AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND BAY AREA COMMUNITY SERVICES, INC.

This Agreement is entered into this ____ day of _____, 2026, by and between the County of San Mateo, a political subdivision of the state of California, hereinafter called "County," and Bay Area Community Services, Inc., hereinafter called "Contractor."

* * *

Whereas, pursuant to Section 31000 of the California Government Code, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof; and

Whereas, it is necessary and desirable that Contractor be retained for the purpose of providing Full-Service Partnership (FSP) Services Programs.

Now, therefore, it is agreed by the parties to this Agreement as follows:

1. Exhibits and Attachments

The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

Exhibit A – Services
Exhibit AR – Behavioral Health and Recovery Services Requirement
Exhibit B - Payments and Rates
Exhibit C – San Mateo County Mental Health CalAIM Contractor Outpatient Rates
Attachment H - HIPAA Business Associate Requirements
Attachment I - § 504 Compliance
Attachment T – Sample Template for Disaster and Emergency Response Plan

2. Services to be performed by Contractor

In consideration of the payments set forth in this Agreement and in Exhibit B, Contractor shall perform services for County in accordance with the terms, conditions, and specifications set forth in this Agreement and in Exhibit A.

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A, County shall make payment to Contractor based on the rates and in the manner specified in Exhibit B. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. In no event shall County's total fiscal

obligation under this Agreement exceed FIVE MILLION TWO HUNDRED TWENTY-NINE THOUSAND NINE HUNDRED NINETY-SEVEN DOLLARS ($5,229,997). In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the County at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

4. Term

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2026, through June 30, 2028.

5. Termination

This Agreement may be terminated by Contractor or by the Chief of San Mateo County Health or his/her designee at any time without a requirement of good cause upon thirty (30) days' advance written notice to the other party. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that prorated portion of the full payment determined by comparing the work/services actually completed to the work/services required by the Agreement.

County may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon the unavailability of Federal, State, or County funds by providing written notice to Contractor as soon as is reasonably possible after County learns of said unavailability of outside funding.

County may terminate this Agreement for cause. In order to terminate for cause, County must first give Contractor notice of the alleged breach. Contractor shall have five business days after receipt of such notice to respond and a total of ten calendar days after receipt of such notice to cure the alleged breach. If Contractor fails to cure the breach within this period, County may immediately terminate this Agreement without further action. The option available in this paragraph is separate from the ability to terminate without cause with appropriate notice described above. In the event that County provides notice of an alleged breach pursuant to this section, County may, in extreme circumstances, immediately suspend performance of services and payment under this Agreement pending the resolution of the process described in this paragraph. County has sole discretion to determine what constitutes an extreme circumstance for purposes of this paragraph, and County shall use reasonable judgment in making that determination.

6. Contract Materials

At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by Contractor under this Agreement shall become the property of County and shall be promptly delivered to County. Upon termination, Contractor may make and retain a copy of such contract materials if permitted by law.

7. Relationship of Parties

Contractor agrees and understands that the work/services performed under this Agreement are performed as an independent contractor and not as an employee of County and that neither Contractor nor its employees acquire any of the rights, privileges, powers, or advantages of County employees.

8. Hold Harmless

a. General Hold Harmless

Contractor shall indemnify and save harmless County and its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description resulting from this Agreement, the performance of any work or services required of Contractor under this Agreement, or payments made pursuant to this Agreement brought for, or on account of, any of the following:

(A) injuries to or death of any person, including Contractor or its employees/officers/agents;

(B) damage to any property of any kind whatsoever and to whomsoever belonging;

(C) any sanctions, penalties, or claims of damages resulting from Contractor's failure to comply, if applicable, with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended; or

(D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of County and/or its officers, agents, employees, or servants. However, Contractor's duty to indemnify and save harmless under this Section shall not apply to injuries or damage for which

County has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

b. Intellectual Property Indemnification

Contractor hereby certifies that it owns, controls, and/or licenses and retains all right, title, and/or interest in and to any intellectual property it uses in relation to this Agreement, including the design, look, feel, features, source code, content, and/or other technology relating to any part of the services it provides under this Agreement and including all related patents, inventions, trademarks, and copyrights, all applications therefor, and all trade names, service marks, know how, and trade secrets (collectively referred to as "IP Rights") except as otherwise noted by this Agreement.

Contractor warrants that the services it provides under this Agreement do not infringe, violate, trespass, or constitute the unauthorized use or misappropriation of any IP Rights of any third party. Contractor shall defend, indemnify, and hold harmless County from and against all liabilities, costs, damages, losses, and expenses (including reasonable attorney fees) arising out of or related to any claim by a third party that the services provided under this Agreement infringe or violate any third-party's IP Rights provided any such right is enforceable in the United States. Contractor's duty to defend, indemnify, and hold harmless under this Section applies only provided that: (a) County notifies Contractor promptly in writing of any notice of any such third-party claim; (b) County cooperates with Contractor, at Contractor's expense, in all reasonable respects in connection with the investigation and defense of any such third-party claim; (c) Contractor retains sole control of the defense of any action on any such claim and all negotiations for its settlement or compromise (provided Contractor shall not have the right to settle any criminal action, suit, or proceeding without County's prior written consent, not to be unreasonably withheld, and provided further that any settlement permitted under this Section shall not impose any financial or other obligation on County, impair any right of County, or contain any stipulation, admission, or acknowledgement of wrongdoing on the part of County without County's prior written consent, not to be unreasonably withheld); and (d) should services under this Agreement become, or in Contractor's opinion be likely to become, the subject of such a claim, or in the event such a third party claim or threatened claim causes County's reasonable use of the services under this Agreement to be seriously endangered or disrupted, Contractor shall, at Contractor's option and expense, either: (i) procure for County the right to continue using the services without infringement or (ii) replace or modify the services so that they become non-infringing but remain functionally equivalent.

Notwithstanding anything in this Section to the contrary, Contractor will have no obligation or liability to County under this Section to the extent any otherwise covered claim is based upon: (a) any aspects of the services under this Agreement which have been modified by or for County (other than modification performed by, or at the direction of, Contractor) in such a way as to cause the alleged infringement at issue; and/or (b) any aspects of the services under this Agreement which have been used by County in a manner prohibited by this Agreement.

The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

9. Assignability and Subcontracting

Contractor shall not assign this Agreement or any portion of it to a third party or subcontract with a third party to provide services required by Contractor under this Agreement without the prior written consent of County. Any such assignment or subcontract without County's prior written consent shall give County the right to automatically and immediately terminate this Agreement without penalty or advance notice.

10. Insurance

a. General Requirements

Contractor shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by County's Risk Management, and Contractor shall use diligence to obtain such insurance and to obtain such approval. Contractor shall furnish County with certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending Contractor's coverage to include the contractual liability assumed by Contractor pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to County of any pending change in the limits of liability or of any cancellation or modification of the policy.

b. Workers' Compensation and Employer's Liability Insurance

Contractor shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, Contractor certifies, as required by Section 1861 of the California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for

workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

c. Liability Insurance

Contractor shall take out and maintain during the term of this Agreement such bodily injury liability and property damage liability insurance as shall protect Contractor and all of its employees/officers/agents while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from Contractor's operations under this Agreement, whether such operations be by Contractor, any subcontractor, anyone directly or indirectly employed by either of them, or an agent of either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amounts specified below:

(a) Comprehensive General Liability…….	$1,000,000
(b) Motor Vehicle Liability Insurance…….	$1,000,000
(c) Professional Liability……..…….	$1,000,000

County and its officers, agents, employees, and servants shall be named as additional insured on any such policies of insurance, which shall also contain a provision that (a) the insurance afforded thereby to County and its officers, agents, employees, and servants shall be primary insurance to the full limits of liability of the policy and (b) if the County or its officers, agents, employees, and servants have other insurance against the loss covered by such a policy, such other insurance shall be excess insurance only.

In the event of the breach of any provision of this Section, or in the event any notice is received which indicates any required insurance coverage will be diminished or canceled, County, at its option, may, notwithstanding any other provision of this Agreement to the contrary, immediately declare a material breach of this Agreement and suspend all further work and payment pursuant to this Agreement.

11. Compliance With Laws

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, ordinances, regulations, and executive orders, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Regulations promulgated thereunder, as amended (if applicable), the Business Associate requirements set forth in Attachment H (if attached), the Americans with

Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability in programs and activities receiving any Federal or County financial assistance, as well as any required economic or other sanctions imposed by the United States government or under state law in effect during the term of the Agreement. Such services shall also be performed in accordance with all applicable ordinances and regulations, including but not limited to appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and any applicable State, Federal, County, or municipal law, regulation, or executive order, the requirements of the applicable law, regulation, or executive order will take precedence over the requirements set forth in this Agreement.

Further, Contractor certifies that it and all of its subcontractors will adhere to all applicable provisions of Chapter 4.107 of the San Mateo County Ordinance Code, which regulates the use of disposable food service ware. Accordingly, Contractor shall not use any non-recyclable plastic disposable food service ware when providing prepared food on property owned or leased by the County and instead shall use biodegradable, compostable, reusable, or recyclable plastic food service ware on property owned or leased by the County. (This paragraph may be deleted without County Attorney Review if not relevant to this agreement)

Contractor will timely and accurately complete, sign, and submit all necessary documentation of compliance.

12. Non-Discrimination and Other Requirements

a. General Non-discrimination

No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

b. Equal Employment Opportunity

Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County upon request.

c. Section 504 of the Rehabilitation Act of 1973

Contractor shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to contractors who are providing services to members of the public under this Agreement.

d. Compliance with County's Equal Benefits Ordinance

Contractor shall comply with all laws relating to the provision of benefits to its employees and their spouses or domestic partners, including, but not limited to, such laws prohibiting discrimination in the provision of such benefits on the basis that the spouse or domestic partner of the Contractor's employee is of the same or opposite sex as the employee.

e. Discrimination Against Individuals with Disabilities

The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

f. History of Discrimination

Contractor certifies that no finding of discrimination has been issued in the past 365 days against Contractor by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other investigative entity. If any finding(s) of discrimination have been issued against Contractor within the past 365 days by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or other investigative entity, Contractor shall provide County with a written explanation of the outcome(s) or remedy for the discrimination prior to execution of this Agreement. Failure to comply with this Section shall constitute a material breach of this Agreement and subjects the Agreement to immediate termination at the sole option of the County.

g. Reporting; Violation of Non-discrimination Provisions

Contractor shall report to the County Executive Officer the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or the Section titled "Compliance with Laws". Such duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Executive Officer, including but not limited to the following:

i. termination of this Agreement;
ii. disqualification of the Contractor from being considered for or being awarded a County contract for a period of up to 3 years;
iii. liquidated damages of $2,500 per violation; and/or
iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Executive Officer.

To effectuate the provisions of this Section, the County Executive Officer shall have the authority to offset all or any portion of the amount described in this Section against amounts due to Contractor under this Agreement or any other agreement between Contractor and County.

h. Compliance with Living Wage Ordinance

As required by Chapter 2.88 of the San Mateo County Ordinance Code, Contractor certifies all contractor(s) and subcontractor(s) obligated under this contract shall fully comply with the provisions of the County of San Mateo Living Wage Ordinance, including, but not limited to, paying all Covered Employees the current Living Wage and providing notice to all Covered Employees and Subcontractors as required under the Ordinance.

13. Anti-Harassment Clause

Employees of Contractor and County shall not harass (sexually or otherwise) or bully or discriminate against each other's employee on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender

identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information. Any misconduct by Contractor's employees towards County employees may be grounds for termination of the Contract. Contractor shall timely address any allegations of their employee's misconduct by a County employee including immediately removing that employee from work on the Contract.

14. Compliance with County Employee Jury Service Ordinance

Contractor shall comply with Chapter 2.85 of the County's Ordinance Code, which states that Contractor shall have and adhere to a written policy providing that its employees, to the extent they are full-time employees and live in San Mateo County, shall receive from the Contractor, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with Contractor or that the Contractor may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, Contractor certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if Contractor has no employees in San Mateo County, it is sufficient for Contractor to provide the following written statement to County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply unless this Agreement's total value listed in the Section titled "Payments", exceeds two-hundred thousand dollars ($200,000); Contractor acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value exceeds that threshold amount.

15. Retention of Records; Right to Monitor and Audit

(a) Contractor shall maintain all required records relating to services provided under this Agreement for three (3) years after County makes final payment and all other pending matters are closed, and Contractor shall be subject to the examination and/or audit by County, a Federal grantor agency, and the State of California.

(b) Contractor shall comply with all program and fiscal reporting requirements set forth by applicable Federal, State, and local agencies and as required by County.

(c) Contractor agrees upon reasonable notice to provide to County, to any Federal or State department having monitoring or review authority, to County's authorized representative, and/or to any of their respective audit agencies access to and the right

to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules, and regulations, to determine compliance with this Agreement, and to evaluate the quality, appropriateness, and timeliness of services performed.

16. Merger Clause; Amendments

This Agreement, including the Exhibits and Attachments attached to this Agreement and incorporated by reference, constitutes the sole Agreement of the parties to this Agreement and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement, or specification set forth in the body of this Agreement conflicts with or is inconsistent with any term, condition, provision, requirement, or specification in any Exhibit and/or Attachment to this Agreement, the provisions of the body of the Agreement shall prevail. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications or amendments shall be in writing and signed by the parties.

17. Controlling Law; Venue

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

18. Notices

Any notice, request, demand, or other communication required or permitted under this Agreement shall be deemed to be properly given when both: (1) transmitted via facsimile to the telephone number listed below or transmitted via email to the email address listed below; and (2) sent to the physical address listed below by either being deposited in the United States mail, postage prepaid, or deposited for overnight delivery, charges prepaid, with an established overnight courier that provides a tracking number showing confirmation of receipt.

In the case of County, to:

Name/Title:	Ally Hoppis, Clinical Services Manager
Address:	802 Brewster Avenue, Redwood City, CA 94063
Telephone:	(650) 399-6783
Email:	ahoppis@smcgov.org

In the case of Contractor, to:

Name/Title: Jamie Alamanza, CEO
Address: 390 40th Street, Oakland, CA 94609
Telephone: (510) 613-0330
Facsimile: (510) 569-4589
Email: jalmanza@bayareacs.org

19. Electronic Signature

Both County and Contractor wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and County's Electronic Signature Administrative Memo. Any party to this Agreement may revoke such agreement to permit electronic signatures at any time in relation to all future documents by providing notice pursuant to this Agreement.

20. Payment of Permits/Licenses

Contractor bears responsibility to obtain any license, permit, or approval required from any agency for work/services to be performed under this Agreement at Contractor's own expense prior to commencement of said work/services. Failure to do so will result in forfeit of any right to compensation under this Agreement.

* * *

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For Contractor: BAY AREA COMMUNITY SERVICES, INC.

Signed by: Jamie Alamanza 2CFE83C6436342A...	05/26/2026	Jamie Alamanza
Contractor Signature	Date	Contractor Name (please print)

COUNTY OF SAN MATEO

By:

President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:

Clerk of Said Board

In consideration of the payments set forth in Exhibit B, Contractor shall provide the following services:

I. Full-Service Partnership (FSP) Services Program

The Behavioral Health and Recovery Services (BHRS or "County") Adult and Older Adult Full-Service Partnership (FSP) programs provide comprehensive, intensive community-based behavioral health and housing support services to the highest risk adults and highest risk older adults/medically fragile adults living with a severe mental illness and/or substance use disorders in San Mateo County.

The purpose of FSP program is to assist eligible clients to achieve independence, stability and wellness within the context of their cultures, and communities. Adult FSP services will be based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help clients progress toward recovery, health, and well-being. Services aim to help clients increase their ability to function at optimal levels, promote housing stability and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations and justice-system involvement.

Contractor shall operate the FSP program in alignment with Behavioral Health Services Act (BHSA) requirements for high-intensity service models, including Assertive Community Treatment (ACT), Forensic ACT (FACT), and FSP Intensive Case Management (ICM), as applicable to the agreed-upon level(s) of care. Contractor shall maintain written policies and procedures describing the FSP service model, staffing pattern, and service delivery approach consistent with the applicable evidence-based practices (EBP) or interventions adopted by the County (e.g., ACT/FACT, FSP ICM, Individual Placement and Support (IPS) model for supported employment, and other EBPs identified in County guidance)

Contractor shall work with County staff to implement these services in accordance with requirements of the California BHSA requirements.

A. Values and Principles

1. "Whatever It Takes": FSP services are delivered with a high level of intensity and flexibility, using a "whatever it takes" approach to support clients in meeting their goals, including frequent contact, assertive outreach, and field-based services as clinically appropriate. Services are adjusted in intensity over time based on client need rather than program convenience.

2. Evidence Based: Services are grounded in evidence-based and promising practices appropriate to the FSP level of care (e.g., ACT, FACT, ICM, and other EBPs adopted by the County).

3. Community Based: Community-based services are those that foster the greatest independence in the least restrictive, most accessible, familiar setting. A substantial proportion of services are provided in the community (e.g., homes, shelters, encampments, workplaces, and other natural settings) that are responsive to client needs.

4. Strength-Based and Person-Centered: Services build on each client's strengths, preferences, culture, and goals. Client participation is voluntary and treatment and support plans are developed collaboratively, are person-centered rather than program-driven, and are regularly updated based on client feedback and changing needs.

5. Integrated Care: Services will ensure that mental health and substance use treatment are integrated to meet the needs of clients with co-occurring disorders. Substance use needs are to be identified and addressed as soon as possible and appropriate treatment and/or referrals provided that are tailored to the clients' unique needs and engage families and the community as appropriate.

6. Collaboration and System Navigation: FSP teams collaborate with physical health, housing, justice, social services, education, and other systems to coordinate care and advocate on behalf of clients.

