**Amended Provider Rates," incorporated herein and made by reference a part hereof.

5) **ARTICLE 3, SERVICES AND ACCESS PROVISIONS,** 5. ADDITIONAL CLARIFICATIONS, A. Criteria, of the Agreement is amended in its entirety to read as follows:

ARTICLE 3, SERVICES AND ACCESS PROVISIONS
5. ADDITIONAL CLARIFICATIONS

A. **Criteria**
   I. A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service listed within Amended Exhibit A of this Agreement can be provided 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.

6) **ARTICLE 4, AUTHORIZATION AND DOCUMENT PROVISIONS, 1**. SERVICE AUTHORIZATION, of the Agreement is amended in its entirety to read as follows:

ARTICLE 4, AUTHORIZATION AND DOCUMENT PROVISIONS
1. SERVICE AUTHORIZATION

A. Provider will collaborate with County to complete authorization requests in line with County and DHCS policy.
   I. County shall not require prior authorization for the following services/service activities:
      a. Crisis Intervention;
      b. Crisis Stabilization;
      c. Mental Health Services, including initial assessment;
      d. Targeted Case Management;
      e. Intensive Care Coordination;
      f. Peer Support Services; and;
      g. Medication Support Services.
   II. County shall require prior authorization or referral for the following outpatient services:
      a. Intensive Home-Based Services;
      b. Day Treatment Intensive;
      c. Day Rehabilitation;
      d. Therapeutic Behavioral Services;
      e. Therapeutic Foster Care.

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.

7) **ARTICLE 4, AUTHORIZATION AND DOCUMENT PROVISIONS, 4**. ICD-10, B, of the Agreement is amended in its entirety to read as follows:

ARTICLE 4, AUTHORIZATION AND DOCUMENT PROVISIONS
4. ICD-10
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.

8) **ARTICLE 16, CONTRACT ADMINISTRATOR,** of the Agreement is amended in its entirety to read as follows:

ARTICLE 16, CONTRACT ADMINISTRATOR
The County Officer or employee with responsibility for administering this Agreement is Christianne Kernes, LFMT, Deputy Director, Behavioral Health, Health and Human Services Agency, or successor. In the instance where the named Contract Administrator no longer holds this title with County and a successor is pending, or HHSA has to temporarily delegate this authority, HHSA Director shall designate a representative to temporarily act as the primary Contract Administrator of this agreement and shall provide the Contractor with the name, address, email, and telephone number for this designee via notification in accordance with the article titled "Notice to Parties" herein.

Except as herein amended, all other parts and sections of that Agreement #7937 shall remain unchanged and in full force and effect.

Requesting Contract Administrator Concurrence:

By: ChristianneKernes (Nov 15, 2023 10:48 PST) Dated: 11/15/2023

Christianne Kernes, LMFT
Deputy Director
Health and Human Services Agency, Behavioral Health Division

Requesting Department Head Concurrence:

By: Olivia Byron-Cooper
Olivia Byron-Cooper (Nov 15, 2023 10:50 PST)

Dated: 11/15/2023

Olivia Byron-Cooper, MPH
Director
Health and Human Services Agency

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment to Agreement for Services #7938 on the dates indicated below.

-- COUNTY OF EL DORADO --

By: _____ Dated: _____

Chair
Board of Supervisors
"County"

Attest:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: _____

Deputy Clerk

-- SUMMITVIEW CHILD & FAMILY SERVICES, INC. --

By: Anna gleason (Nov 15, 2023 12:32 PST) Dated: 11/15/2023

Anna Gleason
Chief Executive Officer
"Provider"

By: Corinne Morrison (Nov 15, 2023 16:03 PST) Dated: 11/15/2023

Corrine Morrison
Chief Financial Officer

Summitview Child & Family Services, Inc.
Amended Exhibit A
Amended Scope of Services

SPECIALTY MENTAL HEALTH SERVICES FOR CHILDREN AND YOUNG ADULTS

1. INTRODUCTION
   A. Provider shall provide evidence and strength-based, culturally competent, flexible, individual-centered, family driven, effective, and quality Specialty Mental Health Services (SMHS) to all eligible individuals referred from the County's Health and Human Services Agency (HHSA) Behavioral Health Division, who meet the criteria for outpatient SMHS set forth in California Welfare Institutions Code (WIC) Section 5600.3 and California Code of Regulations (CCR), Title 9, Division 1 and who are referred from the County ("Client" or "Beneficiary").
   B. As an organizational provider agency, Provider shall provide administrative and direct program services to County's Medi-Cal Clients as defined in Title 9, Division 1, Chapter 11 of the California Code of Regulations.
   C. For Clients under the age of 21, the Provider shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welfare & Inst. Code 14184.402 (d)).
   D. Provider has the option to deliver services using evidence-based program models. Provider must submit to the Contract Administrator, and receive written approval from the Contract Administrator, for any Evidence-Based Practices (EBPs) prior to implementation within an existing or new program.
   E. Provider shall provide said services in Provider's program(s) as described herein.

2. PROGRAM SERVICE HOURS

Service Hours of Operation	Services available to beneficiaries twenty-four (24) hours a day, seven (7) days a week, when medically necessary

3. TARGET POPULATION
   A. Provider shall provide services to the following populations:
      I. The target population for the services herein are individuals aged twenty-one (21) and under who are eligible for outpatient.
      II. In cases in which there is more than one (1) individual in the same family receiving mental health services, each individual shall be a separate Client.
      III. The terms "Medi-Cal Beneficiary" or "Medi-Cal Beneficiaries" refer to those Clients who have Medi-Cal as of the date of the Authorized Service provided.

4. PROGRAM DESIGN**:**
   A. Provider shall maintain programmatic services as described herein.
      I. General Program and Service Requirements: Provider agrees to furnish the personnel and equipment necessary to provide comprehensive outpatient SMHS, as defined in the California Code of Regulations (CCR) Title 9, Division 1, including services identified by the State as part of the Continuum of Care Reform, and includes the use of parent partners and peer

advocates for Clients referred to the Provider from the County. For the purposes of this Agreement, "parent partners" shall mean parents who have lived experience with the Child Welfare System, and "peer advocates" shall mean individuals who have prior personal participation with Child Welfare Services as a child/youth.

II. Provider agrees to be responsible to ensure all provided services and documentation are consistent and in accordance with MHP Agreement(s) with the DHCS in effect at the time services are provided (the "MHP Agreement"). Said agreement(s) are available at http://www.edcgov.us/HHSAForProviders.

III. SMHS shall be provided based on clinically indicated need in accordance with a Problem List, as approved and authorized by County. Provider shall provide SMHS to the individual Client, which may include family/parents/caregivers/guardians, or other significant support persons. Provider shall ensure that families are offered training and given information that will support them in their roles as active, informed decision-makers for and with their family member who is the Client.

IV. Provider shall collaborate with all parties that may be involved with the Client and family, including but not limited to parents, schools, doctors, social services, County CWS, Alta Regional, County Substance Use Disorder Services, and County Probation.

V. Provider shall ensure the form included herein marked "Children's Specialty Mental Health Services Eligibility to Pathways to Well-Being Checklist," is completed at intake, and when any life changes occur that would impact eligibility for enhanced services.

VI. If a Client is determined to be eligible for Pathways to Well-Being, the Provider will ensure an initial Child Family Team (CFT) meeting is held to determine the course of treatment, and the Provider will provide Intensive Care Coordination (ICC) and Intensive Home-based Services (IHBS) services as clinically appropriate. The Provider will provide ICC-CFTs at a minimum of every 90 days and use the billing code ICC-CFT for those meetings.

VII. Provider shall abide by all applicable State, federal, and county laws, statutes, regulations, and information notices ("Program Requirements"), and all Policies and Procedures adopted by County to implement said Program Requirements.

