NEGOTIATED NET AMOUNT

ARTICLE I. FORMATION AND PURPOSE

A. Authority

State and the Contractor enter into Exhibit C by authority of Chapters 3.3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which will be reimbursed pursuant to this Exhibit C. State and the Contractor identified in the Standard Agreement are the only parties to this Contract. This Contract is not intended, nor shall it be construed, to confer rights on any third party.

B. Control Requirements

1. Performance under the terms of Exhibit C is subject to all applicable federal and state laws, regulations, and standards. In accepting the State drug and alcohol combined program allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (*i*) establish, and shall require its Subcontractors to establish, written procedures consistent with the following requirements; and (*ii*) be held accountable for audit exceptions taken by the State against the Contractor and its Subcontractors for any failure to comply with these requirements:

   (a) HSC, Division 10.5, commencing with Section 11760;

   (b) Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000;

   (c) Government Code Section 16367.8;

   (d) Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130;

   (e) Title 42 United State Code (USC), Sections 300x-21 through 300x-35, 300x-51, and 330x-65 and 66;

   (f) Title 31 USC Sections 7501 through 7507 and the Single Audit Act Amendments of 1996 (31 USC Sections 7501-7507) and the Office of Management and Budget (OMB) Circular A-133 revised on June 27, 2003;

   (g) Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137;

(h) Title 42, CFR, Sections 8.1 through 8.34;

(i) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and,

(j) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

Contractor shall be familiar with the above laws and regulations and shall assure that its Subcontractors are also familiar with such laws.

2. The provisions of Exhibit C are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Contract.

3. Contractor shall adhere to the applicable provisions of Title 45, CFR, Part 96, Subpart L, in the expenditure of the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Document 1A, 45 CFR 96, Subparts C and L, is incorporated by reference.

4. This Contract is subject to any additional restrictions, limitations, or conditions enacted by the federal or state government that affect the provisions, terms, or funding of this Contract in any manner.

5. Documents 1C, 1D(a), and 1D(b), incorporated by this reference, contain additional requirements that shall be adhered to by those Contractors that receive the types of funds specified by each document and referenced in Exhibit A1. These exhibits and documents are:

   (a) Exhibit A1, which is comprised of the Fiscal Allocation Detail, the County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data;

   (b) Document 1C, Driving-Under-the-Influence Program Requirements.

   (c) Document 1D(a), Services to California Department of Corrections and Rehabilitation (CDCR) - Parolee Services Network (PSN), and,

   (d) Document 1D(b), SAPT Female Offender Treatment Project (FOTP).

6. Contractor shall comply with the requirements contained in Document 1F, incorporated by this reference, "Matrix of Documents, Reports, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs."

7. Contractor shall comply with the requirements for perinatal programs funded under Exhibit C contained in Document 1G, incorporated by this reference, "Perinatal Services Network Guidelines 2004" until such time new Perinatal Services Network Guidelines are established and adopted. No formal amendment of this contract is required for the guidelines to apply.

8. Contractor shall comply with the requirements which address the collection of information required in the SAPT Block Grant contained in Document 1T, incorporated by this reference ("CalOMS Prevention User Manual"). The manual is updated quarterly and the most current version is available via the California Outcomes Measurement Service (CalOMS) for Prevention support site at http://kitusers.kithost.net/support/ca/Manual/tabid/261/Default.aspx). Prevention data is to be reported to the Department via CalOMS Prevention by all funded primary prevention providers. Services should be reported as they occur; however, no more than one week's data shall be aggregated into one reported service. The State recommends reporting all services no later than one week after the date of occurrence. All CalOMS Prevention data shall be reviewed by each county and released to the State no later than the end of the first month following the close of each quarter. The reporting quarters are: July through September, October through December, January through March, and April through June.

9. Contractor should follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines", in developing and implementing youth treatment programs funded under Exhibit C, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this contract is required for the guidelines to apply.

C. Contract Negotiation

Contract negotiations may be conducted between the Contractor and the State through their authorized representative(s) each year of the multi-year contract period. Negotiations may be conducted at ADP, 1700 K Street, Sacramento, California, 95811 once during the multi-year contract period. In the alternative, negotiations may be conducted by correspondence.

ARTICLE II. DEFINITIONS

A. The words and terms of this Contract are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage pursuant to Division 10.5 of HSC, Section 11750 et seq., and Title 9, CCR, Section 9000 et seq. The following definitions shall apply to Exhibit C:

1. **"Available Capacity"** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

2. **"Contractor"** means (a) the county identified in the Standard Agreement or (b) the department authorized by the County Board of Supervisors to administer alcohol and drug programs.

3. **"Dedicated Capacity"** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide non-Drug Medi-Cal (DMC) drug and alcohol services to persons eligible for Contractor services.

4. **"Encumbered Amount"** means the amount reflected on the Standard Agreement of this Contract and supported by Exhibit A1, the County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data as the Negotiated Net Amount (NNA).

5. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by State for the current fiscal year.

6. **"Modality"** means those necessary general activities identified in the Dedicated Capacity Reports included in the County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data, Exhibit A1, to provide alcohol and/or drug prevention or treatment that conform to the services described in Division 10.5 of the HSC.

7. **"Negotiated Net Amount"** means the contracted amount of funds for services agreed to by the State and the Contractor, less funds budgeted for DMC. The net amount reflects only those funds allocated to the Contractor by the State and the required county match for State General Funds (SGF) as reflected in the County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data portion of the Exhibit A1. The NNA does not include other revenue budgeted by the Contractor such as client fees or revenue in excess of the required match for SGF. The cost per unit for the dedicated capacity to be provided for each service modality identified in the Contract will be based on the net amount of the contract. Exhibit A1 will be used as a negotiating document.

8. **"Performance"** means providing the dedicated capacity in accordance with Exhibit A1 and abiding by the terms of Exhibits B and C of this Contract, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), in expending funds for the provision of alcohol and drug services hereunder.

9. **"Preliminary Settlement"** means the initial settlement of non-DMC funding and Parolee Services Network funding through the cost report settlement process.

10. **"Revenue"** means Contractor's income from sources other than the State allocation and the required county match.

11. **"Service Element"** is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Contract as Document 1H(a) "Service Code Descriptions", and Document 1H(b), "Program Code Listing."

12. **"State"** means the California Department of Alcohol and Drug Programs.

13. **"Unit of Service"** means the type of unit used to quantify the service modalities/elements in the dedicated capacity reports. The units of services are listed below:

Support Services	staff hours
Primary Prevention Services	staff hours
Secondary Prevention Services	staff hours
Nonresidential Services (Outpatient and Aftercare)	staff hours
Intensive Outpatient Services (Day Care Rehabilitative)	visit days
Residential Treatment Services	bed days
Narcotic Treatment Program	
Inpatient Detoxification	bed days
Outpatient Detoxification	slot days
Narcotic Replacement Therapy Methadone	slot days
Ancillary Services	staff hours
Driving Under-the-Influence	persons served

14. **"Utilization"** means the total actual units of service used by clients and participants.