7. Whole Person Care: Services will use a whole person care model of treatment, as opposed to a medical model, meaning health and wellness are based on the well-being of the whole person, including all areas that contribute to wellness, such as emotional, financial, social, spiritual, occupational health.

8. Equity and Responsive Care: Services are designed and delivered to promote equity in access, quality, and outcomes across race, ethnicity, language, gender identity, sexual orientation, disability, socioeconomic status, and other identities. Barriers to engagement are actively identified and reduced, including through flexible hours, locations, modalities, and culturally responsive approaches including the use of language access services.

9. Trauma-Informed: Services will incorporate all six key principles of a trauma-informed approach: safety, trustworthiness and transparency, peer support, collaboration, empowerment and cultural, historical and gender issues.

10. Recovery Oriented: Services are to be recovery based and guided by an individualized plan developed between client and staff. Staff will employ a

variety of supportive recovery techniques to encourage clients to assume responsibility for their own wellness and recovery.

11. Lived Experience: Persons with lived experience with mental illness or substance use are actively recruited for staff positions so as to incorporate the client perspective throughout the agency. Efforts will be made to develop specific positions for persons with lived experience.

12. Peer Supports: Clients are provided self-help and peer support opportunities, including access to peer staff and peer-run groups. Peer support offers hope, models recovery, and helps clients build trusting relationships and natural supports.

13. Family Engagement: Services will integrate client's family members or other supportive people into treatment whenever possible when the client consents to their involvement. Clients will be given ongoing opportunities to choose which family members or other supportive people, if any, they would like to be involved.

14. Shared Decision-Making: clients will be encouraged to have an active role in making decisions about program operations through an advisory board or similar structure. Substantive changes in program structure and service operations will be communicated back to clients via the FSP governing board or other communication method.

B. FSP Program Goals

1. FSP services will be provided across all County designated FSP levels of care (e.g., ACT, FACT, ICM, etc.), ensuring that clients are served at the least restrictive, medically necessary level of care and are able to step up or down in intensity as their needs change.

2. Divert adults and older adults with serious mental illness (SMI) and/or substance use disorders (SUD) and other complex needs from the criminal justice system.

3. Provide a "whatever it takes" approach to outreach, engagement, and ongoing supports to engage and retain adults and older adults living with SMI and/or SUD in voluntary services and in partnership with them, to achieve their individual wellness and recovery goals.

4. Utilize culturally responsive, linguistically appropriate, and community-defined practices to increase the likelihood of positive behavioral health outcomes for racially, ethnically, and culturally diverse clients and other underserved communities.

5. Maximize the use of community based, field based, and preventative services and supports, thereby reducing avoidable use of crisis, emergency, and institutional care and improving continuity of care across levels of care.

6. Implement best practice strategies for permanent housing, tenancy supports employment, education, recreation, socialization, peer support, and self help that increase community integration and collaboration.

7. Address substance use needs by providing assertive, field-based initiation for SUD treatment services, rapid access and initiation of medications for addiction treatment (MAT), and linkage or warm handoff to ongoing SUD care.

C. Priority Outcomes

1. Increased stable housing
2. Reduced criminal justice involvement
3. Reduced utilization of psychiatric facilities
4. Increased rapid initiation of SUD treatment
5. Increased social connectedness
6. Improved quality of life
7. Increased meaningful use of time and sense of purpose (e.g., employment, volunteering, education)
8. Decreased disparities in engagement and retention

II. POPULATION TO BE SERVED

The FSP program will be open to adults and older adults meeting the population criteria described below, however special consideration is directed towards historically underserved populations including but not limited to Asian-American, Native Hawaiian and Pacific Islander, Latinx and African American, LGBTQ+ and justice involved populations.

Adults living with serious mental illness (SMI) or co-occurring serious mental illness and moderate/severe substance use disorders (SMI/SUD) with functional impairment served by the FSP will often present with histories of hospitalization, institutionalization, co-occurring conditions, are not engaged in medication treatment, and have difficulty in participating in structured activities and living independently. Some individuals may have histories of assaultive behavior. It is possible that many clients may have resided in long-term care facilities for extended periods. For some of these individuals, patterns of service have relied almost exclusively on emergency and institutional care. Others have bounced in and out of every type of service without improved outcomes.

Older adults with SMI or SMI/SUD will often present with cognitive difficulties and medical comorbidities. Some SMI or SMI/SUD adults and older adults may be medically fragile. This group of clients may have resided in long-term care facilities for extended periods or be at risk of placement. The program will serve as a step-down program for

acute care, locked placements, and skilled nursing facilities in order to avoid prolonged institutional placements that often hasten the loss of an individual's sense of wellness, independence, and overall quality of life. Population criteria are as follows:

1. Individuals whose SMI or SMI/SUD and the complex nature of their diagnoses and medical or other concerns result in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of incarceration or institutional placement.

2. Individuals who meet the CARE Court eligibility criteria.

3. Adults with SMI or SMI/SUD who may be disengaged from services and have a history of not following through with treatment for their mental illness, have previously refused treatment and are challenged to live safely and stably in the community.

4. Adults with SMI or SMI/SUD and current incarceration, and for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re- hospitalization.

5. Adults with SMI or SMI/SUD currently placed in locked MH facilities; the FSP will explicitly target individuals living in sub-acute locked facilities located outside the county as a step-down, enabling them to return to their community. Many of these individuals will have behavioral problems that have caused them to be viewed as "difficult" IMD residents.

6. Older adults with SMI or SMI/SUD who are medically fragile and may have additional complex issues are at risk of institutionalization or currently institutionalized and who, with more intensive supports, could live in a community setting.

III. ELIGIBILITY CRITERIA

Clients will be referred for FSP services (CARE, SB43) based on acuity and need for intensive level community-based services. BHRS FSP Review Committee will determine eligibility by assessing and determining appropriate medical necessity by age criteria and core focal population criteria. There is a possibility that the other core focal populations may be referred to FSP services.

1. Medical Necessity by Age Criteria

A. Eligibility criteria for beneficiary access is divided by age group.
   i. Category 1 is 18 to 21 years of age
   ii. Category 2 is above 21 years of age
B. Clients must meet either Category 1 or Category 2 and the Core Focal Population Criteria as described in items 2-4 below.

2. Category 1 (ages 18-21)

Clients must be between 18 to 21 years old and meet the following criteria:

A. The beneficiary has a condition placing them at high risk for a mental health and/or co-occurring mental health and moderate to severe substance use disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

B. The beneficiary meets both of the following requirements in items i) and ii) below:

i. The beneficiary has at least one of the following:
   a) A significant impairment
   b) A reasonable probability of significant deterioration in an important area of life functioning
   c) A reasonable probability of not progressing developmentally as appropriate.
   d) A need for specialty mental health and/or co-occurring mental health and moderate to severe substance use disorder services, regardless of presence of impairment, that are not included within the Medi-Cal managed care plan benefits.

ii. The beneficiary's condition as described in subparagraph (2.B.i) above is due to one of the following:
   a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders 5 and the International Statistical Classification of Diseases and Related Health Problems.
   b) A suspected mental health disorder that has not yet been diagnosed.
   c) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the medical necessity by age criteria as described above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

3. Category 2 (ages above 21)

Client must be above 21 years old and meet the following criteria:

A. Has a severe mental illness (SMI) (e.g., schizophrenia, bipolar disorder, schizoaffective disorders, or other serious mental health diagnosis resulting in significant impairments to functioning).

AND

B. Meets the medical necessity requirements for specialty mental health services, defined as meeting both items i. and ii. below:

i. The beneficiary must have one of the following:

a) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities)

OR

b) A reasonable probability of significant deterioration in an important area of life functioning.

ii. The beneficiary's condition in item i. above is due to:

a) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria

b) A suspected mental disorder that has not yet been diagnosed

4. Core Focal Population Criteria

Clients who meet at least one of the following core focal population criteria are eligible for enrollment into the Adult FSP program:

A. High utilizers of emergency or high acuity behavioral health services, as evidenced by, but not limited to at least one of the following:

i. An individual who has had three (3) or more visits to Psychiatric Emergency Services (PES)/Emergency Department (ED) due to psychiatric concern in the last 60 days

AND/OR

ii. An individual with at least two (2) inpatient psychiatric hospitalizations in the last 6 months with the most recent hospitalization in the past 30 days

AND/OR

iii. Transitioning out of a locked/secure facility and requiring field-based wrap around support to be successful in step down of current placement (i.e.,

Mental Health Rehabilitation Center (MHRC), Secured Skilled Nursing Facility (SNF), Jail with history of high psychiatric acuity need, or Out of County Placement)

AND/OR

iv. Loss of current support system that would potentially result in hospitalization, incarceration or other form of locked placement without FSP level services based on past history. Lower level of community supports have been attempted but have been unsuccessful.

OR

B. CARE Court, must meet all criteria as defined by the CARE Act :

i. 18 years old and over

ii. Schizophrenia spectrum or other psychotic disorder, including Bipolar 1 with psychotic features

iii. Not stabilized in on-going voluntary treatment

iv. At least one of the following is true:

a) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
b) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as used in Section 5150.

OR

C. SB43 (Grave Disability expansion, adding severe substance use disorder as a reason for an involuntary hold and adding inability to provide for one's personal safety or necessary medical care as a reason for an involuntary hold) clients will meet the following criteria:

i. 18 years or older

ii. San Mateo County resident

iii. Diagnosis of severe substance use disorder based on DSM-5 criteria

iv. At risk of or recently found gravely disabled

v. History of complex mental health and/or substance use needs

D. Experiencing homelessness, at risk of homelessness, or chronically homeless (as per the BHSA Policy Manual Appendix A) who also meet the high utilizers core focal population criteria mentioned above.

For purposes of this Agreement, the following terms related to homelessness are summarized below. County and Contractor agree that, if there is any inconsistency between the summaries below and the BHSA Policy Manual, the BHSA Policy Manual supersedes.

i. Experiencing Homelessness means an individual or family who lacks a fixed, regular, and adequate night-time residence, including people:

a) Staying in places not meant for human habitation (for example, streets, vehicles, parks, abandoned buildings, encampments, or other outdoor locations).

b) Living in emergency shelters, transitional housing, or hotels/motels paid for by charitable or government programs.

c) Exiting institutions (such as hospitals, jails, or other facilities) who were homeless immediately before entry or became homeless during the stay.

d) It also includes individuals and families who will imminently lose their housing within a short time, have no subsequent residence identified, and lack resources or support networks to obtain other permanent housing, as well as certain youth and families who meet homelessness definitions under specified federal statutes or who are fleeing domestic or other violence and have no safe alternative housing.

ii. At-Risk of Homelessness (Summary)“At-risk of homelessness” means an individual or family who lacks sufficient resources or support networks to remain in their current housing and is likely to enter an emergency shelter or another homeless situation, and who meets at least one specified risk factor, such as:

a) Recent multiple moves due to economic reasons.

b) Doubling up in another person’s home because of economic hardship.

c) Written notice that they must leave their current housing within a short time (for example, 30 days).

d) Living in a hotel or motel they pay for themselves (not funded by assistance programs).

e) Living in overcrowded or otherwise unstable housing conditions or exiting institutions or systems of care without stable housing identified.

f) It also includes certain children, youth, and families who are considered homeless under specified federal education and youth statutes but do not otherwise meet the “experiencing homelessness” definition above.

iii. Chronically Homeless means an individual (or family with an adult or minor head of household) who:

a) Has a qualifying disability; and

b) Has been living in a place not meant for human habitation, a safe haven, or an emergency shelter for extended or repeated periods such that the total time homeless over the last three years is at least 12 months (on any number of occasions); or

c) Is exiting an institution and met these criteria immediately prior to entering the institution.

IV. PROJECTED CAPACITY

BACS CARE FSP	**60 FSP SLOTS**
BACS SB43 FSP	**25 FSP SLOTS**

V. FSP SERVICE REQUIREMENTS

Adult FSP programs will provide and/or facilitate provision of integrated mental health, physical health, and substance use services to highly vulnerable individuals with complex needs and/or co-occurring disorders. For individuals that are homeless, adult FSP programs will help them transition from street to home by providing immediate housing and related supports and ongoing coordination with County housing support services, transitional rent providers and long-term housing subsidy administrators, to ensure clients secure and maintain their housing.

Adult FSP services will be based on clients’ individual needs and goals, with a commitment to do “whatever it takes” to help them progress toward recovery, health, and well-being. Services aim to help clients increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations.

FSP services are based on the Assertive Community Treatment model (ACT), Forensic ACT (FACT) and FSP Intensive Case Management (ICM), as applicable to the agreed upon level(s) of care. FSP provider will need to work towards fidelity in a phased approach as required by BHSA.

Flex Funds are available to support individuals in their recovery by providing items necessary for daily living and community integration, such as food, clothing, transportation, schoolbooks/supplies, employment-related supplies, furnishings, appliances and one-time emergency rental assistance. FSP provider teams must effectively use all of these funds to support individuals in their recovery.

A. Minimum Service Requirements:

At minimum, adult and older adult FSP programs will include the following services:

1. Evidence-Based Practice (EBP) implementation (including ACT, FACT, FSP ICM, Individual Placement and Support (IPS) and BH-CONNECT)
2. Outreach and Ongoing Engagement
3. Enrollment
4. Assessment, Diagnosis, and Service Planning
5. Mental Health Services (including individual therapy and psychiatry)
6. Co-Occurring Capacity (including ASAM screening and medications for addiction treatment)
7. Crisis Management and Response Services
8. Medication Management
9. Care Coordination
10. Housing Supports and Coordination
11. Peer and Family Supports
12. Services for Older Adults
13. Services for Core Focal Population
14. Other Recovery-Oriented Services (including psychosocial rehabilitation and educational counseling and assistance)
15. Additional Supportive Services - Flexible Funding
16. Program Completion Procedures

B. Evidence-Based Practice (EBP) Implementation

1. Assertive Community Treatment model (ACT)
   Where the contracted FSP level of care is ACT and/or FACT, Contractor shall implement services with fidelity to an ACT model that meets BHSA requirements for ACT as the highest level of outpatient FSP care for adults. At minimum, Contractor shall:

   a) Maintain an interdisciplinary team with, at a minimum, a licensed clinician serving as team lead and a mix of clinical, rehabilitation, peer, and support staff consistent with ACT guidance.

   b) Maintain caseloads and staffing ratios consistent with County direction and state ACT expectations (e.g., full-size ACT team of approximately 10 FTE serving a caseload of approximately 80–110 individuals, unless otherwise approved in writing by County).

c) Provide mobile, community-based, and field-based services with the capacity to deliver services multiple times per week and, for ACT, to provide or coordinate 24/7 crisis response consistent with County policy for FSP ACT teams.

2. Forensic ACT (FACT)

For FACT services, Contractor shall ensure that justice-involved participants receive ACT-level intensity tailored to criminogenic needs, and that the ACT team either includes dedicated FACT staffing or meets County requirements for FACT specialization (e.g., inclusion of at least one team member with lived experience of the criminal legal system and/or team completion of FACT-specific training)."

3. FSP Intensive Case Management (ICM)

Where the contracted FSP level of care is FSP ICM, Contractor shall provide intensive case management and rehabilitative services consistent with BHSA FSP ICM guidance for individuals with significant behavioral health needs who do not meet eligibility criteria for ACT/FACT but who require enhanced support beyond standard outpatient services. Contractor shall:

a) Maintain team composition and caseloads consistent with County direction for FSP ICM, ensuring caseloads do not exceed County-specified maximums (e.g., not more than 25 participants per primary case manager, unless otherwise approved).

b) Provide proactive outreach and engagement, frequent contact, and coordination of services (including housing, benefits, physical health, substance use, and social supports) consistent with FSP principles.

c) Offer step-up and step-down pathways between FSP ICM and ACT/FACT in collaboration with County to ensure participants receive the least restrictive, medically necessary level of care.

4. Other EBP and practice requirements

a) Contractor shall make available other evidence-based and promising practices required or endorsed by County and DHCS for BHSA-funded FSP programs, including, Individual Placement and Support (IPS) model of supported employment.

b) Contractor shall coordinate and make available, IPS-consistent supported employment services for FSP participants. This may require participation in the County's implementation of IPS model of supported employment in accordance with County guidance and BHSA requirements.

5. Fidelity review participation

Contractor shall participate in all fidelity and quality reviews required by County and/or DHCS for BHSA-funded ACT, FACT, FSP ICM, and other EBPs implemented under this Agreement. Participation shall include, at a minimum:

a) Allowing County and/or DHCS representatives access to de-identified records, staff, and stakeholders, as permitted by law, for the purposes of fidelity and quality review.

b) Completing fidelity self-assessments, surveys, and tools (e.g., ACT fidelity scales, supported employment scales, or other County-approved instruments) within timeframes established by County.

c) Developing and implementing corrective action or quality improvement plans when fidelity scores fall below County-established thresholds, and participating in technical assistance offered by County or its designees.

6. Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

The State's BH-CONNECT initiative establishes requirements for implementation of key EBPs under Medi-Cal, including ACT, FACT, and Individual Placement and Support (IPS). These requirements apply to FSP programs. Contractor shall implement FSP services in a manner that is consistent with applicable BH-CONNECT EBP standards, including requirements for:

a) Participation in EBP training and technical assistance offered or designated by the County and/or DHCS.

b) Completion of baseline and ongoing fidelity assessments for ACT, FACT, and any other BH-CONNECT EBP implemented under this Agreement, using fidelity tools and processes specified by DHCS and the relevant Center of Excellence.

c) Development and implementation of quality improvement plans when fidelity assessments identify areas not meeting BH-CONNECT standards.

d) Collection and reporting of EBP data (including required client-level and service-level data elements at intake, at least every six months, and at discharge) in the format and on the schedule established by County to

support BH-CONNECT reporting and evaluation.