VIII. Provider shall ensure compliance with the terms and conditions of this Agreement, including but not limited to the following:

a. All references to County Agreements with California Department of Health Care Services (DHCS) and governing legislation shall be as currently exists or as may be amended during the term of this Agreement. Replaced, amended, or new DHCS/County Agreements and governing legislation will not necessitate an amendment to this Agreement.

b. SMHS shall be provided to the individual Client and may include family/parents/caregivers/guardians, or other significant support persons.

c. Provider shall ensure that families are offered training and given information that will support them in their roles as active, informed decision-makers for and with their family member who is the Client.

d. Provider shall collaborate with all parties that may be involved with the Client and family, including but not limited to parents, schools, doctors, social services, County Child Welfare Services (CWS), Alta Regional, County Substance Use Disorder Services, and County Probation.

IX. Provider shall provide referrals and/or facilitate linkage to community-based and social service organizations for needs such as housing, food, clothing, and transportation as may be appropriate based upon Client needs.

X. To the extent required based upon Client's legal status, Provider shall insure that all staff accompanying a Client into the community as a part of SMHS delivery will maintain ongoing supervision and care for the Client throughout the service event, to include receiving the Client from and returning the Client to Client's current placement and advising the appropriate responsible adult of the Client's return. Provider shall develop and maintain a policy and procedure reflecting this requirement and submit any updates to the Contract Administrator.

XI. In the event a Client is placed in an out-of-county psychiatric emergency facility and is newly referred to Provider or is an existing Client of Provider, Provider shall serve as the main point of contact for all discharge, aftercare and other care coordination for Client.

XII. Provider must submit a referral via fax to the El Dorado County Behavioral Health Division for Therapeutic Behavioral Services (TBS) for authorization and assignment of services.

a. This referral request can be sent via the following methods:
   Via secure fax to: Fax: 530-303-1526, El Dorado County Behavioral Health Division - SMHS Referral or Authorization Request; or
   Via telephone by referral call to: El Dorado County Behavioral Health Division front desk at (530) 621-6290
b. TBS requires a County service authorization initially for 30 days, then no more than two (2) additional 60-day authorization periods, each requiring new service authorization from the El Dorado County Behavioral Health Division.
c. Upon approval, El Dorado County Behavioral Health Division will provide the service authorization to Provider.
d. Provider shall develop and deliver a separate treatment plan for TBS services.
e. Discharge planning will be a focus throughout treatment.

XIII. Provider shall identify all Clients due to age-out of SMHS and oversee transition of Client into Adult SMHS. Provider will initiate appropriate treatment referrals to the El Dorado County Behavioral Health Division via secure fax to (530) 303-1526 to ensure that mental health treatment linkages are in place, and will participate with the Client, County or designated staff, and other key support providers in creating a plan that assures a successful transition of Client(s). To the extent possible, transition planning will commence at least one (1) year prior to the Client's anticipated transition from Provider's SMHS to Adult SMHS.

XIV. Provider is prohibited from using any unconventional mental health treatments. Such unconventional mental health treatments include, but are not limited to: Rebirthing Therapy, Holding Therapy, Quiet Play Program, Strong Sitting Time-Out, Isolation, Wrapping, Eco-Therapy, Theraplay and Reparative or Conversion Therapy for the purpose of altering a person's sexual orientation or gender identity. Such unconventional treatments also include, but are not limited to, any treatments that violate the Client's personal rights.

5. CLIENT SERVICES

A. Provider shall provide the following medically necessary covered SMHS, as defined in the DHCS Billing Manual available at, https://www.dhcs.ca.gov/provgovpart/Documents/DMC-Billing-Manual-Jan-2023.pdf or subsequent updates to this billing manual to Clients who meet access criteria for receiving specialty mental health services.

B. Provider shall observe and comply with all lockout and non-reimbursable service rules, as specified in the DHCS Billing Manual.

C. SMHS interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development,

independent living, and enhanced self-sufficiency. Unless otherwise specified, activities may be offered to all Clients ages twenty-one (21) and under referred to the Provider from the County for services under this Agreement. SMHS services under this Agreement, may include, but are not limited to:

I. Case Management
II. Collateral
III. Family Therapy or Rehabilitation
IV. Assessment
V. Individual Therapy
VI. Individual Rehabilitation
VII. Group Therapy or Rehabilitation
VIII. Medication Support Services
IX. Crisis Intervention
X. Therapeutic Behavioral Services (Clients under age twenty-one (21) only)
XI. Plan Development
XII. Intensive Care Coordination (ICC) (Clients under age twenty-one (21) only)
XIII. Intensive Home-Based Services (IHBS) (Clients under age twenty-one (21) only)
XIV. Non-Mental Health Supportive Services and Goods:
    a. Non-Mental Health Supportive Services and Goods may be utilized to support the client by providing services and/or goods that fall outside of the client's medical necessitates. These may include but are not limited to transportation support and vehicle repairs, over-the-counter medications and non-mental health medical procedures, extra-curricular and recreational activities, home-related needs and repairs, education and professional development support, and client engagement incentives including meals and snacks.

6. REFERRAL AND INTAKE PROCESS
    A. Provider shall follow the referral and intake process as specified herein.
        I. New Requests for Services:
        Provider shall refer all new requests for SMHS to the El Dorado County Behavioral Health Division. These referrals can be made via walk-in, phone call, or secure fax as follows:
        a. Via secure fax to:
            El Dorado County Behavioral Health Division
            Reference: SMHS Referral or Authorization Request
            Fax: (530) 621-6290
        b. Via telephone by referral call to:
            El Dorado County Behavioral Health Division front desk at (530) 621-6290
        c. Via walk-in referral at the office located at:
            768 Pleasant Valley Road, Suite 201, Diamond Springs, CA 95619
        d. For non-Child Welfare Services Clients, the parent or legal guardian, or an organization or agency such as a school or primary care provider, is to phone and request mental health services: Western Slope Region (530) 621-6324 or South Lake Tahoe Region (530) 573-7970.
    B. Eligibility:
        I. Determination of Medi-Cal eligibility will be conducted by the El Dorado County Behavioral Health Division, Mental Health Clinicians unless delegated otherwise by County.

a. If eligibility is established, El Dorado County Behavioral Health Division will provide a referral packet via fax or email to the Provider. The referral packet provided by County to Provider will contain the following documentation:
   i. Admission and Client and Services Information (CSI) Data Sheet
   ii. Summary of presenting problem/reason for request for SMHS with progress note completed by El Dorado County Behavioral Health Clinician
   iii. Initial 60-day authorization

7. PROGRAM OR SERVICE SPECIFIC AUTHORIZATION REQUIREMENTS

A. Appointments: In response to receipt of the referral packet from the El Dorado County Behavioral Health Division, the Provider shall attempt to set a treatment appointment with the referred Client as follows:
   I. Psychiatric Appointments**:** within 15 business days from receipt of referral to appointment
   II. Other Outpatient SMHS: within 10 business days from receipt of referral to appointment for all other outpatient SMHS.
   III. Provider shall follow up with any open client within seven (7) days of release from an inpatient facility to provide am SMHS services.
   IV. Provider shall maintain documentation in the chart to record all attempts at outreach to the family and the outcome of each attempt.

B. Client Assessment:
   I. Within 60 days after initial authorization is provided, the Provider's clinician shall complete the intake process with the Client, including, but not limited to, completing the following documents: California CANS 50, PSC-35, Assessment, and Problems List.
   II. The Provider shall also provide the Client with the following forms: Notice of Privacy Practices, Guide to Medi-Cal, Informed Consent, Advanced Directive (Clients aged 18 and above), and obtain all necessary signatures verifying receipt of said notices and guides.
   III. Consent to Treat: No services, even Plan Development, can be billed until the Client and appropriately licensed Provider staff have signed a "consent for treatment" from Client. All activities preceding the signed "consent for treatment" are to be documented in the chart and NOT invoiced to the County. [Note: it is fraudulent to back-date a "consent for treatment."]