ARTICLE III. FISCAL PROVISIONS

A. Funding Authorization.

1. Exhibit C is valid and enforceable subject to sufficient funds being made available to the State by the United States Government and subject to authorization and appropriation of sufficient funds pursuant to the State's Budget Act.

2. In the event the United States Government and/or the State Government do not authorize and appropriate sufficient funds for the State to allocate amounts pursuant to the Payment Provisions of Exhibit C, it is mutually agreed that the Contract shall be amended to reflect any reduction in the Payment Provisions and the Performance Provisions.

3. Contractor shall bear the financial risk in providing any alcohol and/or drug services covered by this Exhibit C.

B. Payment Provisions

1. The NNA shall be based on the projected cost of services less the projected revenues. The projected cost of services shall be based on historical data of actual costs and current capacity, which shall be provided to the State by the Contractor.

2. For each fiscal year, the total amount payable by the State to the Contractor under Exhibit C shall not exceed the encumbered amount. The funds identified for the fiscal years covered by Exhibit C are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by the State for that fiscal year or the NNA, whichever is less. Changes to encumbered funds will require written amendment to the Contract. State may settle costs for NNA services based on the year-end cost settlement report as the final amendment to the approved single state/county contract.

3. In the event a contract amendment is required pursuant to the preceding paragraph, Contractor shall submit to the State the contract exhibits requested by the State in order to initiate the contract amendment. Any such requested exhibits shall be forwarded to the State sixty (60) days after the State issues a notice of the State Budget Act allocation or any revised allocation with the exception of the final allocation. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Contract, the State and the Contractor may agree to amend the contract after the issuance of the first revised allocation.

4. State shall reimburse the Contractor monthly in arrears an amount equal to one-twelfth of the amount encumbered for the NNA portion of the approved contract (Exhibit C) or the most recent allocation based on the Budget Act Allocation, whichever is less.

   However, based on the expenditure information submitted by the counties in the Quarterly Federal Financial Management Report (QFFMR), State may adjust monthly payments of encumbered federal funds to extend the length of time (not to exceed 21 months) over which payments of federal funds will be made.

5. Monthly disbursements to the Contractor at the beginning of each fiscal year of the Contract shall be based on the preliminary allocation of funds, as detailed in Exhibit A1, County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data.

   Final allocations will reflect any increases or reductions in the appropriations as reflected in the Budget Act Allocation and any subsequent allocation revisions. To the extent that any amendment encumbers an amount that is less than the Budget Act Allocation, the monthly disbursements will reflect the lesser amount.

6. State may withhold monthly payments if the Contractor fails to timely submit reports and data required by the State, including but not limited to, reports required pursuant to Exhibit C, Article V. Upon the State's receipt of the complete and accurate reports, or data, Contractor's monthly payment shall commence with the next scheduled monthly payment, and shall include any funds withheld due to late submission of reports or data.

   State may withhold monthly payments if the Contractor fails to submit the contract amendment, including the Contractor and its Subcontractors fiscal detail data that is due to the State within sixty (60) days after the release of the Budget Act Allocation.

7. Adjustments may be made to the total NNA of the Contract and amounts may be withheld from payments otherwise due to the Contractor hereunder, for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit C.

C. Accrual of Interest

Any interest retained from SGF by the Contractor must be used for the purpose it was allocated.

D. Transfer of Money

In a fiscal year, transfers by the Contractor of more than 10 percent of the contracted amount between modalities included in Exhibit C require an amendment to the Contract. Transfers of 10 percent or less of the contracted amount between modalities require prior written approval by the State and are subject to subsequent reporting by the Contractor to the State consistent with Article V reporting requirements when the transfers are between service elements. In determining whether to grant approval, State will consider the amount to be transferred, the modalities involved in the transfers, the need for the transfers, and the effect on the negotiated service delivery.

E. Additional Audit Requirements

1. Pursuant to OMB Circular A-133, Contractor shall require and ensure that its non-profit Subcontractors expending $500,000 effective January 1, 2004, or more in federal funds in a fiscal year, has a single or program-specific audit performed with respect to the funds covered by Exhibit C.

   (a) The audit shall be performed in accordance with OMB Circular A-133 (Revised June 2003), entitled "Audits of States, Local Governments, and Non-Profit Organizations." OMB Circulars can be obtained from the Office of Management and Budget, Washington, D.C. 20503, or www.whitehouse.gov/omb/circulars/index.html.

   (b) The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, 2007 Revision, issued by the Comptroller General of the United States. The Government Auditing Standards can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, or www.gao.gov.

   (c) A copy of the audit performed in accordance with OMB Circular A-133 (Revised June 2003) shall be submitted to the State within 30 days of completion, but no later than nine months following the end of the Subcontractor's fiscal year.

   (d) The cost of the audit made in accordance with the provisions of the most recent version of OMB Circular A-133 can be charged to applicable federal awards. Where apportionment of the audit cost is necessary, such apportionment shall be made in accordance with generally accepted accounting principles, but shall not exceed the proportionate amount that the award represents of the Subcontractor's total revenue.

   (e) The work papers and the audit reports shall be retained for a minimum of three years from the date of the audit reports, and longer if the independent auditor is notified in writing by the State to extend the retention period.

(f) Audit work papers shall be made available upon request to the State, and copies shall be made as is reasonable and necessary.

(g) Contractor, in coordination with the State, shall ensure that its Subcontractor's follow-up and take all necessary corrective action on any audit findings in the single or program-specific audit report.

2. Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting required single or program-specific audit reports, or failure to comply with all other audit requirements. The sanctions shall include:

(a) Withholding a percentage of federal awards until the audit is completed satisfactorily;

(b) Withholding or disallowing overhead costs;

(c) Suspending federal awards until the audit is conducted; or,

(d) Terminating the federal award.

3. Pursuant to OMB Circular A-133, Contractor shall monitor the activities of all its non-profit Subcontractors to ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of the contracts or grant agreements, and that performance goals are achieved.

Limited scope audits, on-site visits, and reviews of documentation supporting requests for reimbursement are monitoring procedures that are acceptable in meeting the Contractor's monitoring objectives. Also, Contractor may charge federal awards for the cost of these monitoring procedures.

(a) Limited scope audits, as defined in the OMB Circular A-133, only include agreed-upon engagements that are (1) conducted in accordance with either the American Institute of Certified Public Accountant's generally accepted auditing standards or attestation standards; (2) paid for and arranged by pass-through entities (counties); and (3) address one or more of the following types of compliance requirements: (*i*) activities allowed or unallowed, (*ii*) allowable costs/cost principles; (*iii*) eligibility; (*iv*) matching, level of effort and earmarking; and (*v*) reporting.