C. Outreach and Ongoing Engagement

Outreach is defined as the initial step in connecting, or reconnecting, an individual to needed behavioral health services. Engagement is defined as the process by which a trusting relationship between a service provider and an individual or family is established. The engagement period can be lengthy and depends on the unique needs of the individual. The goal of outreach and engagement is to achieve enrollment for every eligible client referred to the team. FSP teams will be persistent, even relentless, in engaging clients who meet FSP focal population criteria.

The FSP Provider(s) will conduct outreach and engagement to individuals who are referred to their programs within 1-3 business days of receiving a referral. Priority will be made for individuals in an inpatient hospital, emergency room, urgent care center, residential treatment facility, jail, or other institutional setting where discharge is imminent.

1. FSP teams will use a variety of methods, relentless efforts to locate, and multiple times per week to pursue engagement with clients, including:

    a) Make at least weekly attempts to locate the individual face-to-face in the field
    b) Make repeated contact with friends, family, referring providers, prior providers, community partners, and others who may know of the individual's whereabouts
    c) Provide 24/7 contact information and encourage these referring providers, family, friends, and community partners who may see the individual to contact the FSP team if the individual is located
    d) Designate an FSP team member available 24/7 to go out to engage the individual immediately if located. This would include clients stepping down from higher level of care such as jail or inpatient units.
    e) Conduct assertive and immediate follow up if the individual does not present or respond to outreach by making field visits; contacting friends, family, referring providers, and community partners; and reminding others to contact the team immediately if the individual is located
    f) Individuals with a history of trauma, who lack insight into their mental illness (i.e., anosognosia), and/or who are paranoid due to symptoms of their mental illness should receive more frequent and varied engagement efforts for a longer period of time.
    g) Conduct outreach together with other trusted providers, including repeatedly with referring providers to build rapport and pursue an extended "warm handoff" between services
    h) Visit face-to-face with the individual at least weekly with different offers of help
    i) Invite other FSP team members to visit the individual to encourage engagement
    j) Conduct trauma-informed engagement by assembling an engagement team based on the individual's history and safety needs (e.g., if the individual is known to have fear of male staff, FSP team uses female staff to conduct outreach and engagement)

k) Respond to the gender, ethnicity, and language preferences of the client, such as by using a diverse engagement team when the individual prefers this
l) Use evidence-based techniques, such as Motivational Interviewing, to build the individual's intrinsic motivation for services
m) Pursue engagement together with the Public Guardian or conservator if the client is conserved. An individual on LPS conservatorship cannot decline behavioral health services recommended by the Public Guardian or conservator, but engagement can be utilized to build motivation for services
n) Utilize Contingency Management intervention

2. FSP teams will provide outreach and engagement services to individuals residing in the community who are referred and approved for FSP services.

   a) Outreach and engagement for individuals in the community can last up to 60 days and will entail regular, consistent contact.
   b) Outreach and engagement lasting longer than 60 days requires consultation with the appropriate BHRS Clinical Services manager.
   c) Adult FSP provider teams will have the ability to provide and/or facilitate receipt of any necessary mental health, physical health or substance use services, and housing desired by individuals during the outreach and engagement process.

3. FSP teams will provide outreach and engagement services to individuals referred by Licensed Facilities Institutions.

   a) Institutions include County or fee-for-service (FFS) acute care hospitals; Enriched Residential/Medicaid Institutions for Mental Disease (IMD)Step Downs; Mental Health Rehabilitation Center (MHRC); Locked Skilled Nursing Facility (LSNF); Skilled Nursing Facilities (SNF); State Hospitals (SH); Psychiatric Health Facilities (PHF); Short-Term Residential Treatment Programs (STRTP); Crisis Residential Centers, Social Rehabilitation Centers, and Board and Cares where discharge is imminent.

D. Enrollment

If following Outreach and Engagement, the individual is enrolled in FSP services, the provider team will complete enrollment as follows:

1. Participate in case conferencing regarding the client's eligibility and the course of outreach and engagement with the BHRS Clinical Services Manager

2. Coordinate with FSP referent as follows:

   a) Coordinate with referring staff a warm handoff
   b) Obtain client histories (i.e., psychiatric history, medical history, legal and treatment history), institutional treatment plans, and medication lists from institution staff as a prerequisite for enrollment

c) Ensure that the client has an adequate medication supply or prescriptions upon program discharge

3. Provide the BHRS Clinical Services Manager with documentation of its multiple efforts to locate and/or engage the client if client is not engaging with FSP provider

4. If enrolled from an institution the FSP team will:

   a) Coordinate with staff at the institution on discharge planning, including residential placement, or housing, coordination with the County transitional rent provider, discharge date, and plans for transportation to new residential setting
   b) Obtain client histories (i.e., psychiatric history, medical history, legal and treatment history), institutional treatment plans, and medication lists from institution staff as a prerequisite for enrollment
   c) Ensure that the client has an adequate medication supply or prescriptions upon discharge
   d) Coordinate on residential treatment with the Public Guardian/conservator for conserved clients.
   e) When indicated by the referring party, FSP team will make contact with the client's parole/probation officer to coordinate services.

E. Assessment, Diagnosis and Service Planning

Adult FSP provider teams will complete a comprehensive face-to-face initial assessment and Service Plan (Individual Services and Supports Plan) for each individual receiving ongoing adult FSP services. Adult FSP teams will provide services to all clients based on the Service Plan co-developed by the team and each client. The written Initial Assessment will be completed within 60 business days upon receipt of the referral. In special circumstances (as required by the placement agency of the client), the Initial Assessment may have to be completed within three (3) business days upon receipt of the referral.

1. The Initial Assessment will consist of:

   a) Mental health initial assessment is composed of review of referral packet, speaking with referral source(s), conducting face-to-face assessment with the client, interview with collateral and/or significant others as needed and completing the Initial Assessment form
   b) Mental health initial assessment: history and current status of the individual's mental health; relevant social, cultural, and developmental history; mental health diagnoses with differential diagnoses under consideration
   c) Physical health initial assessment: medical history, evaluation of current physical health status plus plans for needed medical follow up

d) Substance use initial assessment: screening for substance use, current and past substance use, substance use diagnoses with differential diagnoses under consideration, level of readiness to work toward change
e) Clients' recovery goals, preferences for services, and priorities for clinical outcomes
f) For providers serving adults 60+, assessments should include screenings for age-related cognitive impairments

2. A Service Plan (Individual Services and Supports Plan) will be developed and monitored. The FSP team will:

a) Obtain a client's past psychiatric history from BHRS and other County electronic records (e.g., by working with the BHRS liaison), including the client's history of emergency room visits, Regional Center treatment, psychiatric hospitalizations, LPS conservatorships, IMD placements, and any other relevant information. Meet together with the client and their family/significant others if appropriate to develop the initial Service Plan
b) Work collaboratively with the client and others as appropriate to develop recovery goals, objectives and recovery supports needed, including referrals to primary care, medication management and other community resources.
c) Include the 24 hours, 7 days a week contact information in the Service Plan.
d) Obtain client authorization to participate in the FSP program by requesting the client's signature on a Service Plan Participation Agreement, within 60 days of receiving FSP referral.

   If obtaining signature is not possible, client/authorized person collaboration on and agreement to receive FSP services will be clearly documented on the Service Plan and associated progress note.

e) Review the Service Plan at least once every 12 months, or more frequently as needed to incorporate new goals and objectives.

F. Mental Health Services - Individual & Group Psychotherapy Services

A variety of individual- and group-based therapeutic interventions will be available to FSP clients, including primarily short-term, solution-focused therapeutic interventions to assist clients in managing symptoms, understanding problematic behaviors, and developing and using more adaptive behaviors.

1. The selected FSP Provider will ensure that clinical staff are adequately trained and meet all necessary competencies to provide any type of therapeutic services that require certification.

2. Psychotherapy services should be provided by a licensed or license eligible clinical staff.

3. Therapy interventions should meet the following criteria:

a) Provide trauma-informed services throughout each stage of the recovery process
b) Offer support for improving social functioning and problem-solving skills
c) Provide psychoeducation and support to clients and their family members

4. Required therapy services include:

a) Cognitive Behavior Therapy (CBT)
b) Co-Occurring
c) Motivational Interviewing
d) Harm Reduction
e) Wellness Recovery Action Plan (WRAP)
f) Risk-need-responsivity model for offender assessment and rehabilitation (justice-involved population)

5. Endorsed therapy services include:

a) Eye movement desensitization and reprocessing (EMDR)
b) Neurosequential Model of Therapeutics (NMT)
c) Dialectic Behavioral Therapy (DBT)
d) Acceptance and Commitment Therapy
e) Thinking for a Change (justice-involved population)
f) Seeking Safety

G. Co-Occurring Capacity Requirements

1. FSP teams will ensure capacity to serve individuals with co-occurring SMI and moderate/severe SUD and provide services that are evidence-based. These services will include:

a) Conducting ASAM screening as part of an integrated assessment upon intake into the FSP, and connecting individuals to SUD providers, as appropriate.
b) When detected through screening and evaluation, entering a diagnosis of substance use in the client's chart and including treatment for the co-occurring substance use disorder within the client's service plan
c) Referring clients with co-occurring disorders to the FSP team Substance Use Counselor for individual support and recovery goal planning.
d) Providing individual and group-based interventions using motivational interviewing, trauma informed, strengths-based approaches, Acceptance and Commitment Therapy, or referrals to 12-step or other community resources to support recovery.
e) Coordinating with County Assertive Field-Based SUD initiatives including facilitating warm handoffs and maintaining care coordination when clients require field-based SUD initiation services.

f) Having an effective referral process in place to offer medications for addiction treatment (MAT) services to clients (i.e., established relationship with a MAT provider and transportation to appointments for MAT).
g) Equipping FSP program staff at all levels of care to provide comprehensive care to individuals living with significant co-occurring behavioral health needs (e.g., motivational interviewing, engagement, and training for prescribers who are not familiar or comfortable with prescribing MAT).
h) Providing Medication-Assisted Treatment, for alcohol and opioid use disorders (OUD): such as Naltrexone (oral or intramuscular), Buprenorphine (oral or subcutaneous), other medications as indicated to manage cravings, withdrawal symptoms and support recovery. Linking to Bay Area Addiction Research and Treatment (BAART)/BayMark for methadone evaluation where appropriate and ensuring individuals with OUD have Narcan.
i) Providing a harm reduction approach and tools (such as Narcan, fentanyl testing strips) throughout the recovery process to help clients reduce the harm and risks associated with using substances.
j) Developing strategies for billing and claiming the appropriate service/delivery system within the context of co-occurring care delivery (e.g., Medi-Cal Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal (DMC)/Drug-Medi-Cal Organized Delivery System (DMC-ODS).

2. FSP teams will link clients to substance use services as follows:

a) All community-based substance use treatment programs are voluntary and client motivation must be evaluated by FSP provider to assess client readiness and ability to participate.
b) Clients may be directly referred to County Assertive Field-Based SUD initiatives and outpatient (OP) / intensive outpatient (IOP) programs in the community.
c) When client is motivated for residential substance use treatment, they can be linked to the BHRS Residential Treatment (RTX) team for residential assessment and authorization by calling: 650.802.6400, ask for RTX Officer of the Day.
d) FSP providers will also provide linkage and warm handoffs to community-based recovery supports including self-help groups and peer-based resources such as Voices of Recovery.
e) When withdrawal management (detox services) are indicated, all clients require medical clearance (through SMMC ED or Street Medicine/ Mobile Clinic teams) prior to entering. Medical provider issuing clearance typically helps conduct telephone screen intake with facility, and clients are typically expected to arrive with medical clearance paperwork and any indicated medications in hand.

H. Crisis Management & Response Services

1. FSP teams will have the ability to:

a) Provide 24 hours per day and 7 days per week (24/7) Assessment and Crisis Response Services
b) Assess acute psychiatric and other emergency situations
c) Initiate psychiatric evaluation by writing a 5150 hold and arrange safe transportation to an emergency room
d) Transport or arrange transportation for clients who require emergency medical care to an appropriate medical facility.

2. Crisis response hours are defined as 5 pm until 8 am the following business day, holidays and weekends.

   a) All other hours are considered regular business hours when a client's individual FSP Team should be available for scheduled and/or crisis response services.

3. Clients will have the option of in-person crisis assessment visits during after-hours and on weekends.

4. An FSP Team member known to the client will be the staff that are available for crisis response services.

   a) This could include availability from other qualified individual(s) that are also core members of the FSP Team and are known to the client.
   b) In the event of an emergency when the Case Manager or other qualified individual known to the client is not available, another qualified individual will be available to respond to the client.

5. The 24/7 emergency FSP phone number will be provided to each FSP client upon enrollment.

6. The 24/7 emergency FSP phone number should be publicly posted and easy to locate (e.g., on a website or on a clinic voicemail).
   This number will be specific to the FSP Team (i.e., not 911 or a suicide hotline).

I. Medication Management

1. Medication support services include:

   a) Prescribing, administering, and monitoring routine psychiatric medications, long-acting injectable antipsychotic medications, clozapine, and medication assisted treatment for substance use
   b) Utilizing shared decision-making techniques during medication prescribing
   c) Obtaining, interpreting and following up as needed on clinical laboratory results either directly from a lab on site or through an outside laboratory (e.g., Federally Qualified Health Center (FQHC), free clinic, medical laboratory, etc.)

d) Monitoring medications prescribed by other physicians for clients' physical health conditions, including for managing chronic pain and multiple chronic health conditions, and monitoring patients for misuse of prescription medications
e) Providing the full range of medication support services in the field for those clients unable to come to the clinic to receive them
f) Medication services will include support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. FSP team members will work with individual consumers to arrange for delivery/prompts/reminders that will support regular scheduled medications.
g) Assist with Medi-set preparation for those who may have difficulty organizing and adhering to their complex medication regimen, and/or teaching caregivers or clients to prepare Medi-set.
h) Will follow Medi-Cal guidelines for providing services during the pandemic/COVID
i) Involuntary Medication Orders (IMO)

J. Care Coordination

Care coordination involves communication and coordination with medical providers, emergency rooms, hospitals, IMDs, the Office of the Public Guardian, the justice system and other County agencies.

1. Hospital and Emergency Services:

    a) Coordinate with Urgent Care Centers and emergency service providers to set a treatment plan to prevent psychiatric hospitalization or to advocate for the need for psychiatric hospitalization and LPS or Probate Conservatorship
    b) Visit and/or call clients when clients are hospitalized, in IMDs, incarcerated, or in emergency rooms
    c) Coordinate in person and by phone with staff throughout a hospital or emergency room stay, and coordinate discharge planning with hospital, emergency room, or jail staff

2. Medical Service Providers:

    a) Ensure that clients have regular access to medical care as part of a treatment plan, see that clients receive appropriate health screenings (e.g., diabetes, cardiovascular disease, hypertension), and coordinate with medical service providers to follow up on results
    b) Accompany and/or transport clients to important medical services, and coordinate in person and on the phone with medical service providers to plan for obtaining of necessary medical care
    c) With client consent, provide information about clients' mental health conditions to physical health providers

3. Other County Agencies:

    a) Coordinate with and understand the processes of the Probation Department and their contracted service providers
    b) Accompany clients, if needed or required by the court, to Mental Health Court and other court proceedings
    c) When clinically indicated, compile a dossier for presentation to an inpatient psychiatric hospital considering LPS conservatorship for the client

    d) For LPS conserved clients, when clinically indicated, complete conservatorship paperwork (e.g., Physicians' Declaration) for reappointment
    e) For LPS conserved clients, coordinate treatment planning, assist the client in financial management, and secure housing in licensed facilities in collaboration with the client's Public Guardian or conservator
    f) Testify in conservatorship initiation and reappointment proceedings as clinically indicated or required by Mental Health Court
    g) For clients with developmental disabilities, coordinate care with the Regional Center (GGRC)
    h) Providing support to clients who are transitioning between different levels of care (e.g. stepping down from jail to the community) with temporary housing arrangement, transportation, foods, clothing, resources kits, etc.

K. Housing Supports and Coordination

Contractor will participate in the implementation of and coordination with the County designated housing navigation, deposits, tenancy supports and transitional rent providers, long-term subsidy administrators, and/or other partners to facilitate access to temporary, transitional, and permanent housing resources. The FSP housing liaison will provide on-site supports to the client and coordination with property service coordinators, property management, and the clients' clinical teams.

1. FSP teams will assist clients in all coordination and steps needed to attain temporary shelter and permanent housing and support ongoing housing maintenance.

2. *Emergency Housing:* FSP teams will identify local or County-wide resources for crisis housing including motel, crisis residential beds, and shelter beds and coordinate CES or BHRS Facilities Utilization Management team to ensure clients' access to shelter beds.

3. Interim Housing Coordination: FSP teams will coordinate with transitional rent provider, CES and other housing partners to assist clients with attaining safe and appropriate interim housing.
4. *County Housing:* FSP teams will coordinate with transitional rent provider and/or long-term subsidy administrator, CES and other housing partners to assist clients with attaining access to permanent supportive housing including, but not limited to, the following support services:

a) Participate in the Service Area Coordinated Entry System (CES) and other coordination efforts, including outreach coordination.
b) Serve as the CES and transitional rent point of contact for linkage to housing resources.
c) Coordinate and case conferencing with CES matchers, transitional rent providers and other community partners to facilitate matches to housing resources. Keep abreast of changes to the provision of homeless housing services in the community.
d) Coordinate with additional County partners (e.g., Department of Housing (DOH) staff) to assist clients with accessing housing.
e) Work with Clinical Services Manager for FSP clients in MHSA Units, NPLH Units, upcoming vacancies and eviction prevention.