C. Authorization for Continued Services: Prior to the expiration of Initial Authorized Services, as needed, Provider shall seek continued authorization from El Dorado County Behavioral Health Division for continued services as follows:
   I. Provider shall submit the Client Authorization Packet to the El Dorado County Behavioral Health Division no later than 60 days after the initial authorization is provided by the El Dorado County Behavioral Health Division.
   II. The Authorization Packet must include the following forms:
      a. Completed authorization form included herein titled, "Children's Specialty Mental Health Services Authorization Checklist (Initial/6-Month/Annual)" signed by the Provider's clinician and Provider's supervisor;
      b. CSI Admission;
      c. CSI Assessment;
      d. Assessment, with included primary mental health diagnosis and
      e. Problem List.

f. Progress Note(s) containing Care Plan for provision of Targeted Case Management, Intensive Care Coordination (ICC), and Intensive-Home Based Services (IHBS); when applicable. Please note that Case Management, ICC, and IHBS will not be authorized for ongoing services without an attached Care Plan.
g. CANS-50
h. PSC-35

III. Eligibility for Pathways to Well-Being Checklist included herein. Once a complete authorization packet is received by the El Dorado County Behavioral Health Division, the division will conduct an audit of the chart to confirm compliance with medical necessity, treatment planning, and progress note documentation.

IV. Upon approval of continuation of services, Provider will receive emailed reauthorization from El Dorado County Behavioral Health Division for (six) 6 months of continued services from the date of completion of the CANS 50 and PSC 35 tools, whichever was completed first.

V. Reauthorization for services to continue after the initial Authorization should be requested no later than six (6) months from completion of the initial CANS and PSC completion date. This should be submitted every six (6) months for continued authorization.

VI. The Reauthorization Packet must include the following forms:
a. Completed reauthorization form included herein titled, "Children's Specialty Mental Health Services Authorization Checklist (Initial/6-Month/Annual);"
b. CANS-50; and
c. PSC-35

8. AVAILABILITY OF SERVICES:
A. In accordance with CCR, Title 9, Section 1810.405, Provider shall:
I. Comply with timely access requirements for services as established by the State, taking into account the urgency of need for services.
II. Ensure services are available to Medi-Cal Beneficiaries that are no less than the hours of operation available to non-Medi-Cal Beneficiaries.
III. Make services available to beneficiaries twenty-four (24) hours a day, seven (7) days a week, when medically necessary.

B. Services must be provided in each Client's preferred language. To the extent that it may be needed, language interpretation services will be made available for Clients, at no cost to Client or County, in the preferred language and/or format (e.g., large font, audio, braille) identified by the Client. All service related correspondence must be provided in the Client's preferred language.

C. Provider shall provide services throughout the community including home, school, office, or other appropriate sites in order to enhance delivery and access to service to achieve the most effective provision of services. Provider hours shall be flexible to include weekends and evenings to accommodate the family/care provider/significant support provider.

D. Compliance with "Availability of Services" requirements shall be subject to audit by County. Noncompliance shall result in a Corrective Action Plan (CAP).

9. CLIENTS INVOLVED IN CHILD WELFARE SERVICES (CWS):
A. Provider shall provide services to Clients involved with CWS if referred to the Provider from the County.

B. In addition to the requirements set for herein, Provider will provide services to Clients involved in CWS based on Child Welfare outcomes pertaining to safety, permanency, and well-being as per WIC Section 10601.2.
C. Services will be provided in collaboration with the Client and family support system including as appropriate, but not limited to, Child Family Team (CFT), Client's parents/caregivers/guardians, education, primary care providers, social services, Alta Regional Center, Substance Use Disorder Services, listed tribe or Indian custodian (if applicable), foster family agency social worker or Short-Term Residential Therapeutic Program (STRTP) representative, Court Appointed Special Advocates (CASA), parent partners, peer advocates, and County Probation/Justice Services.
D. Families will have a high level of decision-making influence and will be encouraged to use their natural supports. Provider shall involve the CFT and Client support system as appropriate, in all treatment planning and decision making regarding the Client's services as documented in the Client's treatment plan.
E. Provider shall insure a licensed or license waived Clinician, as defined in the County MHP Agreement, has the primary responsibility for carrying all CWS-involved cases. Provider may use unlicensed or non-waived staff in accordance with County guidelines to provide non-therapy services, including case management services and collateral contact services.
F. Provider shall provide the Client's CWS Social Worker with a copy of the following documents in the time frame specified:

Document Completed / Event	**Time Frame**
Assignment of Case Manager	Within three (3) working days of receiving a referral for SMHS from the County
Treatment Plan	Within two (2) weeks of completion
Discharge Summary or Termination Report	Within five (5) days of discharge or termination of services
Written Progress Report	Every ninety (90) days during the time in which the Client is receiving services
No response to request to schedule an appointment	Within five (5) working days of initial request to Client or parent/legal guardian/caregiver.
Scheduled appointment missed without twenty-four (24) hours prior notice.	Same business day as the scheduled appointment.

10. DOCUMENTATION AND INFORMATION REQUIREMENTS

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

A. Clinical Record: 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.

B. 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.

C. 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 County's documents titled "What is a Grievance" and "Grievance Form," and document the provision of this information in the Clients' clinical record.

D. Services Provided in Language Other Than English**:**

I. **I**f services are provided to a Client in a language other than English, Provider shall document the use of an alternate language in the Client's clinical record and identify the language in which services were provided.

II. 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.

E. Progress Notes: Progress notes must 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.

11. REQUEST TO MOVE CLIENT TO HIGHER/LOWER LEVEL OF SERVICE PROGRAM

A. Based on a Client's clinical need, Provider shall submit a completed "Children's Specialty Mental Health Services Program Transfer Request Form," included herein on page 17, to the El Dorado County Behavioral Health Division to request to move a client to a higher or lower level of care.

B. El Dorado County Behavioral Health Division will make the final determination to authorize a higher/lower level of service.

C. Periodically, and minimally upon request for treatment reauthorization, El Dorado County Behavioral Health Division shall review Client charts for appropriate levels of care.

D. The El Dorado County Children's System of Care is designed to retain Clients in services with the same Contracted Provider when their clinical needs are subject to an increase or a decrease in service intensity for SMHS. By allowing this flexibility within the program, children, youth and their families are able to retain their relationship with their contracted Provider and are not required

to transfer to another outpatient program as their needs fluctuate or change.

12. DISCHARGE CRITERIA AND PROCESS

A. Discharge planning will include regular reassessment of Client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals. When possible, discharge will include treatment at a lower level of care or intensity appropriate to Client's needs and provision of additional referrals to community resources for Client to utilize after discharge.

B. Provider shall conduct the following discharge process steps for each Client served under this agreement.

I. Engage in discharge planning beginning at intake for each Client served under this agreement.

II. Complete a discharge summary (reason for discharge, discharge diagnosis, discharge remarks, all identifying information) for each Client served under this agreement.

III. Complete final California Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist (PSC) for each Client served under this agreement.

IV. Complete a final Intensive Care Coordination (ICC) with the Client's Child and Family Team (CFT) (ICC-CFT), when applicable, for each Client served under this agreement.

V. Complete Transition of Care Tool, per BHIN-22-065, when appropriate, for each Client served under this agreement.

VI. In instances when the youth is receiving medication support services from an El Dorado County contracted medication provider, the youth shall not be discharged from the Provider until the youth has been linked with a new medication provider at a lower level of care.

C. Provider shall submit a completed "Children's Specialty Mental Health Services Checklist Discharge Form," included on page 18 herein, to the El Dorado County Behavioral Health Division, no later than 30 days after a Client's discharge. The completed Checklist Discharge Form must be signed by the Provider's clinician and Provider's supervisor, and this form, along with the following documentation shall be provided to the El Dorado County Behavioral Health Division, no later than 30 days after discharge:

I. Diagnosis
II. ICC-CFT Minutes, if applicable
III. CANS-50
IV. PSC-35
V. PAF/KET, if applicable
VI. Discharge Summary

13. AUTHORIZATION FOR SERVICES

A. County Behavioral Health Division Authorizations for Service(s):

I. For the required referral and services authorizations detailed herein this "Scope of Services," Provider shall obtain an HHSA Authorization from the County Behavioral Health Division designated HHSA staff.

II. Provider shall send all referrals and service authorization requests to County as follows:

Attention: El Dorado County Behavioral Health Division
Reference: SMHS Referral or Authorization Request
Fax: 530-303-1526
Email: BHDchildrens@edcgov.us OR edcmh-referral@edcgov.us

III. El Dorado Behavioral Health Division will provide emailed authorization to Provider within an average of seven (7) days.