(b) On-site visits focus on compliance and controls over compliance areas. The reviewer must make site visits to the subrecipient's location(s), and document the visits using a checklist or program focusing on the compliance areas. All findings noted during the on-site monitoring shall be handled in the same manner as any exceptions noted during single or program-specific audits.

(c) Reviews of supporting documentation submitted by providers include, but are not limited to, reviews of copies of invoices, canceled checks, and time sheets. Prior to reimbursement the reviewer shall determine if the costs are allowable under the terms of the federal award.

4. Reports of audits conducted by the State shall reflect all findings, recommendations, adjustments, and corrective action as a result of its findings in any areas.

5. Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the Bureau of State Audits, as a result of any audit exception that is related to the Contractor's responsibilities herein. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds. State shall invoice Contractor 60 days after issuing the final audit report or upon resolution of an audit appeal. Contractor agrees to develop and implement any corrective action plans in a manner acceptable to State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within one year from the date of the plan.

If differences cannot be resolved between the State and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit C, Contractor may request an appeal in accordance with the appeal process described in Document 1J(a), "NNA Audit Appeal Process," incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which its Subcontractors may file an audit appeal via the Contractor.

Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Article IV, Division I, of this Contract.

F. Revenue Collection

Contractor shall conform to revenue collection requirements in Division 10.5 of the HSC, Sections 11841, by raising revenues in addition to the funds allocated by the State. These revenues include, but are not limited to, fees for services, private contributions, grants, or other governmental funds. These revenues shall be used in support of additional alcohol and other drug services or facilities. Each alcohol and drug program shall set and collect client fees based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

G. County Match Requirements

Contractor shall comply with the following requirements pursuant to HSC, Sections 11840 and 11840.1.

1. Counties with populations over 100,000:

   (a) Non-DMC SGF allocations shall be funded on the basis of 90 percent SGF and 10 percent county funds, except local hospital inpatient costs to the extent there are allocations made for local hospital inpatient costs, which shall be funded on a basis of 85 percent SGF and 15 percent county funds; and,

   (b) State Hospital programs shall be funded on the basis of 85 percent SGF and 15 percent County funds.

2. Perinatal Services Network counties with populations over 100,000:

   Perinatal Services Network programs shall be funded on the basis of 90 percent Perinatal State General Fund (PSGF) and 10 percent county funds. The 10 percent county funds match to PSGF funds must be used for perinatal-related activities. The 10 percent county match requirement does not apply to the Women and Children's Residential Treatment Services funds.

3. Counties with populations under 100,000:

   Non-DMC SGF, non-DMC PSGF, and Women and Children's Residential Treatment SGF allocations do not require a county fund match, with the exception of State Hospital programs, which shall be funded on the basis of 90 percent SGF and 10 percent county funds to the extent that allocations of SGF are made available for such programs.

H. Cost Efficiencies

1. It is intended that the cost to the Contractor in maintaining the dedicated capacity and units of service shall be met by the NNA allocated to the Contractor and other Contractor or Subcontractor revenues. Amounts awarded pursuant to Exhibit C shall not be used for services where payment has been made, or can reasonably be expected to be made under any other state or federal compensation or benefits program, or where services can be paid for from revenues.

2. Pursuant to HSC, Sections 11758.12 (e) and (h), unexpended discretionary SGF provided through this Contract shall be treated as follows:

   (a) Contractor shall include any non-DMC SGF, non-DMC PSGF, and Women and Children's Residential Treatment SGF funds redirected from the current fiscal year to the next fiscal year plus any accrued interest, (see Article III, Section C) on the identified lines of the budget summary for the next fiscal year contract.

   (b) Unspent non-DMC SGF, non-DMC PSGF, and Women and Children's Residential Treatment SGF funds may be retained by the Contractor, less:

      i Amounts reimbursable to the CDCR pursuant to Document 1D(a);

      ii Amounts deemed necessary by the Contractor to fund allowable DMC costs that exceed DMC maximum rates.

   (c) Retained non-DMC SGF, non-DMC PSGF, and Women and Children's Residential Treatment SGF funds shall only be spent on identified drug and alcohol service priorities in accordance with this Contract and shall be included on the identified lines of the budget summary for the subsequent fiscal year.

I. Expenditure of SAPT Block Grant Funds

1. SAPT Block Grant funds are allocated based upon the Federal Grant award period. These funds must be expended for activities authorized pursuant to 42 USC Sections 300x-21(b) through 300x-64, and Title 45, CFR, Subpart L, within the availability period of the grant award. Any SAPT Block Grant funds that have not been expended by a Contractor at the end of the expenditure period identified below shall be returned to the State for subsequent return to the Federal government.

   (a) For State Fiscal Year (SFY) 2007-08, the expenditure period of the Federal Fiscal Year (FFY) 2008 award is October 1, 2007, through June 30, 2009.

(b) For SFY 2008-09, the expenditure period of the FFY 2009 award is October 1, 2008, through June 30, 2010.

(c) For SFY 2009-10, the expenditure period of FFY 2010 award is October 1, 2009, through June 30, 2011.

2. Contractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 92, Sections 92.20(b)(1) through (6), and Title 45, CFR, Part 96, Section 96.30.

3. Non-profit Subcontractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.

4. Contractors receiving SAPT Block Grant funds shall track obligations and expenditures by individual SAPT Block Grant award, including, but not limited to, obligations and expenditures for primary prevention, services to pregnant women and women with dependent children, and HIV early intervention services. "Obligation" and "expenditure" shall have the same meaning as used in Title 45, CFR, Part 92, Section 92.3.

5. Contractors and Subcontractors receiving Substance Abuse Treatment Trust Fund (SATTF) funds shall comply with the financial management standards Contained in Title 9, CCR, Sections 9535(c), (d), (e), and (f).

ARTICLE IV. PERFORMANCE PROVISIONS

A. Monitoring

1. Contractor's performance under Exhibit C shall be monitored by the State during the term of this Contract. Monitoring criteria shall include, but not be limited to:

   (a) Whether the quantity of work or services being performed conform to Exhibit A1;

   (b) Whether the Contractor has established and is monitoring appropriate quality standards;

   (c) Whether the Contractor is abiding by all the terms and requirements of this Contract; and,

   (d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Guidelines (Document 1G), until such time new Perinatal Services Network Guidelines are established and adopted.

2. Failure to comply with the above provisions shall constitute grounds for the State to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of the Contract or both.

B. Performance Requirements

1. Contractor shall provide the NNA dedicated capacity by service modality and capacity, negotiated by the Contractor and the State, as set forth in Exhibit A1.

2. Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations. Contractor shall assure that in planning for the provision of services, the following barriers to services are considered and addressed:

   (a) Lack of educational materials or other resources for the provision of services;

   (b) Geographic isolation and transportation needs of persons seeking services or remoteness of services;

   (c) Institutional, cultural, and/or ethnicity barriers;

   (d) Language differences;

(e) Lack of service advocates; and,

(f) Failure to survey or otherwise identify the barriers to service accessibility.

3. Contractor shall comply with any additional requirements of the documents that have been incorporated herein by reference, including, but not limited to, those on the "List of Exhibit C Documents" which is attached to Exhibit C.

4. Amounts awarded pursuant to Exhibit C shall be used exclusively for providing alcohol and/or drug program services consistent with the purpose of the funding.

ARTICLE V. REPORTING REQUIREMENTS

A. Financial Reports

1. Contractor shall submit the County and Provider Prevention and Treatment Programs Fiscal Summary and Detail Data, which are part of Exhibit A1, in accordance with the State's drug and alcohol fiscal reporting system requirements contained in Division 10.5 of HSC. Contractor agrees to submit the Exhibit A1 documents with the original contract and with each contract amendment.

2. Contractor shall submit timely the Quarterly Federal Financial Management Report (QFFMR) and end-of-year cost data in the form of year-end cost settlement reports, including Document 2P, "County Certification Cost Report Year-End Claim for Reimbursement" with the original signature of the Contractor's authorized designee in accordance with Document 1F, "Matrix of Documents, Report, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs."

B. Additional Reports

1. In accordance with HSC, Section 11758.12(d), Contractor shall submit, and shall require its Subcontractors to submit, information required by the State. The information shall include, but is not limited to, utilization reports, compliance reports, financial reports, treatment and prevention services reports, demographic characteristics of service recipients, and data as required pursuant to the following:

Document 1K:	Drug and Alcohol Treatment Access Report (DATAR) records in an electronic format as provided and/or approved by the State, and which complies with ADP compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method. Effective July 1, 2007, the format for submission shall be limited to electronic format only.
Document 1T:	CalOMS Prevention User Manual – Submit CalOMS prevention data in the format prescribed in the CalOMS Prevention User Manual. The manual is updated quarterly and the most current version is available via the CalOMS Prevention support site at http://kitusers.kithost.net/support/ca/Manual/tabid/261/Default.aspx.

Document 3J: CalOMS Treatment records – Submit CalOMS Treatment admission, discharge, annual update, resubmission and "provider no activity report" records in an electronic format provided and/or approved by the State, which complies with ADP compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and report method. Meet re-certification requirements whenever there are substantial changes to the Contractor's CalOMS Treatment system.

2. Contractor agrees that it shall submit all data requested pursuant to Article V in a manner identified, or on forms provided, by the State by the applicable due dates or the dates in Document 1F, "Matrix of Documents, Report, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs."

3. Charitable Choice

Contractor shall submit annually the total number of referrals necessitated by religious objection to other alternative substance abuse providers. This information must be submitted to ADP in a format prescribed by ADP and at time required by ADP. (Reference is ADP Bulletin 04-5).

C. Subcontractor Documentation

Contractor shall require it's Subcontractors that are not licensed or certified by the State to submit organizational documents to the State within thirty (30) days of its execution of an initial subcontract, within ninety (90) days of the renewal or continuation of an existing subcontract or when there has been a change in Subcontractor name or ownership. Organizational documents shall include the Subcontractor's Articles of Incorporation or Partnership Agreements (as applicable), and business licenses, fictitious name permits, and such other information and documentation as may be requested by the State.

ARTICLE VI. GENERAL PROVISIONS

A. Records

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for the State to audit contract performance and contract compliance. Contractor shall make these records available to the State, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

1. Contractor shall include in any contract with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.

2. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.

3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the Bureau of State Audits has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not begun within three years, the interim settlement shall be considered as the final settlement.

4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

5. Contractor's subcontracts shall require that all Subcontractors comply with the requirements of Article III, Section A.

6. Should a Subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the Subcontractor's fiscal and program records for the required retention period. The SAM contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements.

If the Contractor cannot physically maintain the fiscal and program records of the Subcontractor, then arrangements shall be made with the State to take possession and maintain all records.

7. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

8. In the event this Contract is terminated, Contractor shall deliver all of its fiscal and program records pertaining to the performance of this Contract to the State, which will retain the records for the required retention period.

B. Dispute Resolution Process

1. In the event of a dispute under this Exhibit C, other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to the State before exercising any other available remedy. Written notice shall include the contract number. The Director (or designee) of the State and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from the State within sixty (60) days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.

2. In the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with the "NNA Audit Appeal Process" (Document 1J(a)). When a financial audit by the Federal Government, the State, or the Bureau of State Audits is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

   Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Article IV, Division I, of this Contract.

3. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by the State during prospective contract negotiations.

C. Negotiated Net Amount Limitations

Pursuant to HSC Section 11818, Contractor shall reimburse its Subcontractors that receive a combination of Medi-Cal funding and other federal or state funding for the same service element and location based on the Subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX of the Social Security Act; Title 22, and the State's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.

LIST OF EXHIBIT C DOCUMENTS INCORPORATED BY REFERENCE FISCAL YEAR 2007-08

The following documents are hereby incorporated by reference into Exhibit C and, as applicable, into Exhibit D regardless of whether or not they are actually attached to the Contract.

Document 1A:	Title 45, Code of Federal Regulations 96, Subparts C and L, Substance Abuse Prevention and Treatment Block Grant Requirements http://www.access.gpo.gov/nara/cfr/waisidx_04/45cfr96_04.html
Document 1B:	Title 42, Code of Federal Regulations, Charitable Choice Regulations http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr54_04.html
Document 1C:	Driving-Under-the-Influence Program Requirements
Document 1D(a):	Services to California Department of Corrections and Rehabilitation – Parolee Services Network
Document 1D(b):	SAPT Female Offender Treatment Project (FOTP)
Document 1F:	Matrix of Documents, Reports, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs
Document 1G:	Perinatal Services Network Guidelines 2004 (for Non-DMC Perinatal Programs) http://www.adp.ca.gov/perinatal/pdf/guidelines_04.pdf
Document 1H(a):	Service Code Descriptions
Document 1H(b):	Program Code Listing
Document 1J(a):	NNA Audit Appeals Process
Document 1K:	Drug and Alcohol Treatment Access Report (DATAR) http://www.adp.ca.gov/datar/manuals/DATARWeb_manual.pdf
Document 1P:	Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)
Document 1T:	CalOMS Prevention User Manual http://www.kitsco.com/casupport/WebHelp/CalOMS_Manual.htm