5. *Applications and Documentation:* FSP teams will coordinate with County designated housing support providers, transitional rent providers and/or long-term subsidy administrator to assist clients with their applications and documentation for housing including, but not limited to, the following support services:

    a) Assist clients with obtaining any documentation needed to apply for housing.
    b) Assist clients with locating permanent housing, including helping client to search for units, touring Board and Cares, making appointments with landlords.
    c) Assist clients with completing and submitting housing applications and transporting and accompanying clients to meetings with property managers, Board and Care operators, and/or housing authorities.
    d) Assist clients to overcome barriers to accessing and maintaining permanent housing such as credit history, criminal history and eviction history.
    e) Assist clients with accessing funding for security deposits and one-time rental payments to prevent eviction, if necessary .
    f) Track the status of housing applications with client and providing any necessary advocacy.
    g) Assist with online applications for housing if clients do not have computer access.

6. *Move-in Supports:* Adult FSP teams will coordinate with County designated housing support providers, transitional rent providers and/or long-term subsidy administrator to assist clients with move-in needs including, but not limited to, the following support services:

    a) Coordinate lease and rental agreement signings and establishment of a move-in date for clients
    b) Educate clients on the rental/lease agreement and tenant rights and responsibilities prior to move-in including the importance of complying with the lease agreement or facility rules; how to communicate effectively with

property management staff and other entities; how to be a good tenant and neighbor and when, how and to whom to report maintenance problems.

c) Assist clients with securing furniture and other household goods
d) Assist clients with move-in and orientation to their unit/building. Meet with client with onsite supportive service staff.
e) Mentor clients in household maintenance and the use of home appliances including the stove, vacuum cleaner, smoke alarm and fire extinguisher
f) Work with clients to develop housing goals and deliver ongoing supports to assist clients to retain their housing as part of the individual treatment plan
g) Provide move-in support to identify close transportation options in the neighborhood
h) Connect clients with in-home support services if applicable and/or suggest for possible referrals for in-home services or other supports

7. *Sustaining Housing:* Adult FSP teams will coordinate with County designated housing support providers, transitional rent providers and/or long-term subsidy administrator to assist clients with sustaining their housing including, but not limited to, the following supports:

a) Work with landlords, property managers, developers, facility managers, and other partners to provide any needed advocacy and support to help clients retain housing
b) Assist clients with applying for representative payees for clients who are at-risk for non-payment of rent
c) Anticipate and assist clients with housing subsidy renewal processes as applicable.
d) Respond immediately to lease violations or concerns of the landlord, property manager, facility manager, developer and/or other tenants to avoid eviction
e) Assist clients with obtaining legal services as needed to avoid eviction
f) Provide home visits with the frequency required to ensure housing retention and meet any housing subsidy requirements.
g) Assist clients with relocation as necessary.
h) Assist clients with housing subsidy renewal process annually
i) Attend operational meetings as appropriate for the housing type (e.g., MHSA housing, NPLH housing) to understand issues that a client may be facing and prevent issues such as eviction
j) Assist clients in developing independent living skills (cooking, cleaning routines, managing budget, etc.)
k) Attend case conferences with housing support providers and/or transitional rent provider as needed in order to ensure care coordination on any issues that threaten clients' housing stability.

L. Peer and Family Support Services

1. Peer-*Support Services*: Each Adult FSP client will have access to a Peer Support Specialist, who is an individual with lived behavioral health experience who can provide peer-to-peer counseling and support.

    a) Peer Partners who will be part of the FSP team and will be assigned to significant support person(s) to provide support services.

    b) In order to reduce turnover in these positions, Peer Partners will:
        i. Receive certifications in line with SB803
        ii. Receive training on best practices and consistent service delivery
        iii. Have clear pathways to promotion, in collaboration with Lived Experience Academy
        iv. Receive supplemental financial compensation if they provide non-English language skills
        v. Receive consistent supervision
        vi. Have access to additional staff and/or support for data collection and entry
        vii. Collaborate with the BHRS Office of Consumer & Family Affairs (OCFA)

    c) The Peer Specialist will provide the following, but not limited to, support services:
        i. Participate with all other team members in Outreach and Engagement activities
        ii. Participate with all other team members in the development of a service plan.
        iii. Support delivery of Housing Services
        iv. Support the delivery of Recovery-Oriented Services
        v. Help to link the clients to Peer based organizations in the community
        vi. Facilitate Peer support groups to foster healthy peer relationships and to build client capacity to address challenges to their recovery as well as celebrate their accomplishments on the journey to recovery

2. *Family Support Services*: Services will integrate client's family members or other supportive people into treatment whenever possible via consumer consent.

    a) Consumers will be given ongoing opportunities to choose what family members or other supportive people, if any, they would like to be involved.
    b) Identified family members and loved ones of the consumer will be given information with consumer consent, upon consumer's intake into the program and annually, about effective ways to respond to the consumer if/when consumer is experiencing a psychiatric crisis.
    c) The program staff will encourage family members and/or other identified consumer supports to inform staff when noticing signs of decompensation.

d) Family members and/or other identified consumer supporters will be given suggestions regarding what resources to call in different types of situations.
e) Family support resources may include, but are not limited to, the following:
    i. FSP Provider and team emergency or regular contact phone numbers
    ii. Toll free crisis hotline
    iii. 911 and local department numbers with potential aid of CIT trained police officers
    iv. Family Assertive Support Team (FAST) information

M. Services for Older Adults

1. Older Adult FSP clients will receive all of the services indicated for Adult FSP programs with additional service requirements as follows:
    a) Assessment, diagnosis, and service planning will be completed in coordination with medical professionals and should include screenings for age-related cognitive impairments.

    b) Staff will be trained specifically to meet the needs of older adults including, but not limited to, the following skills:
        i. Accurately assess older adults for mental and physical health issues including cognitive impairment, falls risk, and care planning
        ii. Engage with older adults and exercising patience and persistence in encouraging them to participate in FSP services
        iii. Utilize service extenders, including peers and volunteers, trained to work with older adults to accompany older adults to appointments, conduct home visits, link older adults to community services, and conduct other activities designed to reduce isolation.
        iv. Provide medical support specific to the needs of older adults, including access to Gero psychiatrists, Geriatricians, Gero pharmacists, and/or neuropsychologists, as needed.

    c) Staff will be trained in and incorporate the use of several evidence-based and community-defined best practices.

        i. Every FSP team member that delivers direct client care should have protected time away from clinical responsibilities to participate in training activities.
        ii. Direct service providers should receive at a minimum 20 hours of training per calendar year.
        iii. Trainings may take place online or in person and may be individual or group activities. Training activities may include:
            - Trainings or community-of-practice activities sponsored by BHRS or BHRS partners
            - Conferences or trainings sponsored by professional organizations
            - Structured supervision, mentoring or coaching by an expert
            - Accredited courses designed for continuing education

2. *Eligibility Criteria* - to be eligible for additional older adult FSP services, an individual must meet all of the Adult FSP criteria and be 60 years of age and above.

    - Eligibility for older adult FSP services will ultimately be determined by the FSP Review Committee.

N. Services for Core Focal Population (CARE Court)

1. CARE Court focal population includes individuals with schizophrenia spectrum or other psychotic disorder including Bipolar 1 with psychotic features who currently are not receiving treatment and require court intervention to receive treatment. FSP services are based on the Assertive Community Treatment model (ACT). Contractor's will comply with the following if an FSP client is open to CARE Court:

    a) Participate in care coordination meetings with health system providers or other BHRS programs.

    b) Attend treatment planning conferences for prospective and current clients at the request of the treatment teams involved with clients.

    c) Attend routine treatment/discharge meetings at San Mateo Medical Center when CARE FSP clients or prospective clients are in SMMC.

    d) Have the CARE FSP Manager or designee available to BHRS CARE Team 24/7.

    e) CARE FSP staff will respond to BHRS CARE FSP team within 1 hour of call or email during business hours for any issue identified as urgent or emergent.

    f) Deliver immediate practical supports to clients as soon as possible such as case management services around acquisition of food, shelter and medical needs, including linking and transporting client to appointments and housing placement.

    g) Based on information from referral and initial client contact, establish initial needs of client and start on appropriate referrals: housing, residential/outpatient treatment programs for mental health, substance abuse, other co-occurring issues.

2. Court Process, the provider CARE FSP will:

    a) Participate in collaborative meetings with the Court, Private Defender Program, County Attorney and BHRS CARE Team for the purposes of coordinating treatment planning. These meetings may be as frequently as

once a week.

b) Be present in Court as needed by the Court for inclusion in CARE FSP services.

c) Submit all Court requested documents and reports timely as required from legal counsel per Court process.

d) Be present in Court and ensure the CARE FSP client is also present in Court unless the Court, Private Defender Program, County Attorney, CARE FSP and BHRS CARE have mutually agreed that it would be in the best interests of the client to not have to appear in Court.

3. Client Non-Compliance with Treatment

If client is non-compliant with treatment plan including but not limited to taking medications as prescribed, CARE FSP staff will make appropriate efforts to solicit adherence abiding by the treatment philosophy of “whatever it takes” for FSP. If client is still not compliant, CARE FSP will assess if client may need a mental health evaluation and will accompany and transport to hospital if deemed appropriate. Once in the hospital, the CARE FSP case manager will work in collaboration with the client to provide information to the hospital treatment team regarding the circumstances leading up to the admission and what is needed in order to be discharged/released back to the community. The CARE FSP treatment team will work with the hospital around case planning including discharge planning. To accomplish this, it is important for the CARE FSP team to develop a relationship and understanding of a collaborative partnership with the hospital.

If a client court appearance is required, the CARE FSP case manager will accompany client and will be prepared to provide the Court with an update on how the client is doing in regard to their current treatment plan.

4. Client Hospitalizations

When a CARE FSP client is transported to Psychiatric Emergency Services or to an Emergency Department, CARE FSP staff will provide a full report within twenty-four (24) hours to the BHRS CARE team. The CARE FSP case manager will accompany client to PES and will work collaboratively with the PES staff and client.

5. CARE FSP Client incarcerated

When a CARE FSP client open to CARE Court is incarcerated the CARE FSP case manager will make all efforts to coordinate with jail staff including visiting client in jail to continue to coordinate provision of CARE mental health services while incarcerated, coordinate discharge and receive hand-off from jail at discharge to provide needed follow-up care and support for “re-entry” into

community, arrange and coordinate for housing/shelter placement and all follow-up care appointments needed. CARE FSP will update BHRS CARE team of client's incarceration within 24 hours of being incarcerated as well as ongoing updates on pertinent development of the client throughout stay in jail.

O. Services for Core Focal Population (SB43 Grave Disability)

1. SB43 FSP focal population includes individuals with severe substance use disorder. FSP services are based on the Assertive Community Treatment model (ACT). Contractor's will comply with the following if an FSP client is open to SB43 FSP slot:

   a) Participate in care coordination meetings with health system providers or other BHRS programs.

   b) Attend treatment planning conferences for prospective and current clients at the request of the treatment teams involved with clients.

   c) Attend routine treatment/discharge meetings at San Mateo Medical Center when FSP clients or prospective clients are in SMMC.

   d) Deliver immediate same day practical supports to clients as soon as possible such as case management services around acquisition of food, shelter and medical needs, including linking and transporting client to appointments and housing placement.

2. Client Non-Compliance with Treatment

   If client is non-compliant with treatment plan including but not limited to taking medications as prescribed, FSP staff will make appropriate efforts to solicit adherence abiding by the treatment philosophy of "whatever it takes" for FSP. If client is still not compliant, FSP will assess if client may need a mental health evaluation or substance use evaluation and will accompany and transport to hospital if deemed appropriate. Once in the hospital, the FSP case manager will work in collaboration with the client to provide information to the hospital treatment team regarding the circumstances leading up to the admission and what is needed in order to be discharged/released back to the community. The FSP treatment team will work with the hospital around case planning including discharge planning. To accomplish this, it is important for the FSP team to develop a relationship and understanding of a collaborative partnership with the hospital.

3. Client Hospitalizations

   When a FSP client is transported to Psychiatric Emergency Services or to an Emergency Department, FSP staff will provide a full report within twenty-four (24) hours to the BHRS Clinical Services Manager. The FSP case manager will

accompany client to PES and will work collaboratively with the PES staff and client.

4. FSP Client incarcerated

   When a FSP client open to SB43 and is incarcerated the FSP case manager will make all efforts to coordinate with jail staff including visiting client in jail to continue to coordinate provision of mental health services while incarcerated, coordinate discharge and receive hand-off from jail at discharge to provide needed follow-up care and support for “re-entry” into community, arrange and coordinate for housing/shelter placement and all follow-up care appointments needed. FSP will update BHRS Clinical Services Manager of client’s incarceration within 24 hours of being incarcerated as well as ongoing updates on pertinent development of the client throughout stay in jail.

P. Other Recovery Oriented Services

1. Recovery oriented is a value across all FSP services. Services are to be guided by an individualized plan developed between client and staff and signed off by the client. Staff will employ a variety of supportive and recovery techniques to encourage clients to assume responsibility for their own wellness and recovery.

   a) FSP teams will ensure clients' basic needs are met at all times and support clients in pursuing their goals related to meaningful uses of their time, productive roles in their communities, and for their recovery.

   b) *Benefits Establishment*: FSP teams will assist clients in accessing benefits and managing their finances when needed including, but not limited to, the following support services:

      i. Assist clients with securing official identification documents (e.g., driver’s license, birth certificate, social security card, state identification, income verifications (paystub, employer letter, SSA Award letter) and assets verifications (bank account statement, family trust fund and special needs trust fund, Rep Payee statement, vehicle registration)
      ii. Assess the financial status of all clients
      iii. Identify benefits to which clients are entitled (e.g., Cal Fresh, General Relief, Supplemental Security Income [SSI], Social Security Disability Income [SSDI], Medicare, Medi-Cal, and Veterans Benefits, CalWorks, Covered CA)
      iv. Assist clients with enrolling or re-enrolling in benefit programs
      v. Provide advocacy and linkage to benefits establishment programs such as the BHRS Health Insurance Outreach and Public Benefits Coordination Team

   c) *Transportation*: Adult FSP teams will assist clients in accessing transportation when needed including, but not limited to, the following support services:

i. Escort clients or proactively assist them with transportation to critical services as needed to ensure they arrive
ii. Help clients learn to use public transportation systems independently, including by accompanying them on public transportation as needed
iii. Help clients apply to access paratransit services and reduced-cost public transit passes

d) *Life Skills and Activities of Daily Living*: FSP teams will support clients to gain, retain, and improve their independent living skills including, but not limited to, the following support services:
   i. Assist clients with gaining, restoring, improving or maintaining daily independent living skills including shopping, cooking, cleaning and maintaining personal hygiene
   ii. Ensure clients experience food security at all times
   iii. Assist clients to learn illness management and self-care skills
   iv. Assist clients with financial literacy and budgeting and money management skills
   v. Establish or linking to providers who can establish representative payee ship where such supports are needed to help clients with money management to support rent, food security, and/or other basic needs
   vi. Provide money management education and support to prepare clients to transition out of LPS conservatorship or representative payee ship

e) *Employment, Volunteering, and Education*: FSP teams will assist clients to achieve their goals related to meaningful use of time including but not limited to, providing the following support services:

   i. Coordinate and make available, IPS-consistent supported employment services for FSP participants, see EBP Implementation requirement (section V.B of this agreement)
   ii. Assist clients with pursuing preferred educational opportunities, such as finishing high school, obtaining a GED, completing adult education courses, completing certificate or vocational training courses, or advancing in higher education degree programs
   iii. Provide and/or linking to supports and advocacy that will help clients retain and advance in their preferred employment, volunteer, and/or educational opportunities

f) *Social Support and Integration*: FSP teams will assist clients to achieve community integration and maintain and/or expand their social support including, but not limited to, the following support services.

   i. Help the client develop and maintain relationships with natural supports outside of service providers (e.g., friends, employers, clergy, and family)
   ii. Encourage and support the client to develop and maintain a sense of belonging and membership in communities of choice

iii. With client consent, remain in regular contact with family members and/or significant others regarding the client's treatment plan and goals
iv. Provide psychoeducation and support to clients' family members and/or significant others including referrals for supportive services (e.g., NAMI Family-to-Family groups)
v. Coordinate with community resources and social service providers to reduce client isolation, including by escorting client to intake visits and appointments for community services (e.g., Senior Centers, self-help groups), helping clients to develop leisure activities, and participating with the client in community activities that can reduce isolation
vi. Planning of evening and weekend activities for clients to reduce client isolation and promote a sense of belonging in a client's community of choice
vii. Provide information on the county Lived Experience Academy via the Office of Consumer and Family Affairs (OCFA).
viii. Encourage participation in peer led organizations

g) *Field-based Clinical Services*: Field-based services are those provided in a location that has a different address than the provider site and addresses Client's accessibility concerns.

i. FSP Team(s) will provide a minimum of 65%, but ideally 80% of direct services in the field.
ii. The choice of service delivery field-based site will be based on the client's recovery goals and possible transportation limitations.
iii. Examples of sites include drop-in centers, residences, parks, libraries
iv. physical health care settings, and other community sites.