IV. Provider also shall not provide services to Client outside of the authorized service dates identified on said HHSA Authorization.

14. OPERATION AND ADMINISTRATION

A. Provider agrees to furnish at no additional expense to County beyond the amounts identified under Article III "Compensation for Services," all space, facilities, equipment, and supplies necessary for its proper operation and maintenance.

B. 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.

C. 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.

D. If Provider becomes aware that a beneficiary becomes ineligible for Medi-Cal, Provider shall notify the County prior to the beneficiary's next appointment and refer the beneficiary and caregiver to the beneficiary's Medi-Cal Eligibility Worker.

E. All program-related written materials must be provided, minimally, in English and the County's Medi-Cal threshold language.

F. 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.

G. Provider shall have representative staff attend County-sponsored Provider Meetings and other work groups as established and scheduled.

H. Notification of Events:

I. 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.

II. 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.

III. 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.

15. 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 Contractor during the term of this Agreement.

II. Contractor agrees to furnish professional staff in accordance with the regulations, including all amendments thereto, issued by the State or County. Contractor 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 staff shall be qualified in accordance with all applicable laws and regulations.

III. Contractor 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 services under this Agreement.

IV. Contractor 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.

VI. Contractor shall complete and submit a Clinical Supervision or Oversight Plan to the Contract Administrator.

B. Credentialing, Re-Credentialing, and Licensing:

I. Contractor 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: Contractor hereby represents and warrants that Contractor 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 Contractor, staff, and its subcontractors to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Contractor and its subcontractors shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement.

C. Enrollment, Provider Selection, and Screening:

I. Provider shall 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 business transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the provider.

II. 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. Provider may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider

immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected beneficiaries. (42 CFR Section 438.602(b)(2).)

IV. Provider shall have written policies and procedures for selection and retention of providers. (42 CFR Section 438.214(a).) Contractor'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. 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. Provider is not located outside of the United States. (42 CFR Section 602(i).)

VIII. Provider shall perform a background screening of all employees who may access personal health information (PHI) or personal information (PI). 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.

16. CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES

A. Provider shall comply with all requests regarding local, state, and federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.

B. Provider shall work collaboratively with El Dorado County Behavioral Health Division to develop process benchmarks and monitor progress in the following areas:

I. Planned Discharge (Graduation): Provider shall strive to demonstrate a graduation rate of fifty percent (50%) of unduplicated Clients to community resources each fiscal year of this Agreement. For purposes of this Agreement, "graduation" shall mean a planned discharge from Outpatient SMHS to community resources when a Client meets treatment plan goals and/or problem list and "fiscal year" shall mean the period starting July 1 and ending June 30.

II. Provider will submit taxonomies to El Dorado County Behavioral Health when they have a new provider, a provider changes taxonomies, or a provider is no longer providing services. New or updated taxonomy must be submitted within 30 days.

17. REPORTING AND EVALUATION REQUIREMENTS

A. Provider shall complete all reporting and evaluation activities as required by the El Dorado County Behavioral Health Division and described herein, including the following:.

I. The form included on page 21 herein titled, "Children's Specialty Mental Health Services Service Verification Monthly Reporting Grid.

II. Annual Consumer Perception Survey: Provider shall participate in the biannual or other time period specified by the State, Consumer Perception Survey by distributing the required State-

designed surveys to clients, who are referred to Provider from the County, and/or their family/guardians and returning the surveys to the County Behavioral Health Division per the instructions issued by the County. The El Dorado County Behavioral Health Division will provide the Provider of the dates of the Consumer Perception Survey and instructions for completion and return of the surveys.

III. Other Client Satisfaction Surveys: Within fifteen (15) days of the end of each quarter, Provider shall submit to the County the results of any other Client Satisfaction Survey(s) administered by Provider to clients referred to Provider from the County.

IV. Aggregated CANS-50 and PSC-35 Data

V. While a client is enrolled in a Mental Health Services Act (MHSA) Full Service Partnership level of care program, the Provider shall complete required MHSA reporting documents including the following:

i. While a client is enrolled in a MHSA Full Service Partnership level of care program, the Provider will complete the Full Service Partnership Assessment Form (PAF) for children and Transitional Age Youth (TAY) clients ages 0-25, included herein, at the Client's initial assessment to provide information about the history of the client, including living situation, income, education, emergency interventions, as well as other information. This FSP PAF form, based on the appropriate age of client shall be completed by Provider within the first 30 days following the client being enrolled or opened to Full Service Partnership level of care.

ii. While a client is enrolled in a MHSA Full Service Partnership level of care program, the Provider will complete the Quarterly Assessment Form (3M), included herein to report Client's updates, changes and progress. The quarters shall be defined as January through March, April through June, July through September, and October through December.

iii. While a client is enrolled in a MHSA Full Service Partnership level of care program, the Provider will complete the FSP Key Event Tracking (KET) form, included herein; Provider shall complete this FSP KET form at least one (1) time per quarter, or any time there is a significant change for the client, including when a client graduates from a FSP level of care.

iv. All completed forms above shall be emailed to the El Dorado County Behavioral Health Division, MHSA team at: mhsa@edcgov.us.

18. ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

B. El Dorado County Behavioral Health Division will provide Provider with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement, and (b) conduct the quality management activities called for by the Agreement.

C. El Dorado County Behavioral Health Division will provide the Provider with all applicable standards for the delivery and accurate documentation of services.

D. El Dorado County Behavioral Health Division will make ongoing technical assistance available in the form of direct consultation to Provider upon Provider's request to the extent that County has capacity and capability to provide this assistance. In doing so, County is not relieving Provider of

its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this agreement.

E. Any requests for technical assistance by Provider regarding any part of this agreement shall be directed to the County's designated Contract Administrator, or successor.

F. Provider shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first 30 days of their first day of work. Provider shall require all covered individuals to attend, at minimum, one (1) compliance training annually.
   I. These trainings shall be conducted by County or, at County's discretion, by Provider staff, or both, and may address any standards contained in this agreement.
   II. Covered individuals who are subject to this training are any Provider staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing or documenting Client care or medical items or services.

G. Provider shall require all Provider's staff to complete Cultural Competency Training annually (4 hours/per year)

H. Provider shall Complete PAVE registration for all licensed staff within 30 days of licensure or 30 days of hire.

Children's Specialty Mental Health Services
Eligibility for Pathways to Well-Being Checklist

CLIENT INFORMATION	
Name:	**Avatar #:**
Date Determination Made:	**Assessing Clinician:**
Provider: ☐ **Sierra** ☐ **Summitview** ☐ **New Morning** ☐ **Stanford**	

1. Child/youth meets medical necessity criteria for Specialty Mental Health services (SMHS): ☐Yes ☐No
2. Child/youth is eligible for full-scope Medi-Cal: ☐Yes ☐No
3. Child/youth is under the age of 21: ☐Yes ☐No
4. Child/youth meets at least one of the criteria below: ☐Yes ☐No
   - ☐ Are currently in or being considered for Wraparound, TFC, TBS, STRTP, or has specialized care rate due to behavioral health needs
   - ☐ Has experienced two or more hospitalizations in the last 12 months or has had two or more ER visits in the last 6 months due to primary mental health conditions
   - ☐ Has experienced three or more placements within 24 months due to behavioral health needs
   - ☐ Age 0-5 and more than 1 psychotropic medication or more than 1 mental health diagnosis
   - ☐ Age 6-11 and more than 2 psychotropic medications or more than 2 mental health diagnoses
   - ☐ Age 12-17 and more than 3 psychotropic medications or more than 3 mental health diagnoses
   - ☐ Has been discharged within 90 days from, currently reside in, or are being considered for placement in a psychiatric hospital or 24-hour mental treatment facility
   - ☐ Has been detained pursuant to W&I code 601 and 602, primarily due to mental health needs
   - ☐ Has been reported homeless within the prior six months
   - ☐ Are involved with two or more child-serving systems, including, but not limited to: child welfare system, special education, juvenile probation, drug &alcohol, other HHSA or legal system
5. Child/youth has an open Child Welfare Services Case (including voluntary: ☐Yes ☐No