Document 1V:	Youth Treatment Guidelines http://www.adp.ca.gov/youth/pdf/Youth_Treatment_Guidelines.pdf
Document 1W:	Certification Regarding Lobbying
Document 1X:	Disclosure of Lobbing Activities – Standard Form LLL
Document 2F:	Standards for Drug Treatment Programs (October 21, 1981) http://www.adp.ca.gov/dmc/pdf/DMCA_Standrds_for_Drug_Treatment_Programs.pdf
Document 2P:	County Certification - Cost Report Year-End Claim For Reimbursement
Document 3G	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs http://www.calregs.com
Document 3H	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors http://www.calregs.com
Document 3J	CalOMS Treatment Data Collection Guide http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Collection_Guide_2007-05.pdf
Document 3K	Business Associate Agreement: County is the Business Associate of the Department of Alcohol and Drug Programs

DRUG MEDI-CAL ALCOHOL AND OTHER DRUG TREATMENT SERVICES

ARTICLE I. FORMATION AND PURPOSE

A. Exhibit D of this Contract is entered into by and between the State and the Contractor for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for alcohol and other drug (AOD) treatment in the Contractor's service area pursuant to Sections 11848, 11848.5(a) and (b), and 11758.40 through 11758.47 of the Health and Safety Code (hereinafter referred to as HSC), Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1 and consistent with the Interagency Agreement between the Department of Health Care Services (DHCS) and the State.

B. It is further agreed that Exhibit D of this Contract is controlled by applicable provisions of: (a) the Welfare and Institutions Code (hereinafter referred to as W&IC), Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14021, 14021.5, 14021.6, 14043, et seq. and 14132.90; (b) the HSC, in particular but not limited to, Sections 11758.40 through 11758.47; (c) Title 22, including but not limited to Sections 51490.1, 51341.1 and 51516.1; and (d) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

C. It is understood and agreed that nothing contained in Exhibit D shall be construed to impair the single state agency authority of DHCS.

D. The objective of Exhibit D is to make AOD treatment services available to Medi-Cal beneficiaries through utilization of federal funds available pursuant to Title XIX of the Social Security Act for reimbursable covered services rendered by certified DMC providers.

ARTICLE II. DEFINITIONS

The words and terms of this Contract are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 9, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference. The following definitions shall apply to Exhibit D of this Contact:

A. **"Administrative Costs"** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, program review, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Circular A-87. Contractor's indirect costs shall not be distributed to Subcontractors.

B. **"Beneficiary"** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the "Diagnostic and Statistical Manual of Mental Disorders III Revised (DSM)," and/or DSM IV criteria; and (d) meets the admission criteria to receive DMC covered services.

C. **"Contractor"** means the county identified in the Standard Agreement or the department authorized by that county's Board of Supervisors to administer alcohol and drug programs.

D. **"Covered Services"** means those DMC services authorized by Title XIX of the Social Security Act; Title 22 Section 51341.1; HSC Section 11758.46; and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug-free treatment, narcotic replacement therapy, day care rehabilitative (for pregnant, postpartum, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries only), and perinatal residential AOD treatment (excluding room and board).

E. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified AOD treatment providers who are reimbursed for those services with a combination State General Fund (SGF) and federal Medicaid funds.

F. **"Early and Periodic Screening, Diagnosis, and Treatment Program"** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries under 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

"Early and Periodic Screening, Diagnosis, and Treatment Program (Supplemental Service)" means the supplemental individual outpatient drug-free (ODF) counseling services provided to beneficiaries eligible for the EPSDT program. Supplemental individual ODF counseling consists of any necessary individual AOD counseling not otherwise included in the ODF counseling modality under the DMC program.

G. **"Federal Financial Participation (FFP)"** means the share of federal Medicaid funds for reimbursement of DMC services.

H. **"Final Settlement"** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit has not begun within three years, the interim settlement shall be considered as the final settlement.

I. **"Interim Settlement"** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

J. **"Medical Necessity"** means those AOD treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or, in the case of EPSDT, services that meet the criteria specified in Title 22, Section 51340.1.

K. **"Minor Consent DMC Services"** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.

L. **"Narcotic Treatment Program (NPT)"** means an outpatient clinic licensed by the State to provide narcotic replacement therapy using methadone directed at stabilization and rehabilitation of persons who are opiate-addicted and have an AOD diagnosis.

M. **"Perinatal DMC Services"** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

N. **"Postpartum,"** (as defined for DMC purposes) means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.

O. **"Postservice Postpayment (PSPP) Utilization Review"** means the review for program compliance and medical necessity conducted by the State after service was rendered and the claim paid. State may recover prior payments if such review determines that the services did not comply with the applicable statutes, regulations, or standards.

P. **"Projected Units of Service"** means the number of reimbursable DMC units of service, based on historical data and current capacity, Contractor expects to provide on an annual basis.

Q. **"Protected Population"** means: (1) EPSDT-eligible Medi-Cal beneficiaries under age 21; and (2) Medi-Cal-eligible pregnant and postpartum women.

R. **"Provider of DMC Services"** means any person or entity that provides direct AOD treatment services and has been certified by State as meeting the standards for participation in the DMC program set forth in the "DMC Certification Standards for Substance Abuse Clinics", Document 2E and "Standards for Drug Treatment Programs (October 21, 1981)", Document 2F.

S. **"Satellite site"** has the same meaning as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.

T. **"Service Area"** means the geographical area under Contractor's jurisdiction.

U. **"Statewide Maximum Allowances (SMA)"** means the maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Rates are subject to change annually. The SMA for FY 2007-08 is listed in the "Unit of Service" table in this Article II, Section Y.

V. **"Subcontract"** means an agreement between the Contractor and its Subcontractors. A Subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/client services.

W. **"Subcontractor"** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a direct provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit D.

X. **"Uniform Statewide Monthly Reimbursement (USMR) Rate"** means the rate for NTP services based on a unit of service that is a calendar month of treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The following table shows the Fiscal Year (FY) 2007-08 USMR.

Service	Type of UOS	Non-perinatal UOS (*)	Perinatal UOS (*)	Rate
NTP-Methadone	Daily	$11.20 1.02 (*)	$12.15 1.11 (*)	Maximum
	Monthly	$340.67	$369.56	
NTP-Individual Counseling (**)	One 10-minute increment	$14.96 1.37 (*)	$21.22 1.94 (*)	Maximum
NTP Group Counseling (**)	One 10-minute increment	$3.51 0.32 (*)	$7.07 0.65 (*)	Maximum

(*) Administrative Costs incorporated within the rate.

(**) The NTP Subcontractors may be reimbursed for up to 200 minutes (20 10-minute increments) of individual and/or group counseling per calendar month per beneficiary.

Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USMR. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual patient/client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A)).