Q. Additional Support Services – Flexible Funding

1. Flexible funding "Flex Funds" are an integral component of the vision and mission of MHSA and BHRS services, supporting the "whatever it takes" philosophy of FSP. Flex funds are restricted to FSP clients, provide essential supports not typically found on the menu of traditional behavioral health services, and are used when other resources have been exhausted. They promote shared responsibility with the client, such as cost-sharing or a gradual decrease in funds contribution.

a) Flex Funds will correspond to the specific wellness and recovery goals of individual clients and therefore they do not support non-essential items, including alcohol and cigarettes.

b) Flex Funds will not be provided to consumers as cash, rather, payment should be made directly to the source of the support, or in the form of a gift card provided to the client.

c) Flex Funds are not intended to provide ongoing support in lieu of sustainability planning from other sources.

d) *Flex Fund Approval Process* – FSP Provider(s) will be able to draw down Flex Funds from an annual total pool of $3,000 per client enrolled (e.g., if Provider enrolls 100 clients annually, they will have a Flex Fund pool of $300,000 to draw down from as needed).
   i. Before allocating Flex Funds to clients, the Case Manager will verify that the client is actively participating in treatment and has financial need.
      a. At least three potential alternative resources (low cost–no cost options) must have been considered, prior to requesting Flex Funds.
      b. Alternative resources may include utilizing the consumer's support system of friends and family, community, and/or other funding sources.
   ii. Should the client's Case Manager identify a need for Flex Fund usage, they will get approval from their FSP Program Manager prior to allocating Flex Funds to the client.
      a. Any single request in the amount over $3,000 will need approval from the BHRS Clinical Services Manager before reimbursement.
   iii. Documentation of all Flex Funds must be submitted using the standardized Flex Fund Expense Reimbursement Claim Form.
      a. A receipt must be provided for every purchase and the Case Manager will maintain a 'Flex Funds Tracking Sheet' which will account for all expenditures and will include the date of expense, expense amount, the name of the person/organization the funds were paid to, the client's name, and the reason for funding provision.
      b. FSP Providers will submit to the BHRS Contract Monitor a monthly spreadsheet detailing the utilization of flex funds as supporting documentation for their monthly invoice.
      c. BHRS Clinical Services Manager may request access to the Flex Funds Tracking Sheet at any time.
   iv. Items purchased with Flex Funds become the property of the client and the client is not obligated to return the property upon leaving the program.
      a. There may be clinical situations in which a Provider and client make an agreement for the client to reimburse the Provider for the services/ supports, including the payment of rent that the Provider purchased on the client's behalf.

2. *Allowable Expenses* - Listed below is a general guideline for common expenses.

a) Client Housing Support
   i. Hotel/Shelter Subsidies (intended to be a short-term subsidy) (guidelines below should be followed and community resources should be exhausted)
   ii. One time Rent/Lease Subsidies (e.g., apartments, Sober Living Homes, Adult Residential Facilities)

iii. Residential substance use treatment programs
iv. Security Deposits (community resources should be exhausted)
v. Transitional Residential Programs
vi. Credit Reporting Fees
vii. Criminal Background Check Fees
viii. One time Utility payment, e.g., electricity, gas, water (community resources should be exhausted)
ix. Moving Expenses
x. Furniture/Appliances
xi. Household Items (e.g., Kitchenware, Linen/Bedding, Cleaning Products)

b) Client Supports
i. One time auto expense, e.g., gasoline, insurance, payment, registration, repair
ii. Clothing
iii. Culturally appropriate alternative healing methods, e.g., curandero, cupping, acupuncture
iv. Education and Tutorial Expenses
v. Employment, e.g., uniforms, license fees, safety attire, tools of the trade
vi. Food
vii. Hygiene Items
viii. Medical/ Dental/ Optical (all funding in this category must be reviewed and approved by the FSP Program Director).
ix. Recreational/Social Activities
x. Contingency management i.e., inexpensive, small primary reinforcers for behavioral management purposes linked directly to client service plans
xi. Transportation, e.g., Bus Passes, Tokens, Taxi Vouchers
xii. Vocational

3. *Non-Allowable Expenses*
a) Alcohol
b) Costs for staff to accompany clients to venues such as sporting events, concerts or amusement parks
c) Illegal substances / activities
d) Medi-Cal Share of Cost
e) Prescription drugs that would otherwise be available via Indigent Medication / Prescription Assistance programs
f) Sexually explicit materials
g) Tobacco
h) Vehicles for programs

4. *Reasonable and Allowable Purchase Limits*
a) Flex funds will be used when clients do not have resources and other possible avenues for funding have been explored and exhausted.
b) Uses of Flex Funding that are not consistent with the guidelines may be disallowed. However, individual expenses are unique to each client and are not necessarily limited to those listed in the guidelines above.

c) If the Provider or FSP Team member is unsure whether an item is appropriate for the use of Flex Funds, please consult with BHRS FSP Clinical Services Manager.
d) Exceptions to these guidelines may be made on a case-by-case basis with pre-approval by the BHRS Clinical Services Manager.

R. Program Completion Procedures

1. *Client Transfers*: A client may be transferred between FSP teams within the same agency, or between FSP agencies, provided the new FSP program/agency has space available and agrees to the transfer.
   a) Under certain circumstances, client transfers can occur because the client requests a transfer, because a client's linguistic or cultural needs are not being met, or because the client's needs can be better served by a different program.
   b) The reasons for transfer include:
      i. Temporary restraining order (TRO)
      ii. Change of provider request
   c) Transferring clients between FSP teams must be coordinated between the current program, the new/receiving program, and the BHRS Clinical Services Manager.
   d) BHRS Clinical Services manager must authorize all requests for client transfer from the current FSP program prior to an agency officially terminating services.
   e) The FSP program will not stop serving the client until the transfer has been approved by the BHRS Clinical Services manager, the required documentation has been completed, and the case has been opened at the new/receiving program.
   f) When transferring a client to another FSP provider or to other outpatient services, the other FSP provider will be required to send a current referral form, the client's assessment and service plan, medication list, progress notes within the last 6 months on the client, all pertinent legal documents (e.g., copies of restraining order, LPS conservatorship designation), and a short client summary.
   g) The FSP team will report transfer process with the BHRS Clinical Services Manager to ensure that the client was opened to the new FSP program.

2. *Client Disenrollment*: Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within 90 days from the date of last contact. Requests for disenrollment will be considered when clients meet one of the following criteria:
   a) Client decided to discontinue FSP participation or cannot be located.
      i. Client has either withdrawn consent (if enrolled voluntarily), refused services after enrolling, or no longer wishes to participate in FSP.
      ii. Prior to requesting disenrollment, the FSP team should have made significant and repeated attempts, for at least 60 days, to re-engage the

client in FSP services (see section on Outreach and Engagement for guidance on required attempts).

iii. If the client is missing and has not made contact with the FSP provider, the program will make at least 5 attempts in person; at least 5 attempts by phone; at least 3 attempts to contact family, other service providers, and/or significant others; and phone calls to the jail, local hospitals, and other emergency services without locating the client (see section on Outreach and Engagement for guidance on required attempts).

iv. FSP teams will attempt to locate the client for at least 60 days prior to disenrollment.

b) Client has moved to a higher level of care or locked facility where outpatient mental health services are not needed.

i. Appropriateness for disenrollment under these criteria may include:

a. Client is admitted to an IMD, Mental Health Rehabilitation Center (MHRC) or other long-term care facility that will provide mental health services. Client is anticipated to remain in one of these facilities for over 90 days.

b. Client will be detained in jail or will be serving DOJ/jail/prison sentence. Client is anticipated to remain in one of these facilities for over 90 days.

c. Client is admitted to a nursing home or other long-term care facility that will provide mental health services. Client is anticipated to remain in one of these facilities for over 90 days.

c) Client has successfully met goals such that discontinuation of FSP services is appropriate.

i. Appropriateness for disenrollment these criteria may include:

a. stabilization of illness

b. involvement in meaningful activities (e.g., employment, education, volunteerism, social activities)

c. residing in the least restrictive environment possible

d. ability to independently attend to behavioral and physical health follow up

ii. Prior to considering disenrollment of clients based on successfully meeting goals such that discontinuation of FSP services is appropriate, the FSP team will:

a. Engage in a process of client-centered planning over months prior to disenrollment

b. Work with the client to identify the resources and supports needed for the transition to lower intensity services

c. Collaborate with natural supports and social service providers to problem-solve for future challenges

d. Establish procedures for updating the FSP team in case of clinical problems

e. Make the necessary referrals and linkages for treatment, rehabilitation, and/or supportive services

f. Attempt to meet together with the client and with new service providers

g. In the event the client will be stepped down FSP team will continue to keep the case open for 30 days and participate in warm hand off meetings as necessary.
h. Re-enroll the client during this 30-day follow-up period if the client will benefit from a return to FSP care

d) Client has moved to another county. Client relocated to a geographic area outside of San Mateo County.
   i. Appropriateness for disenrollment under these criteria may include:
      a. Supporting client in enrolling medical insurance in the relocation county
      b. Supporting client in accessing appropriate level of care for behavioral health services
      c. Work with relocation county to provide enough medications until case is transferred

e) Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.
   i. Guidance under these criteria include:
      a. Inform BHRS Clinical Service Manager or clients passing and completing an incident report within 24 hours of incident.
      b. Provide support to client's family is appropriate to do so.

3. *Disenrollment Process* - The BHRS Clinical Services Manager or designated alternative representative must authorize all requests for client disenrollment from the FSP program prior to an agency officially terminating services.
   i. All requests for disenrollment of a client receiving services from an Adult FSP provider will be submitted and approved by BHRS Clinical Services Manager prior to the client being disenrolled from services.
   ii. Clients who are acutely decompensated, at high acute risk for dangerous clinical outcomes, and/or at acute clinical risk for hospitalization should not be disenrolled unless appropriate care from another provider is established and the client has demonstrated the ability to receive ongoing services from this new provider.
   iii. The disenrollment authorization process includes the following:
      a. Upon determining that a client meets disenrollment criteria, the FSP provider will complete the Full-Service Partnership Disenrollment Request Form and submit it to the appropriate BHRS Clinical Service Manager for pre-authorization of disenrollment.
      b. The BHRS Clinical services manager will review the disenrollment request within 3-5 business days of receipt.
      c. Clients that meet FSP disenrollment criteria will be authorized and FSP program will be notified.
      d. If disenrollment is authorized, the FSP program can stop serving the client and provider needs to ensure all outcomes are entered prior to filing discontinuation documentation with the authorized disenrollment reason indicated in the Outcome Measurement Application.
      e. For clients that do not meet disenrollment criteria, the BHRS Clinical Services Manager will complete and send the Full-Service

Partnership Disenrollment/Transfer Request Supplemental Form to the FSP program. The FSP provider team must continue providing services.

iv. If an FSP provider does not agree with the decision of the BHRS Clinical services manager, the agency will appeal the decision by completing the Full-Service Partnership Appeal Form and submitting it to the BHRS Deputy of Adult and Older Adult services, overseeing the area in which the agency is delivering FSP services.

v. The BHRS Deputy of Adult and Older Adult services will confer with the appropriate BHRS Program Staff to make a joint determination regarding the disposition.

4. *Graduation or Step-Down of Services* – FSP Clients will be assessed for readiness to step down from FSP services or graduate from services as described below:
   a) Factors that would be evaluated for appropriateness of graduation or step down will include, but is not limited to the following:
      i. stabilization of illness;
      ii. involvement in meaningful activities (e.g., employment, education, volunteerism, social activities);
      iii. residing in the least restrictive environment possible; and
      iv. ability to independently attend to behavioral and physical health follow up.
   b) Clients considered for a reduction in services will be discussed with the BHRS Clinical Services Manager to support next steps, including the transfer to a lower level of care (wellness tier) support within the FSP provider, as needed.
      i. FSP providers may use FSP slots for a client that needs a lower level of care and will invoice for these services accordingly.
   c) FSP Step Down Criteria – the following eligibility criteria will be assessed for step down readiness:
      i. Current FSP client with high risk of hospitalization or incarceration without the need for field-based services.
      ii. Client has not had any inpatient psychiatric hospitalizations in the past year.
      iii. Client is routinely willing and able to take meds with prompts and attends psychiatry appointments as scheduled with minimal support.
      iv. Client has been able to maintain being housed for at least two years
      v. Client has made significant progress of their service plan goals and has been able to identify outside resources such as community support to continue their recovery
      vi. Client has been linked and is engaged in community support networks such as peer led organizations, faith-based groups or other social activities.
      vii. Client is connected to community or County based primary health care services and has demonstrated ability to attend their appointments within the past year.
   d) Graduation of Services - the following eligibility criteria will be assessed for graduation readiness:

i. Client no longer needs field-based services to maintain stability in community
ii. Client has not had any inpatient psychiatric hospitalizations in the past two years.
iii. Client is routinely willing and able to take meds with prompts and attends psychiatry appointments as scheduled with minimal support.
iv. Client has been able to maintain being housed for at least three years
v. Client has met their service plan goals and has been able to identify outside resources such as community support to continue their recovery
vi. Client has been linked and is engaged in community support networks such as peer lead organizations, faith-based groups or other social activities.
vii. Client is connected to community or county based primary health care services and has demonstrated ability to attend their appointments within the past two years.
viii. Client has demonstrated independence in all activities of daily living such as hygiene, cooking, cleaning, shopping, use of transportation, following through with appointments, medication compliance, budgeting for the past two years
ix. Client has created and effectively utilized a WRAP plan for at least one year.

5. *Notification of Death* - FSP provider will immediately notify BHRS Clinical services manager upon becoming aware of the death of any client provided services hereunder.
   a) An FSP provider team member should notify the Clinical services manager immediately by telephone and in writing upon learning of such a death.
   b) The verbal and written notice will include the name of the deceased, the date of death, a summary of the circumstances thereof, and the name(s) of all provider team staff members with knowledge of the circumstances.
   c) An incident report must be filed within 24 hours of being notified of clients passing.

VI. SITE AND HOURS OF OPERATION

1. FSP Service Site(s)

a) FSP Services will be provided in enrollee homes and other community sites throughout the County.
   i. Address(es) where FSP Services will be provided to BHRS to be listed in legal agreement with BHRS.
   ii. Service sites may be changed upon the approval by BHRS.
   iii. See section N.g. on Field-based Services for details on providing services outside of the provider site.

b) All FSP Service Site(s) will post:

i. Written procedures describing appropriate action in the event of a medical emergency; and
ii. A disaster and mass casualty plan of action in accordance with local and state requirements. Such plans and procedures will be submitted to BHRS upon request, within 3 business days.

2. Hours of Operation

a) FSP Services will be provided during regular business hours, but also on evenings, weekends, and holidays, as necessary for the client's wellbeing.
b) An FSP core team member will be expected to be on-call 24/7 in order to provide crisis care as needed.
c) FSP providers will be expected to submit, upon BHRS request, work schedules for each FSP Team at each FSP provider site.
d) The schedules will list the time frames by day of the week, morning, and afternoon and the tasks that will be performed.

Regular Business Hours	Regular business hours are Monday through Friday, 8am - 5pm. The full array of services should be available during these hours.
Evening/Weekend/Holiday Hours	Evening/weekend/holiday hours are after 5pm on a business day until 8am the following business day. The FSP Team(s) will provide in-person FSP services during these non-business hours as necessary for the client's wellbeing. Phone coverage should also be provided for triage and to determine if crisis response is necessary during these hours. Providing in-person services outside of regular business hours can be necessary for the client's wellbeing.
Crisis response hours	Crisis response hours are from 5pm until 8am the following business day, holidays and weekends. A FSP team member should be available during these hours to provide Assessment and Crisis Response Services by phone and in person.

VII. STAFFING

The Adult and Older Adult FSP will be staffed by a multidisciplinary team. Services should be delivered through a team-based model in which expertise is shared and clients are served by an entire team with varied expertise. One FSP team member may serve as the client's primary clinician to ensure client care, but adult FSP clients should be seen by multiple members of an adult FSP team on a regular basis. Most or all

members of the FSP team should serve every client in some manner at some point in time.

1. Staffing Values

Recruitment, hiring and retention strategies, including training of staff will promote the following core values:

a) Integrated Care: staff will have mental health and substance use treatment expertise and training to ensure an integrated service experience.
b) Whole Person Care: staff will have an understanding of whole person care model of treatment, meaning health and wellness are based on the well-being of the whole person.
c) Cultural Responsiveness: staffing objectives that reflect the cultural and linguistic diversity of the clients to ensure staff can provide services in a culturally and linguistically appropriate manner. Staff with fluency in the following languages is preferred, but not required: Spanish, Chinese (Cantonese and Mandarin) and Tagalog.
d) Trauma-Informed: staff will have a practical understanding of how to implement all trauma-informed approaches.
e) Recovery Oriented: staff will promote recovery-based services that are guided by an individualized plan developed between client and staff and signed off by the client to encourage clients to assume responsibility for their own wellness and recovery.
f) Lived Experience: clients are actively recruited for staff positions so as to incorporate the client perspective throughout the agency. Efforts will be made to develop specific positions for persons with lived experience.

2. Staff Contact with Clients

The FSP team will employ the following, but not limited to, guidelines for client visits:
a) Conduct one visit with every enrolled client once a week, with at least two to three total contacts per week
b) Ensure that at least 3 different FSP team members visit with each client within a 2-month period
c) Conduct at least 65% and preferably more of client visits in the field
d) Interventions with clients are mostly face to face visits.
e) Contact with each client will occur as often as clinically needed, which may be daily

3. Staff Team Meetings

a) FSP team members (i.e., those individuals named below) will employ the following, but not limited to, guidelines for team collaboration:
    i. Meet at least 4 days per week for a total of approximately 75 minutes per week per 50 clients served.
        - FSP Team(s) will meet as often as needed to address client needs.

- At least 75% of all team members should be present for at least 75% of the duration of these team meetings

ii. Communicate with one another throughout the day to ensure that the clinical needs of clients are met

iii. Devise communication strategies to ensure key teams members are made immediately aware of time-sensitive or high-risk situations

iv. Offer services in person a minimum of 40 hours a week during the hours that clients are most accessible, including early morning hours, evenings and weekends

b) FSP Team members will receive individual supervision on a regular basis and no less than every two (2) weeks.