ELIGIBLITY DETERMINATION

A. Child/youth meets criteria for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) through Pathways to Well-Being services, if:

- **Answers to items 1-4 are YES**

☐**Eligible for ICC and IHBS services though Pathways to Well-Being services**

B. Answers to 1, 2, 3, OR 4 are NO

☐ **Not Eligible for ICC and IHBS services**

Submit completed form to El Dorado County Behavioral Health Fax: (530) 303-1526 or email to Access Program Coordinator

Children's Specialty Mental Health Services
Program Transfer Request Form

Client Name:	**Avatar #:**
Submitting Clinician:	**Provider: (check applicable)** ☐ Sierra Child & Family ☐ Summitview ☐ New Morning ☐ Stanford Youth
Current Program: **☐ Traditional ☐ Residential ☐ KTA ☐ FSP**	**Requesting Transfer to Program:** **☐ Traditional ☐ Residential ☐ KTA ☐ FSP**
Reason for Program Transfer Request:	

Program Transfer will not be considered until ALL items on checklist are completed

Eligibility for Pathways to Well Being:

☐ Complete form and determine eligibility

ICC-CFT (*KTA/PWB youth only*)

☐ Conduct ICC-CFT meeting

**The CFT should dictate the need for change in level of service and the meeting minutes should reflect this*

PAF/KET/3 Mo/Quarterly (*FSP /KTA youth only*)

☐ Complete PAF packet

☐ Complete KET log, if needed

Items to Submit for El Dorado County Review:

☐ Eligibility to PWB/KTA Form

☐ ICC-CFT Minutes

☐ PAF/KET *(if applicable)*

Signature of Provider Clinician:

_____

Signature of Provider Supervisor:

_____

Date Submitted to El Dorado County Behavioral Health Division:

_____

Children's Specialty Mental Health Services Checklist
Discharge Form

Client Name:	**Avatar #:**
Provider: ☐ Sierra ☐ Summitview ☐ New Morning ☐ Stanford ☐ EDC BH	**Submitting Clinician:**

Discharge will not be considered until ALL items on checklist are completed

Medication Referral and Linkage (*for client's receiving psychiatric services with Dr. Price*)

☐ Coordinate with Dr. Price about appropriateness of discharge

☐ Client ***MUST*** be linked to a community-based medication provider before discharge

Name & Clinic of new medication provider:

_____

Date of Scheduled Appointment**:**

_____

****Client WILL NOT be discharged if still open to services with Dr. Price****

Diagnosis

☐ Review diagnosis for appropriateness; update if needed

ICC-CFT (*KTA/PWB youth only*)

☐ Conduct ICC-CFT meeting

Child and Adolescent Needs and Strengths Assessment (CANS)

☐ Complete CANS-50 with family

Pediatric Symptom Checklist (PSC-35)

☐ Caregiver completes measure

PAF/KET (*FSP /KTA youth only*)

☐ Complete and submit paperwork

Discharge Summary for Episode Close

☐ Reason for discharge

☐ Discharge diagnosis

☐ Discharge remark

☐ All identifying information

Items to Submit for El Dorado County Review:

☐ Diagnosis

☐ ICC-CFT Minutes

☐ CANS

☐ PSC 35

☐ PAF/KET *(if applicable)*

☐ Discharge Summary

Signature of Provider Clinician:

_____

Signature of Provider Supervisor:

_____

Date Submitted to EDC BH

_____

Children's Specialty Mental Health Services
Authorization Checklist (Initial/6-Month/Annual)

Client Name:	Avatar #:	☐ Initial ☐ 6-month ☐ Annual
Program: ☐ Sierra ☐ Summitview ☐ New Morning ☐ Stanford ☐ EDC BH		Submitting Clinician:

Informing Materials (*Initial/Annual Auth only*)
- ☐ Review/sign Informed Consent
- ☐ Offer Guide to Medi-Cal Mental Health Services
- ☐ Offer Beneficiary Problem Resolution Guide
- ☐ Offer Notice of Privacy Practices
- ☐ Offer Advance Directive (18+ only)
- ☐ Obtain signed Acknowledgement of Receipt

Releases of Information (*Initial/Annual Authorization*)
- ☐ Complete/Review Diagnosis

Diagnosis *(Initial Authorization)*
- ☐ Complete/Review diagnosis

Eligibility for Pathways to Well Being
- ☐ Complete form and determine eligibility

ICC-CFT (*KTA/PWB youth only*)
- ☐ Conduct ICC-CFT meeting every 90 days

CANS *(Initial and every 6 months)*
- ☐ Complete CANS-50 collaboratively with family

PSC-35 *(Initial and every 6 months)*
- ☐ Caregiver completes measure

Assessment *(Initial)*
- ☐ Complete/Update Assessment with family

PAF/KET/3 Mo/Quarterly (*MHSA youth only*)
Complete PAF packet
- ☐ Complete PAF packet
- ☐ Complete KET log, if needed

Problem List *(Initial Auth)*
- ☐ Complete Problem List

Care Plan Progress Note(s) *(Initial Authorization)*
- ☐ Complete Care Plan for: TCM, ICC, IHBS (if applicable)

Items to Submit for Initial Authorization:
- ☐ CSI Admission
- ☐ CSI Assessment
- ☐ Diagnosis
- ☐ Eligibility for PWB Checklist
- ☐ Care Plan *(if applicable)*
- ☐ ICC-CFT Minutes *(if applicable)*
- ☐ CANS
- ☐ PSC-35
- ☐ Assessment
- ☐ PAF/KET *(if applicable)*

Items to Submit Every 6 Months:
- ☐ CANS
- ☐ PSC-35

Signature of Provider Clinician:

_____

Date Submitted to El Dorado County Behavioral Health Division:

Signature of Provider Supervisor:

_____

_____

Children's Specialty Mental Health Services
Service Verification Monthly Reporting Grid

Validation Period:	
Contracted Agency:	
Form Completed By:	
Date Form Completed:	

Service Verification

A	B	C	D	E	F	G
Number of face-to-face client visits in the Month	Number of Service Verification Cards Completed	Number Client visits to be validated - at least 5% (Col. A X .05)	Number Surveys validated	Number Surveys validated as out of compliance	Was County notified if fraudulent claims discovered?	Were claim errors processed for deletion
					☐ Yes ☐ No ☐N/A	☐Yes ☐No ☐N/A

FOR OFFICIAL COUNTY USE ONLY:

(Box C Total _____) – (Box D Total _____) = (Box H _____) Total number of SVC needed to be in compliance

☐ **Box H is 0, contracted provider is in compliance**

☐**Box H is > 0, contracted provider is out of compliance**

_____ _____

County Reviewer Signature **Date**

Child / Transition Age Youth: 0-25 Years Partnership Assessment Form (PAF)

Partnership Information

*** Date Completed:**

*** EDC Client Number:** _____

*** Client's First Name:** _____

*** Client's Last Name:** _____

*** FSP/KTA Partnership Data (mm/dd/yyyy):** _____

*** Client's Date of Birth (mm/dd/yyyy):** _____

Who Referred the Client? (Choose One)

- ○ **Self**
- ○ **Family Member (e.g. parent, guardian, sibling, aunt, uncle, grandparent)**
- ○ **Significant Other (e.g. boyfriend / girlfriend, spouse)**
- ○ **Friend / Neighbor (i.e., unrelated other)**
- ○ **School**
- ○ **Primary Care/Medical Office**
- ○ **Emergency Room**
- ○ **Mental Health Facility /Community Agency**
- ○ **Social Services Agency**
- ○ **Substance Abuse Treatment Facility / Agency**
- ○ **Faith-based Organization**
- ○ **Other County I Community Agency**
- ○ **Homeless Shelter**
- ○ **Street Outreach**
- ○ **Juvenile Hall / Camp / Ranch / Division of Juvenile Justice**
- ○ **Acute Psychiatric / State Hospital**
- ○ **Other**