Y. **"Unit of Service"** means a face-to-face contact on a calendar day for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Only one face-to-face service contact per day is covered by DMC except in the case of emergencies when an additional face-to-face contact may be covered for intake crisis intervention or collateral service. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and each contact shall be clearly documented in the beneficiary's record. Units of service and SMA for FY 2007-08 are:

Service	Type of Unit of Service (UOS)	Non-perinatal UOS	Perinatal UOS	Rate
Day Care Rehabilitative	Face-to-Face Visit	$67.55 for EPSDT only	$79.92	Statewide Maximum Allowance
Naltrexone Treatment	Face-to-Face Visit	$21.19	N/A	Statewide Maximum Allowance
Outpatient Drug-Free Treatment	Face-to-Face Individual Group	$74.79 $31.56	$106.08 $63.62	Statewide Maximum Allowance
Perinatal Residential	Residential Day	N/A	$96.81	Statewide Maximum Allowance

ARTICLE III. PROVISION OF SERVICE

A. Covered Services

1. Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for covered services in the Contractor's service area. Covered services include:

   (a) Outpatient drug-free treatment;

   (b) Narcotic replacement therapy;

   (c) Naltrexone treatment;

   (d) Day care rehabilitative (pregnant or postpartum, and EPSDT only); and,

   (e) Perinatal residential AOD treatment services (excluding room and board).

2. In the event of a conflict between the definition of services contained in this Exhibit D and the definition of services in Sections 51341.1, 51490.1, and 51516.1 of Title 22, the provisions of Title 22 shall govern.

B. Federal and State Mandates

1. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

2. Contractor shall comply with any additional legal requirements including, but not limited to, any court-ordered requirements and statutory or regulatory amendments to existing law (including changes in covered services) that are imposed or are effective subsequent to the execution of this Contract. Contractor agrees that this Contract shall be amended to reflect such requirements, amendments, or changes.

3. Contractor shall comply with federal and state mandates to provide alcohol and other drug treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) youth under age 21 who are eligible under the EPSDT Program.

4. Contractor shall comply with the California Family Code Section 6929 in the provision of Minor Consent Medi-Cal Services.

5. Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services in its service area. Such services shall not be limited due to budgetary constraints.

   (a) When a request for covered services is made by a beneficiary, Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.

   (b) Contractor shall submit, and shall require its Subcontractors to submit, information required by the State. The information shall include, but is not limited to, data as required pursuant to the following:

   Document 1K: Drug and Alcohol Treatment Access Report (DATAR) in an electronic format as provided and/or approved by the State, which complies with the Department of Alcohol and Drug Programs (ADP) compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method. Effective July 1, 2007, the format for submission shall be limited to electronic format only.

   Document 3J: California Outcomes Measurement System (CalOMS) Treatment records – Submit CalOMS treatment admission, discharge, annual update, or "provider no activity report" records in an electronic format provided and/or approved by the State, which complies with ADP compliance requirements for data content, data quality, data completeness, reporting frequency, reporting deadlines, and report method. Meet re-certification requirements whenever there are substantial changes to the Contractor's CalOMS Treatment system.

   (c) Contractor agrees that it shall submit all data requested in (a) and (b) in a manner identified, or on forms provided, by the State by the applicable due dates or the dates in Document 1F, "Matrix of Documents, Reports and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs."

(d) Contractor shall require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

6. Covered services, whether provided directly by the Contractor or through subcontractors with DMC certified programs, shall be provided to beneficiaries without regard to the beneficiaries' county of residence.

7. In the event Contractor fails to comply with subdivisions 1 through 6 of this Section, the State may terminate this Contract for cause.

8. Contractor shall notify the State in writing prior to reducing the provision of covered services. In addition, any proposal to change the location where covered services are provided, or to reduce their availability, shall be submitted in an application to the State sixty (60) days prior to the proposed effective date. Contractor shall not implement the proposed changes if the State denies the Contractor's proposal.

9. Contractor shall amend its subcontracts for covered services in order to provide sufficient DMC SGF to match allowable federal Medicaid reimbursements for any increase in provider DMC services to beneficiaries.

10. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

11. In the event that the Contractor fails to provide covered services in accordance with the provisions of this Contract, at the discretion of the State, Contractor may be required to forfeit its DMC SGF allocation and surrender its authority to function as the administrator of covered services in its service area.

12. The failure of the Contractor or its Subcontractors to comply with Section B of this Article will be deemed a breach of this Contract sufficient to terminate this Contract for cause. In the event the Contract is terminated, the provision of Exhibit B, Paragraph G, subsections 2, 3, and 4 shall apply.

C. Provider Participation, Certification, Recertification, and Appeals

1. State will review and certify eligible providers to participate in the DMC program. Certification agreements will not be time limited. State will conduct recertification on-site visits at clinics for circumstances identified in the "Drug Medi-Cal Certification Standards for Substance Abuse Clinics", (Document 2E). Document 2E contains the appeal process in the event the State disapproves a provider's request for certification or recertification and shall be included in the Contractor's subcontracts.

2. Contractor shall include a provision in its subcontracts informing the provider that it may seek assistance from the State in the event of a dispute over the terms and conditions of subcontracts.

3. Contractor shall require all the providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:

   (a) Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;

   (b) Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Document 2E);

   (c) Title 22, Sections 51341.1, 51490.1, and 51516.1, (Document 2C);

   (d) Standards for Drug Treatment Programs (October 21, 1981) (Document 2F); and

   (e) Title 9, Sections 10000, et seq.

   In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

   Contractor acknowledges that if a provider is under investigation by DHCS or any state, local or federal law enforcement agency for fraud or abuse, the State may temporarily suspend the provider from the DMC program, pursuant to W&IC Section 14043.36(a).

   Contractor and Subcontractors shall participate in DMC orientation training sessions as prescribed by the Department.

4. If, at any time, a Subcontractor's license, registration, certification or approval to operate an AOD treatment program or provide a covered service is revoked, suspended, modified, or not renewed, the State may amend this Contract.

   A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere

ARTICLE IV. FISCAL PROVISIONS

A. Reimbursements

To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Contract, the State agrees to pay the Contractor DMC SGF and federal Medicaid funds according to Article V. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds for allowable expenditures as established by the federal government and approved by DHCS, for the cost of services rendered to beneficiaries.

1. Reimbursement for covered services shall be made in accordance with applicable provisions of Title 22 and all other currently applicable policies and procedures.

2. It is understood and agreed that failure by the Contractor or its Subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the Contractor. If the State, DHCS, or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to the State the federal Medicaid funds and SGF it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

   Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a). This requirement does not apply to the DMC PSPP Utilization Reviews.

   The State shall refund to the Contractor any recovered Drug Medi-Cal overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Title 22, CCR, Section 51047(e).