4. Documentation of Team Staffing

The FSP Team Leader will employ the following, but not limited to, guidelines for tracking and communicating ongoing staffing:

a) Notify BHRS in writing of any permanent changes to service days/hours
b) Maintain an organizational chart that delineates the names, roles, and reporting lines of all staff on the team
c) Name partnering agencies or key community partners such as FQHC clinics, County Health Clinics, and free clinics in the organizational chart
d) Submit the organizational chart to BHRS Clinical Services Manager on a yearly basis
e) Inform BHRS Clinical Services Manager within 2 weeks of any changes in the positions included in the organizational chart or changes to the staff reporting lines
f) Notify BHRS Clinical Services Manager of staff vacancies and provide a remediation plan for addressing prolonged vacancies lasting 4 weeks or longer

5. Staff Training

a) FSP provider will provide training programs for all new employees and continuing in-service training for all employees that provide FSP Services.
   i. Training may take place online or in person.
b) Every FSP Team member that delivers direct FSP Services to clients will participate in training activities.
c) FSP training and onboarding will be provided to new staff in the first month of employment.
d) FSP Team(s) will be trained in and incorporate the use of several evidence-based and community-defined best practices.
   i. Staff will receive a minimum of 20 hours annually of evidence-based and community-defined best practices.
e) BHRS required trainings include but are not limited to the following topics: Assertive Community Treatment (ACT)
   i. Care Team planning
   ii. Harm reduction
   iii. Strength-based case management

iv. Principles and Practices of wraparound
v. Motivational Interviewing, especially as it pertains to providing substance use/mental health integrated care Cognitive Behavioral Therapy (CBT), including Trauma-Focused CBT
vi. Peer support
vii. Life skills training
viii. HIPAA, Compliance, and other mandated trainings
ix. Cultural Humility
x. Working Effectively with Language Interpreters
xi. Sexual Orientation and Gender Identity orientation and gender differences
xii. Trauma-Informed Systems
xiii. Wellness and Recovery Action Plan (WRAP)
xiv. Co-occurring disorder assessment and treatment skill
xv. Risk-need-responsivity model for offender assessment and rehabilitation (justice-involved population)
xvi. Crisis response and de-escalation training
xvii. Disaster and emergency preparedness
xviii. Documentation standards i.e. Psychiatric Advance Directives
xix. Housing retention skills

f) Other suggested trainings:
i. Dialectical behavior therapy (DBT)
ii. Eye movement desensitization and reprocessing (EMDR)
iii. Neurosequential Model of Therapeutics (NMT)
iv. Seeking Safety

v. All training necessary to support the certification of Peer Support Specialists, in accordance with SB 803.

6. Team Staffing Requirements

Contractor shall maintain staffing patterns consistent with the FSP level(s) of care ensuring ACT/FACT/ICM teams meet minimum staffing composition requirements. On average, an ACT or FACT team is comprised of 10 behavioral health practitioners and supports a caseload of 100 individuals, while an FSP ICM team is comprised of 5 behavioral health practitioners and supports a caseload of 125 individuals.

The table below sets out a staffing pattern for FSP teams to serve 85 ACT/FACT enrolled clients, which may be adjusted based on FSP level of care needs, EBP fidelity assessments and in consultation with BHRS.

Client-Facing Positions	FTE
Team Leader / Program Manager=Supervising Clinician Team Leader must be licensed	1

Licensed or Waivered Clinicians/Therapists (e.g., LCSW, LMFT, Psychologist)	1.5
Case Managers/Community Health Workers/Medical Caseworkers	4
Housing Specialist	0.5
Peer Specialists - preferred expertise/experience includes but not limited to occupational therapy, supported employment, and substance use	1
Psychiatrist	.25
Nurse (RN, BSN, LVN, or Psychiatric Technician) - at least 0.5 of 1.0 FTE must be RN	.25
TOTAL Caseload Carrying FTEs	8.5
Non-Client Facing Positions	
FSP Director	0.5
Administrative Support Staff and Data and Billing Specialists – applicants will propose appropriate administrative and quality assurance staff	0.5
Total Non-Caseload FTE	1.0

a) Team Leader/Program Manager - the Team Leader/Program manager will be responsible for overseeing the daily operations of the adult FSP team. The Team Leader's responsibilities include:
   i. Monitoring team function to see that operational targets (e.g., weekly client visits, field-based services) are met
   ii. Facilitating team meetings to discuss the status of each client
   iii. Monitoring the size and relative level of acuity of team caseloads
   iv. Allocating the work of the adult FSP team to meet each client's needs
   v. Distributing the adult FSP staff into pairs to conduct outreach and engagement and deliver ongoing services
   vi. Serving as the point of contact for adult FSP staff throughout the day to address emergent needs
   vii. Ensuring all of the adult FSP staff participate in the timely development of an initial service plan and subsequent plan reviews
   viii. Ensuring that necessary program monitoring data is submitted in a timely fashion
   ix. Ensuring that chart entries are up to date
   x. Completing Critical Incident Reports as needed

b) Licensed or Licensed-Waivered Mental Health Professional - a Licensed Mental Health Professional (e.g., Clinical Social Worker, Marriage and Family Therapist, Psychologist) may either serve as the adult FSP Team Leader or carry a full adult FSP caseload. A Licensed or Licensed eligible Mental Health Professional will be responsible for:
   i. Documenting diagnostic assessments and service plans
   ii. Providing crisis intervention
   iii. Providing other services clinical interventions including psychotherapy that promote behavioral health wellness and recovery.
   iv. Providing individual- and group-based therapeutic interventions, including primarily short-term, solution-focused therapeutic interventions to assist clients in managing symptoms, understanding problematic behaviors, and developing and using more adaptive behaviors.
   v. Provide trauma-informed services throughout each stage of the recovery process.
   vi. Required therapy services include:
      - Cognitive Behavior Therapy (CBT), including Trauma-Focused CBT
      - Co-Occurring assessment and treatment
      - Motivational Interviewing
      - Harm Reduction
      - Risk-need-responsivity model for offender assessment and rehabilitation (justice-involved population)
   vii. Endorsed therapy services:
      - Dialectic Behavioral Therapy (DBT)
      - Acceptance and Commitment Therapy
      - Eye movement desensitization and reprocessing (EMDR)
      - Neurosequential Model of Therapeutics (NMT)
      - Seeking Safety (justice-involved population)
   viii. Offer support for improving social functioning and problem-solving skills
   ix. Provide psychoeducation and support to clients and their family members

c) Case Managers - Case Managers will have a behavioral health-related bachelor's degree or documentation of experience providing behavioral health services for a minimum of 2 years. At least one case manager will have substance abuse certification. Case Managers will be responsible for:
   i. Participating with all other team members in Outreach and Engagement activities
   ii. Participating with all other team members in service planning
   iii. Supporting delivery of Housing Services
   iv. Supporting the delivery of Recovery-Oriented Services
   v. Providing strength-based case management

d) Peer Specialist - a Peer Specialist is an individual with lived behavioral health experience who provides peer-to-peer counseling and support. The Peer Specialist will be responsible for:
   i. Participating with all other team members in Outreach and Engagement activities

ii. Participating with all other team members in service planning
iii. Supporting delivery of Housing Services
iv. Supporting the delivery of Recovery-Oriented Services
v. Helping to link the clients to Peer based organizations in the community
vi. Facilitate Peer support groups to foster healthy peer relationships and to build client capacity to address challenges to their recovery as well as celebrate their accomplishments on the journey to recovery

e) Psychiatric Prescriber - a Psychiatric Prescriber is a Psychiatrist, or Psychiatric Nurse Practitioner with Psychiatrist supervision. The psychiatrist will conduct tasks in close collaboration with other members of the FSP team in order that these activities are integrated into an overall service plan. The psychiatrist will be responsible for:
   i. Service delivery and oversight of the treatment of clients' chronic or episodic psychiatric needs
   ii. Completing and documenting screenings and diagnostic assessments
   iii. Ordering laboratory tests
   iv. Prescribing, dispensing and monitoring the safety and effectiveness of psychiatric medications
   v. Testifying in mental health court proceedings regarding conservatorship when appropriate
   vi. Completing conservatorship paperwork when indicated
   vii. Assisting with communication and care coordination with hospitals and other service providers
   viii. Maintaining Risk Evaluation and Mitigation Strategies (REMS) certification to allow for prescribing of clozapine
   ix. Being familiar with all long-acting injectable antipsychotics, mood stabilizers and other medications used for SMI
   x. Providing Medication-Assisted Treatment, for alcohol and opioid use disorders (OUD): such as Naltrexone (oral or intramuscular), Buprenorphine (oral or subcutaneous), other medications as indicated to manage cravings, withdrawal symptoms and support recovery. Linking to BAART/BayMark for methadone evaluation where appropriate and ensuring individuals with OUD have Narcan.
   xi. Regularly conducting client visits in the field, both for routine evaluations and to serve, as clinically indicated, clients who will not or cannot come to the clinic for visits
   xii. Maintaining LPS certification to be able to place clients on involuntary hold
   xiii. Being available for phone consultation with all adult FSP team members when clinical urgencies arise
   xiv. Being active in facilitating all aspects of hospital admission as needed to support the team (i.e., decision-making, arranging hospital admission, communicating with inpatient unit)

f) Mental Health Nurse - Mental Health Nurses (R.N., B.S.N., or Psychiatric Technician) may have an advanced degree (i.e., RN) or a bachelor's degree in

nursing (i.e., BSN). A Psychiatric Technician may be used in lieu of one but not both RN/BSN nurses. The Mental Health Nurse will be responsible for:

i. Monitoring and administering injectable medications
ii. Monitoring and managing oral medication, including by conducting medication reconciliation with clients
iii. Organizing and supervising filling of prescriptions and pill boxes or Medi-set together with clients.
iv. Regularly conducting client visits in the field, both for routine evaluations and to serve, as clinically indicated, clients who will not or cannot come to the clinic for visits
v. Conducting routine health assessments
vi. Coordinating receipt of needed medical services when indicated.

g) Housing Specialist – a Housing Specialist may be a Community Health Worker, Case Manager, or Clinician with specialized training in providing housing services. Housing Specialists will:

i. Work with all FSP clients to achieve their housing goals
ii. Understand and utilize the Coordinated Entry System (CES)
iii. Outreach to property owners and managers, and maintain professional relationships in order to promptly address concerns to avert evictions
iv. Assist individuals in completing applications for rental subsidies such as Section 8, Mental Health Services Act (MHSA) or No Place like Home (NPLH) housing, Canyon Vista, or other voucher opportunities and for housing programs or private rental agreements.
v. Work with other FSP team members to ensure delivery of all housing services and provide housing retention support in coordination with the client's case manager.

h) Employment Specialist or Occupational Therapist - an Employment Specialist will ideally be a Licensed or License-Waivered Occupational Therapist, but this position may also be filled by a Community Health Worker with specialized training. The Employment Specialist or Occupational Therapist will:

i. Work with other FSP team members to ensure delivery of all Employment, Volunteering, and Education services described above.

i) Community Health Worker, Case Manager, or Clinician – this team member will have a minimum of 6 months of training in providing substance use services. This position will:

i. Provide individual, group and/or family informational and educational counseling to clients moving through the continuum of recovery
ii. Help clients access community-based self-help groups, residential programs and detoxification programs
iii. Teach clients harm-reduction skills to manage cravings, triggers, and high-risk behaviors
iv. Provide clients' family members and significant others with a greater understanding of their role in the client's recovery process

v. Work with other FSP team members to ensure integration of all Substance Use services

j) FSP Director – the FSP Director will serve as the leader across all FSP teams. The FSP Director ensures consistent vision across teams and collaboration between teams. BHRS must have access to the FSP Director during regular business hours via telephone and e-mail. The FSP Director will act as a central point of contact with BHRS for all matters related to FSP Services.
k) Administrative Support Staff - support staff will be responsible for overseeing and/or completing administrative tasks (e.g., scheduling, supplying) required by the adult FSP team. It is highly recommended that FSP providers have sufficient administrative staff to support the overall functioning of FSP Programs.

l) Data and Billing Specialists/Quality Assurance Staff - Data and Billing Specialists will be responsible for overseeing and/or supporting the completion and submission of billing data, outcomes data, and any additional data reports for the adult FSP team. It is highly recommended that FSP Providers have sufficient capacity to fulfill the state data requirements and support relevant client outcomes monitoring.

VIII. CULTURAL RESPONSIVENESS

FSP providers will provide culturally responsive services to ensure compliance with the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS). FSP providers will be expected to consult with BHRS if unable to comply with any of the following requirements:

1. Cultural Competence Plan

Submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the BHRS Clinical Services Manager and the Office of Diversity & Equity (ODE) by September 30th of the fiscal year. The annual cultural competence plan will include an update of, not limited to, the following:

a) Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.
b) Forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).
c) Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.
d) Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Recruit, hire and retain staff members who can provide services in a culturally and linguistically appropriate manner.)

e) Ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Collaboration in Equity Efforts

a) Actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend a Health Equity Initiative (HEI), including but not limited to the Diversity & Equity Council (DEC). Participation in an HEI/DEC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders.

b) Submit to BHRS ODE by March 31st, a list of staff who have participated in these efforts. For more information about the HEI/DEC, and other cultural competence efforts within BHRS, contact ODE or visit https://www.smchealth.org/health-equity-initiatives.

3. Services in Threshold Languages

a) Establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are Spanish, Tagalog and Chinese (Mandarin and Cantonese).

b) If unable to provide services in those languages, consult with BHRS for additional resources.

4. Document Translation

a) Translate relevant and appropriate behavioral health- related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner.

b) Use BHRS- translated forms when available in an effort to create uniformity within the system of care.

c) Submit to ODE by March 31st, copies of health-related materials in English and as translated.

IX. QUALITY ASSURANCE

FSP providers will provide quality assurance, quality improvement and utilization management services to ensure compliance with all federal, State and County requirements, including compliance with documentation requirements for Medi-Cal reimbursable services. FSP providers will be expected to monitor all FSP services provided to the satisfaction of the County.

1. Communication and Collaboration

a) FSP program staff will participate in the following meetings:
   i. Bi-weekly case conference meetings with BHRS
   ii. Quarterly meetings with the BHRS Deputy Director
   iii. Annual review panel to assist in the management of the client level of care needs.

b) The FSP staff, Correctional Health Services staff, and BHRS staff will build a collaborative relationship to coordinate and communicate with one another regarding clients, and in particular, transition planning for clients being released from jail.

c) The FSP staff and the BHRS Assisted Outpatient Treatment (CARE) staff will participate in a monthly meeting with the BHRS CARE team to build a collaborative relationship to coordinate and communicate with one another regarding clients, and in particular, transition planning for clients entering into the FSP CARE Program, stepping down and discharges from FSP CARE Program.

d) The FSP staff and BHRS staff will coordinate and communicate with one another regarding the appropriateness and transition of FSP-enrolled clients stepping down to less intensive outpatient service programs and discharges from FSP services.

e) FSP program staff will also communicate substantive changes in a client's health, behavioral health, or criminal justice status immediately to BHRS, and/or the Conservator's office and will collaborate to assist the client to resolve those issues.

f) FSP providers will participate in outreach efforts to County behavioral health providers and local authorities/departments.

2. Quality Improvement Plan

a) FSP provider must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually by June 30.

b) The Quality Improvement Plan should address the following:
   i. How the FSP provider will comply with all elements of this Agreement
   ii. Maintain an audit disallowance rate of less than five percent (5%)
   iii. First appointment will be within ten (10) days of referral or request of service.

c) BHRS QM will provide feedback if the submitted plan is missing critical components related to San Mateo County requirements.

i. Additional feedback may be available if requested prior to the submission date.

3. County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to the FSP provider services at any time during regular business hours.

a) Personnel will not unreasonably interfere with the FSP provider's performance.

X. REPORTING & EVALUATION REQUIREMENTS

The FSP provider will establish and utilize a comprehensive Data Collection and Reporting Plan to assure the County a consistently high level of data throughout the term of the FSP Contracts. FSP providers will be expected to submit to BHRS the Reporting and Evaluation Plan upon request for review.

1. FSP Outcomes

FSP providers will maintain accurate, timely reporting of outcome data to allow for monitoring of program's effectiveness and allow for continuous improvement strategies. The following are prioritized FSP outcomes:

a) Increased stable housing
b) Reduced justice involvement
c) Reduced utilization of psychiatric facilities
d) Increased social connectedness
e) Improved Quality of life
f) Meaningful Use of Time (e.g., employment, volunteering, education)

2. Reporting Requirements

a) FSP Contractor shall comply with all program and fiscal reporting requirements set forth by appropriate Federal, State, and local agencies, and as required by County FSP providers will report (at monthly intervals) state-required client data on caseload, units of service and other evaluation data to the BHRS Management Information System (MIS) Unit.
b) Client registration will be completed within five (5) days of initial contact with the client.
c) The data will become incorporated into a year-end report, which will include such information regarding - reporting, monitoring, and evaluation of FSP program.
d) FSP providers will collect and report on data related to all enrolled CARE FSP clients:
e) For all court-ordered newly referred CARE clients to BACS, State-required set of data has to be entered into a data collection system (provided by a BHRS independent consultant) by the end of the first enrolled fiscal year.

f) Client satisfaction survey results on all CARE clients will be shared with BHRS CARE leadership annually.
g) FSP providers will collect and report a list of consumers that are maintained in a locked setting (including SMMC, 3AB or other psychiatric facility, jail and/or prison) for more than 60 days, to be submitted to BHRS on a monthly basis.
h) FSP providers will provide on a monthly basis a list of consumers that have had no contact with the FSP program (for any reason) for more than 45 days.