Administrative Information

Partnership Status

*** Full Service Partnership (FSP) Program:** _____

*** Name of Provider:** _____

*** Name of Assigned Clinician:** _____

Program Information

In which additional program(s) is the Client involved?	**Currently** (mark all that apply)
1. AB2034	☐
2. Governor's Homeless Initiative (GHI)	☐
3. MHSA Housing Program	☐

Residential Information – Includes Hospitalizations and Incarcerations

Residential Setting	Tonight (Choose one)	Yesterday As of 11:59 pm The day before partnership (Choose one)	During the past 12 months Indicate the total # of occurrences	During the past 12 months Indicate the total # of days (Column must = 365 days)	Prior to the last 12 months (Mark all that apply)
General Living Arrangement					
1. With one or both biological /adoptive parents	○	○	_____	_____	☐
2. With adult family member(s) other than parents - non-foster care	○	○	_____	_____	☐
3. In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate (must hold lease or share in rent/mortgage)	○	○	_____	_____	☐
4. Single Room Occupancy (must hold lease)	○	○	_____	_____	☐
5. Foster Home (with relative)	○	○	_____	_____	☐
6. Foster Home (with non-relative)	○	○	_____	_____	☐
Shelter/Homeless					
7. Emergency Shelter/Temporary Housing (includes living with friends but not paying rent)	○	○	_____	_____	☐
8. Homeless (includes living in their car)	○	○	_____	_____	☐
Supervised Placement					
9. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)	○	○	_____	_____	☐
10. Unlicensed but supervised congregate placement (includes group living homes, sober living homes)	○	○	_____	_____	☐
11. Licensed Community Care Facility (Board and Care)	○	○	_____	_____	☐

Hospital					
12. Acute Medical Hospital	○	○	____	____	☐
13. Acute Psychiatric Hospital/ Psychiatric Health Facility (PHF)	○	○	____	____	☐
14. State Psychiatric Hospital	○	○	____	____	☐
Residential Program					
15. Group Home (Level 0-11)	○	○	____	____	☐
16. Group Home (Level 12-14)	○	○	____	____	☐
17. Short-Term Residential Therapeutic Program (STRTP) (AB 403 Continuum of Care Reform (CCR))	○	○	____	____	☐
18. Community Treatment Facility	○	○	____	____	☐
19. Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)	○	○	____	____	☐
20. Skilled Nursing Facility (physical)	○	○	____	____	☐
21. Skilled Nursing Facility (psychiatric)	○	○	____	____	☐
22. Long-Term Institutional Care (Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC))	○	○	____	____	☐
Justice Placement					
23. Juvenile Hall/Camp/Ranch	○	○	____	____	☐
24. Division of Juvenile Justice	○	○	____	____	☐
25. Jail	○	○	____	____	☐
26. Prison	○	○	____	____	☐
Other					
27. Other	○	○	____	____	☐
28. Unknown	○	○			☐

Education

Highest Level of Education Completed: Choose One

○ Day Care	○ 5th Grade	○ 12th Grade
○ Preschool	○ 6th Grade	○ GED Coursework
○ Kindergarten	○ 7th Grade	○ High School Diploma/ GED
○ 1st Grade	○ 8th Grade	○ Some college/ Some Technical or Vocational Training
○ 2nd Grade	○ 9th Grade	○ Associate's Degree (e.g. A.A., A.S./ Technical or Vocational School)
○ 3rd Grade	○ 10th Grade	
○ 4th Grade	○ 11th Grade	○ Level Unknown (e.g., child/youth in non-public school)

Special Education/S.E.D.

○ Yes	○ No	**Is the client currently receiving special education due to serious emotional disturbance?**

Special Education/Other

○ Yes	○ No	**Is the client currently receiving special education due to another reason?**

Attendance – For Youth, Who are Required by Law to Attend School

During the Past 12 Months estimate the client's attendance level (excluding scheduled breaks and excused absences)	○ Always attends school (never truant)	○ Attends school most of the time	○ Sometimes attends school	○ Infrequently attends school	○ Never attends school
Currently estimate the client's attendance level (excluding scheduled breaks and excused absences)	○ Always attends school (never truant)	○ Attends school most of the time	○ Sometimes attends school	○ Infrequently attends school	○ Never attends school
Grades					
Currently His / her grades are:	○ Very Good	○ Good	○ Average	○ Below Average	○ Poor
During the Past 12 Months His / her grades were:	○ Very Good	○ Good	○ Average	○ Below Average	○ Poor
Suspension/Expulsion					
During the past 12 months, how many times has s/he been suspended?					

During the past 12 months, how many times has s/he been expelled?	

Attendance – For Youth, Who are NOT Required by Law to Attend School		
For the educational settings below, indicate where the Client:	**Was During the Past 12 Months** # of Weeks	**Currently** (mark all that apply)
1. Not in school of any Kind	_____	☐
2. High School / Adult Education	_____	☐
3. Technical / Vocational School	_____	☐
4. Community College / 4 year College	_____	☐
5. Graduate School	_____	☐
6. Other	_____	☐

Recovery Goals		
◯ **Yes**	◯ **No**	Does one of the client's current recovery goals include any kind of education at this time?

Employment Information

Employment During Last 12 Months

Indicate the Client's Employment Status:	# of Weeks (Column must = 52 Weeks)	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided**.**	_____	_____	$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. **AND** 2. Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and *I* or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	_____	$_____

Unemployed		☐			

Current Employment

Indicate the client's employment status:	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. **AND** 2. Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and *I* or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	$_____
☐	**Unemployed:** Check if the Client is not employed at this time.	

◯ Yes	◯ No	Does one of the client's current recovery goals include any kind of employment at this time?

Sources of Financial Support

Indicate all the sources of financial aid used to meet the needs of the client:	During the Past 12 Months (mark all that apply)	Currently (mark all that apply)
1. Caregiver's Wages	☐	☐
2. Client's Wages	☐	☐
3. Client's Spouse/ Significant Other's Wages	☐	☐
4. Savings	☐	☐
5. Child Support	☐	☐
6. Other Family Member/Friend	☐	☐
7. Retirement/ Social Security Income	☐	☐
8. Veteran's Assistance Benefits	☐	☐
9. Loan/Credit	☐	☐
10. Housing Subsidy	☐	☐
11. General Relief/General Assistance	☐	☐
12. Food Stamps	☐	☐
13. Temporary Assistance for Needy Families (TANF)	☐	☐
14. Supplemental Security Income/ State Supplementary Payment (SSI/SSP) Program	☐	☐
15. Social Security Disability Insurance (SSDI)	☐	☐
16. State Disability Insurance (SDI)	☐	☐
17. American Indian Tribal Benefits (e.g., per capita revenue sharing, trust disbursements)	☐	☐
18. Other	☐	☐
19. No Financial Support	☐	☐

Legal Issues/ Designations

Arrest Information		
Indicate the number of times the client was arrested DURING THE PAST 12 MONTHS		☐
○ **Yes**	○ **No**	**Prior 12:** Was the client arrested any time PRIOR TO THE LAST 12 MONTHS?
Probation Information		
○ **Yes**	○ **No**	**Currently:** Is the client CURRENTLY on probation?
○ **Yes**	○ **No**	**Past 12 Months:** Was the client on probation any time PRIOR TO THE LAST 12 MONTHS?
○ **Yes**	○ **No**	**Prior 12 Months:** Was the client on probation any time PRIOR TO THE LAST 12 MONTHS?
Parole Information		
○ **Yes**	○ **No**	**Currently:** Is the client CURRENTLY on parole from the Division of Juvenile Justice?
○ **Yes**	○ **No**	**Past 12 Months:** Was the client on any kind of parole DURING THE PAST 12 MONTHS?
○ **Yes**	○ **No**	**Prior 12 Months:** Was the client on any kind of parole any time PRIOR TO THE LAST 12 MONTHS?
Conservatorship Information		
○ **Yes**	○ **No**	**Currently:** Is the client CURRENTLY on conservatorship?
○ **Yes**	○ **No**	**Past 12 Months:** Was the client on conservatorship DURING THE PAST 12 MONTHS?
○ **Yes**	○ **No**	**Prior 12 Months:** Was the client on conservatorship any time PRIOR TO THE LAST 12 MONTHS?
Payee Information		
○ **Yes**	○ **No**	**Currently:** Does the client CURRENTLY have a payee?
○ **Yes**	○ **No**	**Past 12 Months:** Did the client have a payee DURING THE PAST 12 MONTHS?
○ **Yes**	○ **No**	**Prior 12 Months:** Did the client have a payee any time PRIOR TO THE LAST 12 MONTHS?