3. This Contract encumbers a specific amount of DMC SGF to be used in accordance with the Contractor's allocation as described in the State's final allocation notice. This amount is intended to cover all anticipated need for DMC SGF covered services. If the need for allowable DMC services is less than anticipated in any particular fiscal year, the State may reduce the contract amount of DMC SGF through a contract amendment, the cost settlement process, or other available processes. If, during the term of this Contract, Contractor's cost for allowable DMC services is anticipated to exceed the maximum amount allowed for services described in Exhibit D, and the Contractor anticipates utilizing all available DMC SGF allocated for the

State match, Contractor shall submit a written request by submission of a budget to the State for additional DMC SGF funding.

4. Contractor shall use DMC SGF without DMC FFP to fund Drug Medi-Cal services to clients eligible for those services but not eligible for federal funding under Title XIX of the Social Security Act (42 U.S.C. Ch. 7, Subch. XIX).

B. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit D. Any federal Medicaid funds and DMC SGF paid to the Contractor, but not expended for DMC services shall be returned to the State.

C. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Contract may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Contract was not executed until after that determination. If so, State may amend the amount of funding provided for in this Contract based on the actual congressional appropriation.

D. Additional Restrictions

This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

E. Amendment or Cancellation Due to Insufficient Appropriation

This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purpose of the DMC program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this program, State has the option to void this contract or to amend the Contract to reflect any reduction of funds.

F. Exemptions

Exemptions to the provisions of Section E, above, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the contract.

G. Payment for Covered Services

Any payment for covered services rendered pursuant to this Exhibit D shall only be made pursuant to applicable provisions of Title XIX of the Social Security Act; the W&IC; the HSC; California's Medicaid State Plan; and Sections 51341.1, 51490.1, 51516.1, and 51532 of Title 22.

1. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, including any allowable county administrative costs, not to exceed the unit of service maximum rate.

   Pursuant to HSC Section 11758.42 (h), reimbursement to NTP providers shall be limited to the lower of either the uniform statewide monthly reimbursement rate, or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a Contractor to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A).)

2. Pursuant to HSC Section 11818(b)(2), Contractor shall reimburse providers that receive a combination of Medi-Cal funding and other federal or state funding for the same service element and location based on the provider's actual costs in accordance with Medi-Cal reimbursement requirements as specified in Title XIX of the Social Security Act; Title 22, and the state's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.

H. Allowable Costs

Allowable costs, as used in Section 51516.1 of Title 22 shall be determined in accordance with Title 42, CFR Parts 405 and 413, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov." In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for Medi-Cal administrative activities.

I. Records and Additional Audit Requirements

1. Accurate fiscal records and supporting documentation shall be maintained by the Contractor and its Subcontractors to support all claims for reimbursement. All records must be capable of verification by auditors.

2. Should a Subcontractor discontinue operations, Contractor shall retain the Subcontractor's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records retaining to state funds. Contractor shall follow SAM requirements.

   If the Contractor cannot physically maintain the fiscal and program records of the Subcontractor, then arrangements shall be made with the State to take possession and maintain all records.

3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the Bureau of State Audits has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not begun within three years, the interim settlement shall be considered as the final settlement.

   Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government, the State, or DHCS has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all audit issues.

4. In addition to the audit requirements set forth in Exhibit B, State may also conduct financial audits of DMC programs, exclusive of NTP services provided on or after July 1, 1997, to accomplish any of, but not limited to, the following audit objectives:

   (a) To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

   (b) To ensure that only the cost of allowable DMC activities are included in reported costs;

   (c) To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov, for comparison to the DMC cost per unit;

   (d) To review documentation of units of service and determine the final number of approved units of service;

(e) To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,

(f) To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

5. In addition to the audit requirements set forth in Exhibit B, State may conduct financial audits of NTP programs. For NTP services on or after July 1, 1997, the audits will address items 4(c) through 4(e) above, except that the comparison of the provider's usual and customary charge in 4(c) will be to the DMC USMR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:

(a) For those NTP providers required to submit a cost report pursuant to HSC Section 11758.46(j)(2), a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;

(b) A review of actual costs incurred for comparison to services claimed;

(c) A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;

(d) A review of the number of clients in group sessions to ensure that sessions include no less than four and no more than ten clients at the same time, with at least one Medi-Cal client in attendance;

(e) Computation of final settlement based on the lower of USMR rate or the provider's usual and customary charge to the general public; and,

(f) A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

6. Audit reports by the State and/or DHCS shall reflect all findings and any recommendations, adjustments, or corrective action necessary as a result of those findings.

7. Contractor shall be responsible for any disallowances taken by the Federal Government, State, the State, the Bureau of State Audits, or DHCS as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds.

8. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within one year from the date of the plan.

9. Contractor, in coordination with the State, must provide follow-up on all significant findings in the audit report, including findings relating to a Subcontractor, and submit the results to the State.

10. If differences cannot be resolved between the State and/or DHCS and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit D, Contractor may request an appeal in accordance with the appeal process described in the "DMC Audit Appeal Process," Document 1J(b), incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

    Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process.

11. Providers of DMC services shall, upon request, make available to the State its fiscal and other records to assure that such provider has adequate recordkeeping capability and to assure that reimbursement for covered DMC services are made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

    (a) Provider ownership, organization, and operation;

    (b) Fiscal, medical, and other recordkeeping systems;

    (c) Federal income tax status;

    (d) Asset acquisition, lease, sale, or other action;

    (e) Franchise or management arrangements;

    (f) Patient service charge schedules;

(g) Costs of operation;

(h) Cost allocation methodology;

(i) Amounts of income received by source and purpose; and,

(j) Flow of funds and working capital.

12. In the event this Contract is terminated, Contractor shall deliver all of its fiscal and program records pertaining to the performance of this Contract to the State, which will retain the records for the required retention period.

13. Contractor shall retain records of utilization review activities required in Article VI herein for a minimum of three (3) years.

ARTICLE V. INVOICE/CLAIM AND PAYMENT PROCEDURES

A. Payments

1. State shall reimburse the Contractor:

   (a) The DMC SGF amount upon approval by DHCS of the DMC claims and reports submitted in accordance with Article 5 of Section B, below.

   (b) The federal Medicaid amount upon approval by DHCS of the DMC claims and reports submitted in accordance with Article 5 Section B, below.

   (c) The federal Medicaid and DMC SGF:

      i At either the USMR rate or the provider's usual or customary charge to the general public for NTP's; or,

      ii At a rate that is the lesser of the projected cost or the maximum rate allowance for other DMC modalities.

2. State will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov.

3. Contractors and Subcontractors must accept, as payment in full, the amounts paid by the State in accordance with Title 22, CCR, Section 51516.1, plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the client. However, Contractors and Subcontractors may not deny services to any client eligible for DMC services on account of the client's inability to pay or location of eligibility. Contractors and Subcontractors may not demand any additional payment from the State, client, or other third party payers.