3. Data Collection

a) FSP providers will be expected to collect, data enter, manage and submit data as directed by BHRS to demonstrate FSP client outcomes, inclusive of guidelines set forth by DHCS.
b) FSP providers will utilize the following FSP data collection tools as required by DHCS:
   i. Partnership Assessment Form (PAF); to collect baseline information of clients including referral source, demographics and past history.
   ii. Key Event Tracking (KET) Form; to track major events in the client status; those which are best measured as the changes are occurring.
      - These would be domains such as residential status for which all changes are relevant. For example, it is important to know when and to what type of residence a person moved, in order to count the days in different types of residences, as well as the progression toward more independent living over time. If residential status is only collected on an interim basis, e.g., annually, the resulting data are not very meaningful, nor useful.
   iii. Quarterly Assessments (3M) Form; to collect current client status every three months.
      - This measure will produce quarterly summaries of the client's progress in important areas such as, education, financial support, legal status and issues, health status, substance use, and activities of daily living.

c) FSP Team(s) will ensure the accuracy of their data.

d) Data will be entered either directly into the DHCS maintained Data Collection and Reporting (DCR) system or the FSP provider's electronic healthcare record (EHR) system.
   i. If FSP provider will enter data directly into the DCR; FSP provider will participate in all pertinent DHCS training to ensure timely and accurate data entry.
   ii. If FSP provider will enter data into their agency's EHR system, FSP provider will have the ability to provide the data to BHRS in the format required by DHCS for XML batch data upload into the DCR.
e) FSP providers will submit a year-end report by the fifteenth (15th) of August each fiscal year to the MHSA Manager that includes program narrative, success, challenges and clients' stories.

4. Evaluation Activities

a) FSP providers will be expected to collect data on a consistent basis to allow for annual evaluation reports and at any time as requested for any past time frame.
b) BHRS will work with the FSP provider to ensure that any evaluation data collected includes client and family perspective in order to ensure meaningful interpretation and reporting of data.
c) FSP providers will support facilitation of annual evaluation activities as determined by BHRS, which will include focus groups and/or key interviews of clients and families to assess the impact of FSP services.

5. Continuous Improvement

a) FSP providers will participate in and support all BHRS continuous improvement efforts as they relate to Adult and Older Adult FSP services.
   - This will include quarterly data requests that will be shared with BHRS managers and Counties statewide to support statewide standardization efforts.
b) FSP providers will assist BHRS in the formation and management of the Community Advisory Board, which will be a volunteer group of individuals that represent the interests of adults with serious emotional disturbances in San Mateo County.
   - The Board will advise the FSP programs and provide ongoing direction about program policy, planning and development of Adult FSP services.

XI. FSP HOUSING

The FSP Housing Provider will: develop and maintain a strong continuum of housing options that meet the needs of the range of the FSP target population; work closely and collaboratively with the FSP service providers; be able to respond immediately to emergency or crisis placement needs as required by the Service provider; develop a transition plan that is respectful of current providers, causes no displacement of current clients and no disruption to current operations. Will ensure no unit or bed slot goes unfilled.

Service Approach

Contractor shall provide FSP enrollees with clean, safe, and affordable housing which is maintained in a good state of repair. Housing shall be located in areas that are readily accessible to required services such as transportation, shopping, recreation and places of worship. Contractor understands that there is a scarcity of such housing and securing housing at any level shall be done collaboratively with the needs of all of those being served by the mental health community in mind.

Contractor shall be responsible for providing enrollment opportunities with housing units of mixed types including augmented board and care, dormitory, congregate and supervised living, Single Room Occupancy (SRO), shelter and independent living.

Each type of housing unit shall provide a specific set of community living experiences, shall be supervised at rates determined by the individual's needs, and shall be financially subsidized at predetermined rates appropriate to the individual's needs and abilities. The contractor is responsible for locating niche placements, negotiating rates, paying supplemental costs over and above the client's ability to pay, and ensuring that clients meet their financial obligations.

The living experiences and housing options could include the following:

1. Supplemented/Augmented Board and Care

This housing experience shall focus on developing a permanent living arrangement for the medically frail/elderly individual or an enrollee who needs on-site supervision. The purpose of the supervision is to ensure that the individual is provided with medication management, and, to the degree needed, is provided with assistance in securing both medical as well as psychiatric management. The services could include reminding the individual of medical and psychiatric appointments, providing transportation or escort to appointments, and general observation of the individual's condition to ensure whenever possible interventions to treat problems that may arise occur as early as possible.

Supplemented/Augmented Board and Care services shall be above and beyond those of regular licensed Board and Care programs. The contractor shall be responsible to ensure the Board and Care provider has the necessary skills to provide these services and that they are maintained on a regular basis. These skills may be secured through attending appropriate classes offered in the community, by the Health System or by the contractor.

2. Supervised Living

Contractor shall provide a more permanent housing situation for those individuals who choose to live in more manageable living situations with modest supports. The contractor is responsible to ensure that the rent is paid in a timely manner and that the living unit is maintained in a safe, clean, and secure manner. The contractor shall make monthly room inspections or more often as is required to maintain the room in a clean and safe order.

3. Shelter Services

Contractor shall provide temporary living situations while working to assist individuals in finding permanent housing and securing other basic needs. The contractor shall insure that these temporary living situations are safe and meet minimal housing standards. The contractor shall strive to limit the use of shelters to a minimum and whenever a shelter is used, the individual, with the program staff, will either develop, or be in the process of utilizing a new housing plan as part of the overall service plan.

4. Alcohol and Other Drug (AOD) Treatment Residential Programs

This housing experience shall be limited to those individuals who require a residential alcohol or drug treatment program. This category of housing should be considered temporary for the purpose of achieving a drug or alcohol treatment goal.
Contractor will work with AOD providers to subsidize aftercare permanent housing.

5. Independent Apartment or House Living - Property Management

This housing experience shall focus on providing permanent safe and affordable housing where the individual has maximum control of their environment. The contractor shall ensure the property is rented and maintained in good repair, and that rent, and utility payments are made in a timely manner. The contractor shall inspect the independent units on a regular basis and ensure, when necessary, that all repairs are made as soon as possible. When living problems are identified, the contractor will ensure the treating team is notified and that the team takes immediate action to address any concern. The mechanics of the identification, leasing and ongoing maintenance of independent housing are described below:

Contractor property management assists clients in locating and acquiring safe, affordable housing. They help clients negotiate rental agreements, mediate landlord-tenant issues and establish and maintain utilities. Contractor leases, subleases, and/or acts as a rental guarantor for apartments to clients, enabling clients to establish a positive rental history.
Contractor property management staff shall collect and pay clients' rent. Staff shall work closely with the Housing Authority to acquire, manage, and maintain all housing contracts.

6. Rental Procedures

The contractor will meet the following objectives relating to rent collection and general tenant relations:

a) Contractor will ensure that 24/7 staff coverage is available to respond to housing landlord for any type of housing emergency.
b) Contractor staff will be available during regular business hours to assist tenants with a broad range of issues related to housing stability.
c) Contractor will establish a clear and consistent method for tenants to pay rent, including standard practices for providing notice to tenants regarding late payment.
d) When appropriate, Contractor will establish a 3rd party rent payment mechanism for tenants.
e) Contractor will develop and administer a client satisfaction survey that assesses tenant satisfaction with housing and property management services.
f) Should it be necessary to begin the eviction process, Contractor will proceed according to legal statute and requirements.

7. Eviction Prevention

Individuals who are deemed continuously disruptive will become the subject of a meeting to identify possible intervention to alleviate the problem. The participants in such meeting shall be the Property Manager as applicable, the Program Supervisor, the FSP Provider staff and when possible, the individual tenant. Efforts will be made to determine if the disruption is the result of symptoms of illness, or if the resident is under the influence of alcohol or drugs when the disruption occurs. Meeting participants will seek to determine if there is a cause that can be ameliorated, reduced, or eliminated to avoid eviction and will develop a plan of action based on complete, accurate and factual documentation of the activity. In cases where the disruptive behavior is a coping mechanism for symptoms which are never completely eliminated, participants will seek to identify housing that reduces interaction with others, while maintaining the necessary supports to keep the individual successfully housed.

8. Unit Maintenance and Habitation

One hundred percent (100%) of the units will meet local building and health codes at the time of initial rent-up.

One hundred percent (100%) of the units will be monitored by the contractor for proper functioning of safety issues including smoke detectors, plumbing, gas, electricity and heating systems and any issues or concerns will be reported immediately to the owner or the owner's designee.

Any hazards or other unsafe or unhealthy conditions that are reported by tenant, landlord, or program personnel will be investigated by contractor within twenty-four (24) hours. Life/safety issues (including, but not limited to heating, plumbing, and electrical systems) will be corrected within forty-eight (48) hours, or client will be relocated to temporary housing until hazard or unsafe condition is repaired. Non-emergency repairs will be corrected within fifteen (15) working days.

One hundred percent (100%) of consumers needing accessibility modifications will receive them prior to move-in.

After thirty (30) days of trying to resolve a unit habitability issue, if the suitable resolution has not occurred, Contractor will report such occurrence to BHRS Clinical Services Manager and BHRS Deputy Director for Adult and Older Adult Services.

Contractor will also observe and monitor the effect of the level of the consumer's instrumental activities of daily living (IADLs) upon their ability to maintain the cleanliness of their unit or to report any maintenance issues. Contractor staff will make regular inspections of consumer's units as part of tenancy and will work with consumers to improve the challenges they have in maintaining their living environment.

Contractors will need to develop and provide an evacuation and temporary shelter plan for any adverse events and/or natural disasters.

9. Target Community Area and Population

The program will be open to adults and older adults meeting the population criteria described below and enrolled in a Full-Service Partnership program. Special consideration is directed towards historically underserved populations including but not limited to Asian/Pacific Islander, Latino and African American populations. Both Medi-Cal and non-Medi-Cal eligible consumers will be offered the opportunity to participate.

Most of the adults with severe mental illness (SMI) and/or co-occurring serious mental illness and moderate/severe substance use disorders (SMI/SUD) served by the FSP will have histories of hospitalization, institutionalization, substance use, not engaged in medication treatment, and difficulty in participating in structured activities and living independently. Some individuals may have histories of assaultive behavior. It is possible that many consumers will have resided in long-term care facilities for extended periods. For some of these individuals, patterns of service have relied almost exclusively on emergency and institutional care. Others have bounced in and out of every type of service without improved outcomes.

Older adults with SMI or SMI/SUD will likely have cognitive difficulties and medical co-morbidities. Some SMI or SMI/SUD adults and older adults will be medically fragile. This group of consumers may have resided in long-term care facilities for extended periods or be at risk of placement. The program will serve as a step-down program for acute care, locked placements, and skilled nursing facilities in order to avoid prolonged institutional placements that often hasten the loss of an individual's sense of wellness, independence, and overall quality of life.

a. Populations to be served by the program are:
    i. Individuals whose SMI or SMI/SUD and the complex nature of their diagnoses and medical or other concerns result in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement.
    ii. Adults with SMI or SMI/SUD, and possibly substance use issues and current incarceration, and for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization.
    iii. Adults with SMI or SMI/SUD, often co-occurring substance use, currently placed in locked MH facilities; the FSP will target individuals living in sub-acute locked facilities located outside the county as a step-down, enabling them to return to their community. Many of these individuals will have behavioral problems that have caused them to be viewed as "difficult" IMD residents.
    iv. Individuals enrolled in FSP services

10. Staffing Requirements

FSP Housing program will describe the staffing model that reflects assignment of staff who have extensive experience, skills and knowledge working with a culturally, linguistically, ethnically and gender diverse severely mentally ill population.

11. Training Requirements

a. 20 hours of training per staff per year
b. Topics must include at a minimum:
    i. Confidentiality
    ii. HIPAA
    iii. Compliance
    iv. Fraud, Waste and Abuse
    v. Critical Incident Management
    vi. Cultural Humility
    vii. Gender sensitivity
    viii How to work with Interpreter (if using interpreter services)
    ix. Working with SMI/SUD Co-occurring tenants
    x. Working with peer workers
    xi. Motivational Interviewing
    xii. Critical Incident Management
    xiii. Harm Reduction principles
    xiv. Housing Retention Skills
    xv. Trauma Informed Care
    xvi. Independent life skills building (including, but not limited to, menu/meal planning, basic food preparation, cleaning, laundry, money management, how to use/access transportation and socialization)
c. Level of experience

    The FSP Housing program will have experience with the housing needs of the target population and have success in working with landlords, residential care operators and others. The FSP Housing program will have successful experience collaborating intensely with Full-Service Partnership providers to meet the needs of the FSP target population.

12. Communication/Collaboration Requirements and Reporting Requirements

Regular effective communication and skilled collaborative planning and operations are key components of FSP Housing. Providers will schedule regular meetings internally and with all potential partners to support the FSP tenants.

Ongoing housing operational meetings will be scheduled once a month and will include supervisory staff, collaborative partner supervisors and a BHRS manager.

Designated administrator of the FSP housing program will meet quarterly with Deputy Director of Adult Services to review data and discuss any problems or concerns regarding the program and reasons why they exited.

13. Other reports

Changes to staffing levels must be reported to the BHRS manager on a monthly basis, including staff vacancies.

14. Referrals

All referrals for occupancy of FSP housing units will be seriously mentally ill residents of San Mateo County and will come from any of the FSP providers approved by BHRS.

15. Discharge Process

The BHRS Clinical Services Manager or designated alternative representative must be notified of all pending evictions. Contractor will work with the FSP client's treatment team to identify other housing opportunities.

17. Specific Deliverables

a. Supportive FSP Housing: 90% of tenants will remain housed a least 12 months after move in.

b. Temporary Housing: 90 % of tenants will move to permanent housing within 24 months of move in.

c. Quality of service and housing: 90% of tenants will respond with positive satisfaction with the quality of services.

18. Disaster and Emergency Response Plans

For all FSP Housing programs contractor will develop and maintain a Disaster and Emergency Response Plan (“Emergency Plan”) that includes all of the elements set forth in Exhibit AR, Behavioral Health & Recovery Services Requirements, Section II.A, Disaster and Emergency Response Plans, as well as any additional elements reasonably requested by the County. Disaster and Emergency response plans must be reviewed and updated if any significant changes biannually.

XIII. GOALS AND OBJECTIVES

A. Program

Data to be collected by Contractor.
Goal One: Consumers shall be maintained in stable housing. (Housing)

Objective One: Sixty percent (60%) of consumers who live in supported housing will remain in stable housing for at least one (1) year.

Data to be collected by Contractor.

Objective Two: Ninety Percent (90%) of consumers will be satisfied with property management services. (Housing).

Data to be collected by Contractor.

B. Reporting

Contractor shall comply with all State Department of Health Care Services reporting requirements for Mental Health Services Act Full-Service Partnerships including collections using State instruments, maintenance according to State guidelines, and reporting using State processes. Data collected will include but are not to be limited to:

1. Consumer's Satisfaction
2. Medical/Psychiatric Hospitalization
3. Residential Status
4. Employment
5. Incarceration
6. Emergency Room Contacts
7. Financial Status
8. Legal Events
9. Monthly status reports including enrollments, disenrollment's, jail, locked and twenty-four (24) hour placements.

*** END OF EXHIBIT A ***

EXHIBIT AR
BEHAVIORAL HEALTH & RECOVERY SERVICES REQUIREMENTS

I. HEALTH ORDER COMPLIANCE REQUIREMENTS

Comply with employer requirements established by Cal-OSHA through the COVID -19 Prevention Non-Emergency Regulations which are chaptered in the California Code of Regulations, Title 8-Cal/OSHA, Chapter 4 Division of Industrial Safety, Subchapter 7 General Industry Safety Orders, Section 3205 COVID-19 Prevention.

This section applies to all employees and places of employment with the exception of locations with one employee that does not have contact with other persons, employees working from home, or employees teleworking from a location of the employee's choice, which is not under the control of the employer.

Employers can comply with this section by either maintaining a COVID-19 Plan that was required by previous contract conditions or as part of the required Injury and Illness Prevention Program required by Section 3203.

Employers are required to comply with COVID-19 Prevention requirements of Cal/OSHA.

More information, including access to the text of the regulations, COVID-19 Prevention Plan Templates, Frequently Asked Questions, and Fact Sheets can be found at https://www.dir.ca.gov/dosh/coronavirus/Non_Emergency_Regulations/.

II. ADMINISTRATIVE REQUIREMENTS

A. Disaster and Emergency Response Plans

Contractor will develop and maintain a Disaster and Emergency Response Plan ("Emergency Plan") that includes all of the elements set forth in this Section, as well as any additional elements reasonably requested by the County. The Emergency Plan will also include site-Specific emergency response plan(s) for each of the sites at which Contractor provides services pursuant to this Agreement ("Site Plans"). The Emergency Plan and associated Site Plans will address Contractor preparations to effectively respond in the immediate aftermath of a national, state or local disaster or emergency ("Emergency Response") and plans for the ongoing continuation of Services under the Agreement during and after a disaster or emergency ("Continuity of Operations").

Contractor shall submit the Emergency Plan to the County within ninety (90) days after the beginning of the Term of the Agreement and no later than September 30th. The Emergency Plan will follow the template provided in Attachment T: Sample Template for Disaster and Emergency Response Plan as a guide when developing the plan, adding any categories or items as needed for the Contractor's unique situation. The submitted Emergency Plan will be subject to the reasonable approval of the County. Contractor shall respond reasonably promptly to any comments or requests for revisions that the County provides to Contractor regarding the Emergency Plan. Contractor will update the Emergency Plan and associated Site Plans as circumstances warrant and shall provide County with copies of such updated plans. Contractor shall train employees on the Emergency Plan and the Emergency Plan will include a description of how employees will be trained.