Dependent(W & I Code 300 Status) Information		
○ **Yes**	○ **No**	**Currently:** Is the client CURRENTLY a dependent of the court?
○ **Yes**	○ **No**	**Past 12 Months:** Was the client a dependent of the court DURING THE PAST 12 MONTHS?
○ **Yes**	○ **No**	**Prior 12 Months:** Was the client a dependent of the court any time PRIOR TO THE LAST 12 MONTHS?

Date Of Dependency	
	If the client was ever a dependent of the court, indicate the year the client was first placed on W & I Code 300 status.

Custody Information

Indicate the total number of children the client has who are CURRENTLY:

_____ Number placed on W & I Code 300 Status: (dependent of the court)

_____ Number placed in Foster Care

_____ Number legally Reunified with client Number

_____ Adopted Out

Emergency Intervention

Indicate the number of emergency interventions (e.g., emergency room visit, crisis stabilization unit) the client had DURING THE PAST 12 MONTHS that were:

_____ Physical Health Related

_____ Mental Health / Substance Abuse Related

Health Status

○ **Yes**	○ **No**	**Current PCP**:	Does the client have a Primary Care Physician (PCP) CURRENTLY?
○ **Yes**	○ **No**	**Past 12 Months PCP**:	Did the client have a Primary Care Physician (PCP) DURING THE PAST 12 MONTHS?

Substance Abuse

○ **Yes**	○ **No**	**Ever Issue:**	In the opinion of the Clinician, has the client ever had a co-occurring mental illness and substance use problem?
○ **Yes**	○ **No**	**Current Issue:**	In the opinion of the Clinician, does the client currently have an active co-occurring mental illness and substance use problem?
○ **Yes**	○ **No**	**Current Services:**	Is the client currently receiving substance abuse services?

Child & Transition Age Youth: 0-25 Years

Quarterly Assessment Form (3M)

Partnership Information

*** Date Completed:** _____

*** Date Due:** _____

*** EDC Client Number:** _____

*** Provider & Clinician Names:** _____

*** Client's First Name:** _____

*** Client's Last Name:** _____

* Partnership Date (mm/dd/yyyy): _____

* Client's Date of Birth (mm/dd/yyyy): _____

Education

Special Education/S.E.D.		
○ **Yes**	○ **No**	Is the client **currently** receiving special education due to serious emotional disturbance?

Special Education/Other		
○ **Yes**	○ **No**	Is the client **currently** receiving special education due to another reason?

For Youth, Who are Required by Law to Attend School					
Attendance					
Currently, estimate the client's attendance level (excluding scheduled breaks and excused absences)	◎ Always attends school (never truant)	◎ Attends school most of the time	◎ Sometimes attends school	◎ Infrequently attends school	◎ Never attends school
Grades					

Currently, His/ her grades are:	◎ Very Good	◎ Good	◎ Average	◎ Below Average	◎ Poor

Sources of Financial Support

Indicate all the sources of financial aid used to meet the needs of the client:	**Currently** (mark all that apply)
1. Caregiver's Wages	☐
2. Client's Wages	☐
3. Client's Spouse/ Significant Other's Wages	☐
4. Savings	☐
5. Child Support	☐
6. Other Family Member/Friend	☐
7. Retirement/ Social Security Income	☐
8. Veteran's Assistance Benefits	☐
9. Loan/Credit	☐
10. Housing Subsidy	☐
11. General Relief/General Assistance	☐
12. Food Stamps	☐
13. Temporary Assistance for Needy Families (TANF)	☐
14. Supplemental Security Income/ State Supplementary Payment (SSI/SSP) Program	☐
15. Social Security Disability Insurance (SSDI)	☐
16. State Disability Insurance (SDI)	☐
17. American Indian Tribal Benefits (e.g., per capita revenue sharing, trust disbursements)	☐
18. Other	☐
19. No Financial Support	☐

Legal Issues/ Designations

Custody Information
Indicate the total number of children the client has who are CURRENTLY _____ Number placed on W & I Code 300 Status: (dependent of the court) _____ Number placed in Foster Care _____ Number legally Reunified with client _____ Number Adopted Out

Health Status

○ **Yes**	○ **No**	**Current PCP**: Does the client have a Primary Care Physician (PCP) **CURRENTLY?**

Substance Abuse

○ **Yes**	○ **No**	**Current Issue:** In the opinion of the Clinician, does the client **currently** have an active co-occurring mental illness and substance use problem?
○ **Yes**	○ **No**	**Current Services:** Is the client **currently** receiving substance abuse services?

Child/TAY Ages: 0-25 Years
Key Event Tracking (KET)

*** Date Completed (mm/dd/yyyy):** _____

*** EDC Client Number:** _____

*** Client's First Name:** _____

*** Client's Last Name:** _____

*** Partnership Date (mm/dd/yyyy):** _____

*** Client's Date of Birth (mm/dd/yyyy):** _____

Changes in Administrative Information - Skip this section if there are no changes

Date of Full Service Partnership (FSP) Program change (mm/dd/yyyy) _____

NEW Full Service Partnership (FSP) Program: _____

Date of Clinician change (mm/dd/yyyy) _____

NEW Clinician Name: _____

New Partnership Status -- Skip this section if there are no changes

Date of Partnership Status Change (mm/dd/yyyy): _____

◯ Discontinuation/Interruption of Full Service Partnership and/or Community Services Program ◯ Reestablishment of Full Service Partnership and/or Community Services/ Program

If there is a **Discontinuation / Interruption** of Full Service Partnership and / or Community Services/ Program, indicate the reason (choose one)	
◯	Target Criteria: Target population criteria are not met
◯	Client Discontinued: Client decided to discontinue Full Service Partnership participation after partnership established
◯	Moved: Client moved to another County/ service area
◯	Not Located: After repeated attempts to contact Client, s/he cannot be located
◯	Residential / Institutional Mental Health Services: Client's circumstances reflect a need for Residential/ Institutional Mental Health Services at this time (such as State Hospital)
◯	Jail: Community Services / Program interrupted
◯	Prison: Community Services / Program interrupted
◯	Met Goals: Client has successfully met his/her goals such that the discontinuation of Full Service Partnership is appropriate
◯	Deceased: Client is deceased

Program Information

Program Name	Date of Program Change (mm/dd/yyyy)	Currently Involved (Indicate status below)
1. AB2034		◯ Now enrolled in the AB2034 Program ◯ No longer participating in the AB2034 Program
2. Governor's Homeless Initiative (GHI)		◯ Now enrolled in the GHI Program ◯ No longer participating in the GHI Program
3. MHSA Housing Program		◯ Now enrolled in the MHSA Housing Program ◯ No longer participating in the MHSA Housing Program

Residential Information – Includes Hospitalization and Incarceration

Skip this section if there are no changes

Date of Residential Status Change (mm/dd/yyyy): _____

General Living Arrangement	
○	1. With one or both biological /adoptive parents
○	2. With adult family member(s) other than parents - non-foster care
○	3. In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate(must hold lease or share in rent/mortgage)
○	4. Single Room Occupancy (must hold lease)
○	5. Foster Home (with relative)
○	6. Foster Home (with non-relative)
Shelter / Homeless	
○	7. Emergency Shelter/Temporary Housing (includes living with friends but not paying rent)
○	8. Homeless (includes people living in their car)
Supervised Placement	
○	9. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)
○	10. Unlicensed but supervised congregate placement (includes group living homes, sober living homes)
○	11. Licensed Community Care Facility (Board and Care)
Hospital	
○	12. Acute Medical Hospital
○	13. Acute Psychiatric Hospital/ Psychiatric Health Facility (PHF)
○	14. State Psychiatric Hospital
Residential Program	
○	15. Group Home (Level 0-11)