B. Drug Medi-Cal Claims and Reports

1. Contractors or providers that invoice the State or the County for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with the DMC Provider Billing manual.

   (a) Claims shall be submitted electronically in the Health Insurance Portability and Accountability Act (HIPAA) 837 format.

   (b) All claims shall be accompanied by a Drug Medi-Cal Monthly Summary Invoice (ADP 1592), Document 2H.

   (c) When applicable, claims shall be accompanied by Provider Report of Drug Medi-Cal Claims Adjustment (ADP 5035C), Document 2J.

   Note: The following forms shall be prepared as needed and retained by the provider for review by State staff:

   - Multiple Billing Override Certification (ADP 7700), Document 2K

   - Good Cause Certification (ADP 6065), Document 2L

2. In the absence of good cause documented on the Good Cause Certification (ADP 6065) form, claims that are not submitted within 30 days of the end of the month of service shall be denied. The existence of good cause shall be determined by the State in accordance with Title 22, CCR, Sections 51008 and 51008.5.

3. Claims for reimbursement shall include only those services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&IC, Sections 14132.44 and 14132.47.

4. Contractor shall utilize the Drug Medi-Cal Provider Billing Manual (for a copy, please contact your ADP Fiscal Management and Accountability Analyst) and the Companion Guide for HIPAA 837P and 835 Transactions (Document 2Y) for understanding and obtaining instructions for the DMC billing process.

C. Year-End Cost Settlement Reports

1. State will not accept year-end cost settlement reports from the Subcontractor(s) directly. Pursuant to HSC Section 11758.46 (j)(2) Contractor shall submit to the State, on November 1 of each year, the following documents by paper or electronic submission for the previous fiscal year:

   (a) Document 2P, County Certification Year-End Claim for Reimbursement

   (b) Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Day Care Rehabilitative for Alcohol and Drug or Perinatal (if applicable)

(c) Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Alcohol and Drug or Perinatal (if applicable)

(d) Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Alcohol and Drug or Perinatal (if applicable)

(e) Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)

(f) Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs for Alcohol and Drug or Perinatal (if applicable)

(g) Electronic program as prescribed by the State that contains the detailed cost report data

2. State may settle costs for DMC services based on the year-end cost settlement report as the final amendment to the approved single State/County contract.

3. Reimbursement for covered services, other than NTP services, shall be limited to the lower of: (a) the provider's usual and customary charges to the general public for the same or similar services; (b) the provider's actual allowable costs; or (c) the DMC SMA for the modality.

4. Reimbursement to NTP's shall be limited to the lower of either the USMR rate, pursuant to HSC Section 11758.42(h)(1), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (HSC Section 11758.42(h)(2)(A)).

ARTICLE VI. POSTSERVICE POSTPAYMENT UTILIZATION REVIEW

A. State shall conduct Postservice Postpayment (PSPP) utilization reviews in accordance with Title 22 Section 51341.1. Any claimed DMC service may be reviewed for compliance with all applicable standards, regulations and program coverage after services are rendered and the claim paid.

B. State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate.

Contractor and/or Subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled pursuant to Title 22, CCR, Section 51015, in accordance with the Interagency Agreement between the State and DHCS. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Article IV, Division I, of this Contract.

C. State shall monitor the Subcontractor's compliance with PSPP utilization review requirements in accordance with Title 22. DHCS and the federal government may also review the existence and effectiveness of the State's utilization review system.

D. Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

E. Satellite sites must keep a record of the clients/patients being treated at that location. Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government, the State, or DHCS has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

LIST OF EXHIBIT D DOCUMENTS INCORPORATED BY REFERENCE* FISCAL YEAR 2007-08

The following documents are hereby incorporated by reference into Exhibit D of the combined County contract though they may not be physically attached to the contract:

Document 1F:	Matrix of Documents, Reports, and/or Data – County Submission Requirements for the Department of Alcohol and Drug Programs
Document 1H(a):	Service Code Descriptions
Document 1H(b):	Program Code Listing
Document 1J(b):	DMC Audit Appeal Process
Document 1K:	Drug and Alcohol Treatment Access Report http://www.adp.ca.gov/datar/gen_info.shtml
Document 1P:	Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)
Document 1W:	Certification Regarding Lobbying
Document 1X:	Disclosure of Lobbying Activities – Standard Form LLL
Document 2A:	Sobky v. Smoley, Judgment, Signed February 1, 1995
Document 2C:	Title 22, California Code of Regulations http://ccr.oal.ca.gov
Document 2E:	Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004) http://www.adp.ca.gov/dmc/pdf/DMCA_Drug_Medi-Cal_Certification_Standards.pdf
Document 2F:	Standards for Drug Treatment Programs (October 21, 1981) http://www.adp.ca.gov/dmc/pdf/DMCA_Standrds_for_Drug_Treatment_Programs.pdf
Document 2H:	Drug Medi-Cal Monthly Summary Invoice (ADP 1592)
Document 2J:	Provider Report of Drug Medi-Cal Claims Adjustments (ADP 5035C) – Form/Instructions

Document 2K:	Multiple Billing Override Certification (ADP 7700)
Document 2L:	Good Cause Certification (ADP 6065)
Document 2P:	County Certification - Cost Report Year-End Claim For Reimbursement
Document 2P(a):	Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Alcohol and Drug (forms and instructions)
Document 2P(b):	Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Perinatal (forms and instructions)
Document 2P(c):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Alcohol and Drug (forms and instructions)
Document 2P(d):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Perinatal (forms and instructions)
Document 2P(e):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Alcohol and Drug (forms and instructions)
Document 2P(f):	Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Perinatal (forms and instructions)
Document 2P(g):	Drug Medi-Cal Cost Report Forms – Residential – Perinatal (forms and instructions)
Document 2P(h):	Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Alcohol and Drug (forms and instructions)
Document 2P(i):	Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Perinatal (forms and instructions)
	http://www.adp.ca.gov/ADPLTRS/97-52.shtml
Document 2Y:	Companion Guide for HIPAA 837P and 835 Transactions
	http://www.adp.ca.gov/hp/hipaa.shtml
Document 3E	ADP Bulletin #05-03 – HIPAA Drug Medi-Cal Claim Submission Policy
	http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_05-03.pdf
Document 3F	ADP Bulletin #05-10 – Acceptable Drug Medi-Cal Claim Format for Processing
	http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_05-10.pdf

Document 3G	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs http://www.calregs.com
Document 3H	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors http://www.calregs.com
Document 3J	CalOMS Treatment Data Collection Guide http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Collection_Guide_2007-05.pdf
Document 3K	Business Associate Agreement: County is the Business Associate of the Department of Alcohol and Drug Programs