◯	16. Group Home (Level 12-14)
◯	17. Short-Term Residential Therapeutic Program (**STRTP**) (AB 403 Continuum of Care Reform (CCR))

Residential Program Continued

	18. Community Treatment Facility
	19. Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)
	20. Skilled Nursing Facility (physical)
	21. Skilled Nursing Facility (psychiatric)
	22. Long-Term Institutional Care (Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC))
Justice Placement	
	23. Juvenile Hall/Camp/Ranch
	24. Division of Juvenile Justice
	25. Jail
Other	
	26. Other
	27. Unknown

Education Information -- Skip this section if there are no changes

Date of Grade Level Completion (mm/dd/yyyy):	

Highest Level of Education Completed:

- ◯ Day Care
- ◯ Preschool
- ◯ Kindergarten
- ◯ 1st Grade
- ◯ 2nd Grade
- ◯ 3rd Grade
- ◯ 4th Grade
- ◯ 5th Grade
- ◯ 6th Grade
- ◯ 7th Grade
- ◯ 8th Grade
- ◯ 9th Grade
- ◯ 10th Grade
- ◯ 11th Grade
- ◯ 12th Grade
- ◯ GED Coursework
- ◯ High School Diploma/ GED
- ◯ Some college/ Some Technical or Vocational Training
- ◯ Associate's Degree (e.g. A.A., A.S./ Technical or Vocational School)
- ◯ Level Unknown (e.g., child/youth in non-public school)

For Youth, Who are Required by Law to Attend School	
Suspension/Expulsion /Expulsion	
Suspension Information: Date of Suspension (mm/dd/yyyy):	
Expulsion Information: Date of Expulsion (mm/dd/yyyy):	

For Youth, Who are NOT Required by Law to Attend School	
Date of Education Setting Change (mm/dd/yyyy):	
If there are any educational setting changes, Indicate ALL ne and ongoing statuses including those previously reported. w	Setting (mark all that apply)
1. Not in school of any kind	◯
2. High School / Adult Education	◯
3. Technical / Vocational School	◯
4. Community College / 4 year College	◯
5. Graduate School	◯
6. Other	◯

◯ **Yes**	◯ **No**	If the Client is stopping school, did the Client complete a class and/or program?
◯ **Yes**	◯ **No**	Does one of the Client's current recovery goals include any kind of education at this time?

Employment Information -- Skip this section if there are no changes

Date of Employment Change (mm/dd/yyyy): _____

Current Employment

If there are any changes to the Client's employment status, indicate ALL new and ongoing statuses including those previously reported:	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job- related support services provided.	_____	$_____
Transitional Employment/ Enclave: **Paid jobs in the community that are:** **1.** Open only to individuals with a disability. **AND** **2.** Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency- Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the Client's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and *I* or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	$_____

☐	0B**Unemployed**: Check this box if the Client is not employed at this time.	
◎ **Yes**	◎ **No**	Does one of the Client's current recovery goals include any kind of employment at this time?

Legal Issues / Designations -- Skip this section if there are no changes

Justice System Involvement

Arrest Information: Date Client Arrested (mm/dd/yyyy)

_____

Probation Information: Date of Probation status change (mm/dd/yyyy)

_____ Indicate new Probation status:

◯ Removed from Probation ◯

Placed on Probation

Juvenile Justice Parole Information:

_____ Date of Division of Juvenile Justice Parole status change (mm/dd/yyyy)

Indicate new Division of Juvenile Justice Parole status:

◯ Removed from Division of Juvenile Justice Parole ◯

Placed on Division of Juvenile Justice Parole

Conservatorship Information

Conservatorship Information: Date of new Conservatorship status

_____ change (mm/dd/yyyy)

Indicate new Conservatorship status:

◯ Removed from Conservatorship ◯

Placed on Conservatorship

Payee Information: Date of Payee status change (mm/dd/yyyy)

_____ Indicate new Payee status:

◯ Removed from Payee status ◯

Placed on Payee status

Dependent (W & I code 300 Status) Information: Date of W& I Code 300 status change (mm/dd/yyyy)

_____

Indicate W&I Code 300 status change: ◯

Removed from W&I Code 300 status

◯ Placed on W&I Code 300 status

Emergency Intervention -- Skip this section if there are no changes

Date of Emergency Intervention (mm/dd/yyyy): _____

Indicate the type of Emergency Intervention (e.g. emergency room visit, crisis stabilization unit):

- ◯ Physical Health Related
- ◯ Mental Health / Substance Use Related

Summitview Child & Family Services, Inc.
Amended Exhibit B
Amended Provider Rates

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

Provider Rates are as follows:

Taxonomy	Billing Unit	Rate Per Unit
Psychiatrist/MD	15 minutes	$226.80
Psychiatrist/MD (Group Rate)	15 minutes	$50.40
Licensed Practitioner of the Healing Arts (LPHA)	15 minutes	$63.60
Licensed Practitioner of the Healing Arts (LPHA) (Group Rate)	15 minutes	$14.13
Mental Health Rehab Specialist (MHRS)	15 minutes	$44.40
Mental Health Rehab Specialist (MHRS) (Group Rate)	15 minutes	$9.87
Certified Peer Support Specialist (Peer)	15 minutes	$46.64
Certified Peer Support Specialist (Peer) (Group Rate)	15 minutes	$10.36
Other Qualified Providers (Other)	15 minutes	$44.40
Other Qualified Providers (Other) (Group Rate)	15 minutes	$9.87
Psychiatric Technician (LPT)	15 minutes	$41.55
Psychiatric Technician (LPT) (Group Rate)	15 minutes	$9.23
Registered Nurse (RN)	15 minutes	$92.14
Registered Nurse (RN) (Group Rate)	15 minutes	$20.48
New Patient Evaluation - Psychiatrist/MD	15-29 Minutes	$332.64
New Patient Evaluation - Psychiatrist/MD	30-44 Minutes	$559.44
New Patient Evaluation - Psychiatrist/MD	45-59 Minutes	$786.24
New Patient Evaluation - Psychiatrist/MD	60-74 Minutes	$1,013.04
Established Patient Evaluation - Psychiatrist/MD	10-19 Minutes	$226.80

Taxonomy	Billing Unit	Rate Per Unit
Established Patient Evaluation - Psychiatrist/MD	20-29 Minutes	$378.00
Established Patient Evaluation - Psychiatrist/MD	30-39 Minutes	$529.20
Established Patient Evaluation - Psychiatrist/MD	40-54 Minutes	$710.64
Family Psychotherapy (with patient present) - Psychiatrist/MD	50 Minutes	$756.00
Family Psychotherapy (with patient present) - LPHA	50 Minutes	$212.00
Individual Counseling 1341 (90832) - LPHA	30 minutes	$114.48
Individual Counseling 1341 (90832) - Psychiatrist/MD	30 minutes	$408.24
Individual Counseling 1341 (90834) - LPHA	45 minutes	$190.80
Individual Counseling 1341 (90834) - Psychiatrist/MD	45 minutes	$680.40
Individual Counseling 1341 (90837) - LPHA	60 Minutes	$254.40
Individual Counseling 1341 (90837) - Psychiatrist/MD	60 Minutes	$907.20
Interpretation Services	15 minutes	$30.00
Interactive Complexity	Flat Rate	$16.50

B. Non-Mental Health Supportive Services and Goods for Clients Enrolled in a FSP Program

1. Purchases of goods and services up to $2,000 per Client per fiscal year, may be purchased without prior written approval by the County.

   i. A single purchase or item in excess of $500 must be approved by HHSA Director and Behavioral Health Division Director in writing in advance of incurring the cost to be eligible for reimbursement under this agreement.

   ii. Purchases deemed "emergency" which are urgent and essential to the support of the client may not require pre-approval as long as they are within the scope of work of this contract. This may included, but is not limited to, emergency shelter reservations, emergency auto repairs, and emergency home repairs.

   iii. Purchases of more than $2,000 per Client per fiscal year, must be approved in writing by HHSA Director and Behavioral Health Division Director.

   iv. Non-Mental Health Supportive Services and Goods must be shown separately on invoices, and invoices will include a running balance per Client. In addition, Contractor must provide supporting documentation in the form of original itemized receipts.