The Emergency Plan will indicate, in as much detail as reasonably possible, the categories of additional staff, supplies, and services that Contractor projects would be necessary for effective Emergency Response and Continuity of Operations and the costs that the Contractor projects it would incur for such additional staff, supplies and services. Contractor shall recognize and adhere to the disaster medical health emergency operations structure, including cooperating with, and following direction provided by, the County's Medical Health Operational Area Coordinator (MHOAC). In the event that the Contractor is required to implement the Emergency Plan during the term of the Agreement, the parties will confer in good faith regarding the additional staff, supplies and services needed to ensure Emergency Response and/or Continuity of Operations owing to the particular nature of the emergency, as well as whether the circumstances warrant additional compensation by the County for additional staff, supplies and services needed for such Emergency Response and/or Continuity of Operations.

Contractor shall reasonably cooperate with the County in complying with processes and requirements that may be imposed by State and Federal agencies (including, but not limited to the California Governor's Office of Emergency Services and the Federal Emergency Management Agency) in connection with reimbursement for emergency/disaster related expenditures.

In a declared national, state or local disaster or emergency, Contractor and its employees will be expected to perform services as set forth in the Agreement, including in the area of Emergency Response and Continuity of Operations, as set forth in the Emergency Plan and each

Site Plan. Contractor shall ensure that all of its employees are notified, in writing, that they will be expected to perform services consistent with the Emergency Plan and each Site Plan.

B. Quality Management and Compliance

1. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually by June 30. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within fourteen (14) days of referral or request of service. BHRS QM will provide feedback if the submitted plan is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

2. Quality Improvement Activities and Participation

Contractor shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.

a) Contractor shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Contractor shall measure, monitor, and annually report to the County its performance.

b) Contractor shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Contractor shall assess client/family satisfaction by:

   i. Surveying client/family satisfaction with the Contractor's services at least annually.
   ii. Evaluating client grievances, appeals and State Hearings at least annually.
   iii. Evaluating requests to change persons providing services at least annually.
   iv. Informing the County and clients of the results of client/family satisfaction activities.

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

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

e) Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

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

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

h) Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

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

3. Referring Individuals to Psychiatrist

Contractor will have written procedures for referring individuals to a psychiatrist or physician when necessary, if a psychiatrist is not available.

4. Medication Support Services

For Contractors that provide or store medications: Contractor will store and dispense medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for dispensing, administering and storing medications consistent with BHRS Policy 99-03, Medication Room Management and BHRS Policy 04-08 Medication Monitoring located at www.smchealth.org/bhrs-documents. In particular:

a) Medications are logged in, verified, counted and added to inventory sheets.

b) All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

c) Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.

d) All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

e) Medications are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

f) Medications are disposed of after the expiration date and recorded.

g) Injectable multi-dose vials are dated and initialed when opened.

h) A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.

i. "Stock" medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

5. Timely Access to Services (ONLY IF THE CONTRACTOR IS BILLING FOR MEDI-CAL/SHORT-DOYLE SERVICES)

a) Contractor shall return phone calls to an authorized client within **one (1) business day**. Contractor shall offer an available initial visit with an authorized client within **five (5) business days of the client's request for an appointment**. The client must be seen within **ten (10) business days** of the request for an appointment.

b) The County shall monitor Contractor regularly to determine compliance with timely access requirements. (42 C.F.R. §438.206 (a), (c)).

c) The County shall work with the Contractor to improve timely access and/or take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. §438.206 (a), (c)).

d) TIMELY ACCESS Contractor shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of need for services. The County shall monitor Contractor to determine

compliance with timely access requirements and shall take corrective action in the event of noncompliance.

6. Record Retention

Section 14 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses.

7. Documentation of Services

Contractor shall provide all pertinent documentation required for state and federal reimbursement including but not limited to Consent Forms, assessments, treatment plans, and progress notes. Contractor agencies must submit, via fax to Quality Management at 650-525-1762, their version of these forms for approval before the forms are to be used. Special attention must be paid to documentation requirements for residential treatment facilities. Documentation shall be completed in compliance with the BHRS Policies & Documentation Manuals (as defined in Paragraph II. of this Exhibit). Contractor agencies are required to provide and maintain record of regular documentation training to staff providing direct services. Proof of trainings including attendance by staff may be requested at any time during the term of this Agreement.

System of Care (SOC) Short-Doyle Medi-Cal Mental Health Providers shall document in accordance with the BHRS Mental Health & AOD Documentation Manual located online at: https://www.smchealth.org/sites/main/files/file-attachments/bhrsdocmanual.pdf

SOC contractor will utilize either documentation forms located on http://smchealth.org/SOCMHContractors or contractor's own forms that have been pre-approved.

Substance Use provider services shall be in compliance with the Alcohol and Other Drug Services Provider Handbook which is located online at http://www.smchealth.org/bhrs/aod/handbook.

8. Audits

Behavioral Health and Recovery Services QM will conduct regular chart audits of Contractors. Contractor is required to provide either the original or copies of charts, including all documentation upon request. The Department of Health Care Services and other regulatory agencies conduct regular audits of the clinical services provided by BHRS and Contractors requiring submission of charts as requested. Contractor is required to provide all necessary documentation for external audits and reviews within the stated timeline.

9. Client Rights and Satisfaction Surveys

a) Administering Satisfaction Surveys

Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

b) Beneficiary/Patient's Rights

Contractor will comply with County policies and procedures relating to beneficiary/patient's rights and responsibilities as referenced in the Agreement.

c) Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

10. Beneficiary Brochure and Provider Lists

Contractor must provide Medi-Cal beneficiaries new to BHRS with a beneficiary brochure at the time of their first mental health service from the Contractor. Contractors are required to be aware of and make available to BHRS Medi-Cal clients all mandatory postings listed at this website http://www.smchealth.org/bhrs/providers/mandpost.

11. Licensing Reports

Contractor shall submit a copy of any licensing complaint or corrective report issued by a licensing agency to BHRS Quality Management, BHRS Deputy Director of Youth Services, BHRS Deputy Director of Adult and Older Adult Services, or the Manager of SU Services or their designee, within ten (10) business days of Contractor's receipt of any such licensing report.

12. Compliance with HIPAA, Confidentiality Laws, and PHI Security

a) Contractor must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards. Contractor is required to report any security incident or breach of confidential PHI to BHRS Quality Management within twenty–four (24) hours.

b) Contractor will develop and maintain a written Privacy and Security Program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities.

c) Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:

i. Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;

ii. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

iii. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

d) Confidentiality Training

Contractor is required to conduct, complete and maintain record of annual confidentiality training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

13. Other Required Training

Contractor will complete and maintain a record of annual required trainings. The following trainings must be completed on an initial and then annual basis:

a) Confidentiality & HIPAA for BHRS Mental Health and AOD: All New Staff HIPAA

b) Compliance Training for BHRS New Staff

c) Fraud, Waste, & Abuse Training for BHRS: All New Staff

d) Critical Incident Management for BHRS

e) Cultural Humility

f) Interpreter training (if using interpreter services)

Trainings may be offered through the County's Learning Management System (LMS) located at: https://sanmateocounty.csod.com/LMS/catalog/Welcome.aspx?tab_page_id=-67.

Contractor must register on the LMS site to access the training modules. The link to register for a LMS new account is: https://sanmateocounty.csod.com/selfreg/register.aspx?c=bh

rscp01. Proof of training, such as certificate of completion, may be requested at any time during the term of this Agreement.

14. Site Certification

a) Contractor will comply with all site certification requirements. Contractor shall maintain all applicable certifications through San Mateo County to provide any of the following reimbursable services: Short-Doyle Medi-Cal, Medi-Cal, Medicare, or Drug Medi-Cal.

b) Contractor is required to inform BHRS Quality Management, in advance, of the following major changes:

i. Major leadership or staffing changes.
ii. Major organizational and/or corporate structure changes (example: conversion to non-profit status).
iii. Any changes in the types of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.
iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).
v. Change of ownership or location.
vi. Complaints regarding the provider.

15. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS Quality Management on the same day of the incident or within 24 hours when there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

The incident reports are confidential however discussion may occur with the Contractor regarding future prevention efforts to reduce the likelihood of recurrence. Contractor is required to participate in all

activities related to the resolution of critical incidents, including but not limited to participation in quality improvement meetings, provision of all information requested by the County relevant to the incident, and Contractor staff cooperation.

16. Ineligible Employees

Behavioral Health and Recovery Services (BHRS) requires that contractors comply with Federal requirements as outlined in 42 CFR (438.608) Managed Care Regulations. Contractors must identify the eligibility of employees, interns, or volunteers prior to hiring and on a monthly basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting Form, Policy#93-11) should a current employee, intern, or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns, and volunteers by following procedures included in BHRS Policy # 19-08, which can be found online at: https://www.smchealth.org/bhrs-policies/credentialing-and-re-credentialing-providers-19-08. BHRS Quality Management must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in good standing and must submit a plan to correct to address the matter.

a. Credentialing Check – Initial

During the initial contract process, BHRS will send a packet of contract documents that are to be completed by the Contractor and returned to BHRS. Attachment A – Agency/Group Credentialing Information will be included in the contract packet. Contractor must complete Attachment A and return it along with all other contract forms.

b. Credentialing Check – Monthly

Contractor will complete Attachment A – Agency/Group Credentialing Information each month and submit the completed form to BHRS Quality

Management via email at: HS_BHRS_QM@smcgov.org or via a secure electronic format.

17. Compliance Plan and Code of Conduct

Contractor will annually read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct located at http://smchealth.org/bhrs-documents. In addition, Contractor will assure that Contractor's workforce is aware of compliance mandates and informed of the existence and use of the BHRS Compliance Improvement Hotline (650) 573-2695.

Contractor is required to conduct, complete and maintain record of annual compliance training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

18. Fingerprint Compliance

Contractor certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Contractor shall have a screening process in place to ensure that employees who have positive fingerprints shall:

a) Adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor; OR

b) Obtain an exemption from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as a part of their employment with the contractor.

A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

19. Staff Termination

Contractor shall inform BHRS, in a timely fashion, when staff have been terminated. BHRS Quality Management requires prompt notification to be able to terminate computer access and to safeguard access to electronic medical records by completing the BHRS Credentialing form.

20. Minimum Staffing Requirements

Contractor shall have on file job descriptions (including minimum qualifications for employment and duties performed) for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement. Contractor agrees to submit any material changes in such duties or minimum qualifications to County prior to implementing such changes or employing persons who do not meet the minimum qualifications currently on file. Contractor service personnel shall be direct employees, contractors, volunteers, or training status persons.

21. Medi-Cal Enrollment (MEDI-CAL ONLY SERVICES)

Contractor shall be enrolled in the Medi-Cal program or in the process of becoming enrolled. Contractor will keep BHRS informed on their enrollment status and submit proof of Medi-Cal enrollment.

22. Provider Application and Validation for Enrollment (PAVE)

a) Contractor shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal clients on behalf of Contractor, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to BHIN 20-071 requirements, the 21st Century Cures Act and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.

b) SMHS licensed individuals required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e. PAVE application package) available through the DHCS PED Pave Portal, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Psychologist, Licensed Educational Psychologist, Physician (MD and

DO), Physician Assistant, Registered Pharmacist/Pharmacist, Certified Pediatric/Family Nurse Practitioner, Nurse Practitioner, Occupational Therapist, and Speech-Language Pathologist. Interns, trainees, and associates are not eligible for enrollment.

C. Client Informing Materials

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

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

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

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

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

   a) The format is readily accessible;

   b) The information is placed in a location on the Contractor's website that is prominent and readily accessible;

   c) The information is provided in an electronic form which can be electronically retained and printed;

d) The information is consistent with the content and language requirements of this agreement;

e) The client is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days. (42 C.F.R. § 438.10(c)(6).)

6. Language and Format

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

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

c) Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Contractor's mental health education materials, available in the prevalent non-English languages in the county. (42 C.F.R. § 438.10(d)(3)).

d) Contractor shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Inst. Code § 14727(a)(1); Cal. Code Regs. tit. 9 § 1810.410, subd. (e), para. (4)).

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

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

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

7. Beneficiary Informing Materials

Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SMHS from Contractor. Beneficiary informing materials include but are not limited to:

a) Guide to Medi-Cal Mental Health Services
b) County Beneficiary Handbook (BHIN 22-060)
c) Provider Directory
d) Advance Health Care Directive Form (required for adult clients only)
e) Notice of Language Assistance Services available upon request at no cost to the client
f) Language Taglines
g) Grievance/Appeal Process and Form
h) Notice of Privacy Practices
i) Early & Periodic Screening, Diagnostic and Treatment (EPSDT) poster (if serving clients under the age of 21)

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

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

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

11. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

12. Informing materials will be considered provided to the client if Contractor does one or more of the following:

    a) Mails a printed copy of the information to the client's mailing address before the client first receives a specialty mental health service;

    b) Mails a printed copy of the information upon the client's request to the client's mailing address;

    c) Provides the information by email after obtaining the client's agreement to receive the information by email;

    d) Posts the information on the Contractor's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,

    e) Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If Contractor provides informing materials in person, when the client first receives specialty mental health services, the date and method of delivery shall be documented in the client's file.

13. Provider Directory

    a) Contractor must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.

    b) Contractor must make available to clients, in paper form upon request and electronic form, specified information about the county provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).

    c) Any changes to information published in the provider directory must be reported to the County within two weeks of the change.

d) Contractor will only need to report changes/updates to the provider directory for licensed, waivered, or registered mental health providers.

D. Client Rights

Contractor shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq; Title 9 California Code of Regulations (CCR), Sections 861, 862, 883, 884; Title 22 CCR, Sections 72453 and 72527; and 42 C.F.R. § 438.100.

E. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Office of Diversity & Equity (ODE) at 650- 573-2714 or ode@smcgov.org.

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the BHRS Analyst/Program Manager and the Office of Diversity & Equity (ODE) by September 30th of the fiscal year.

   The annual cultural competence plan will include, but is not limited to the following:

   a) Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.

   b) Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).

c) Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.

d) Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.)

e) Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend a Health Equity Initiative (HEI), including but not limited to the Diversity & Equity Council (DEC), for the term of the Agreement. Participation in an HEI/DEC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders. Contractor shall submit to BHRS Office of Diversity and Equity (ODE) by March 31st, a list of staff who have participated in these efforts. For more information about the HEI/DEC, and other cultural competence efforts within BHRS, contact ODE or visit https://www.smchealth.org/health-equity-initiatives.

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If Contractor is unable to provide services in those languages, Contractor is expected to contact their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact ODE.

4. Contractor will translate relevant and appropriate behavioral health- related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to ODE by March 31st, copies of Contractor's health-related materials in English and as translated.

5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/Program Manager and ODE (ode@smcgov.org) to plan for appropriate technical assistance.

F. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

G. Surety Bond

Contractor shall retain and show proof of a bond issued by a surety company in accordance with Community Care Licensing's regulations for a licensee who may be entrusted with care and/or control of client's cash resources.

H. Telehealth

1. Contractor may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.

2. All telehealth equipment and service locations must ensure that client confidentiality is maintained.

3. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.

4. Medical records for clients served by Contractor under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Contractor. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.

5. County may at any time audit Contractor's telehealth practices, and Contractor must allow access to all materials needed to adequately monitor Contractor's adherence to telehealth standards and requirements.

I. Chart Auditing and Reasons for Recoupment

1. Maintenance of Records

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

2. Access to Records

Contractor shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Contractor shall allow County, CMS, the Office of the Inspector General, the Controller General of the United States, and any other authorized federal and state agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor

pertaining to such services at any time and as otherwise required under this Agreement.

3. Federal, State and County Audits

In accordance with the California Code of Regulations, Title 9, Chapter 11, Section 1810.380(a), County will conduct monitoring and oversight activities to review Contractor's SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to SMHS as established in BHIN 21-073, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Contractor and County, and future BHINs which may spell out other specific requirements.

4. Internal Auditing

a) Contractors of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet SMHS definitions and be documented accurately.

b) Contractor shall provide County with notification and a summary of any internal audit exceptions, and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Contractor's internal audit process. Contractor shall provide this notification and summary to County in a timely manner.

5. Confidentiality in Audit Process

a) Contractor and County mutually agree to maintain the confidentiality of Contractor's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA and California Welfare and Institutions Code, Section 5328. Contractor shall inform all of its officers, employees, and agents of the confidentiality provisions of all applicable statutes.

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

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

6. Reasons for Recoupment

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

b) Such audits may result in requirements for Contractor to reimburse County for services previously paid in the following circumstances:

i. Identification of Fraud, Waste or Abuse as defined in federal regulation.
ii. Fraud and abuse are defined in C.F.R. Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d).
iii. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf
iv. Overpayment of Contractor by County due to errors in claiming or documentation.
v. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.

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

7. Cooperating with Audits

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

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

c) Contractor shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.

d) Contractor shall allow inspection, evaluation and audit of its records, documents and facilities for ten years from the term end date of this Agreement or in the event Contractor has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R.§§ 438.3(h) and 438.230I(3)(i-iii).

J. <u>Grievances, Appeals and Notices of Adverse Benefit Determination</u>

1. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

2. Contractor shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
3. Aligned with MHSUDS IN 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Contractor within

the specified timeframes using the template provided by the County.

4. Add County specific information regarding which, if any NOABDs are delegated to Contractor.

5. NOABDs must be issued to clients anytime the Contractor has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Contractor must inform the County immediately after issuing a NOABD.

6. Procedures and timeframes for responding to grievances, issuing and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).

7. Contractor must provide clients any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.

8. Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

9. Advanced Directives - Contractor must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i) (l), (3) and (4).

10. Continuity of Care - Contractor shall follow the County's continuity of care policy that is in accordance with applicable state and federal regulations, MHSUDS IN 18-059 and any BHINs issued by DHCS for parity in mental health and substance use disorder benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)

K. Compliance Program, including Fraud Prevention and Overpayments

1. Contractor shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608(a)(1), that must include:

2. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements.

3. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.

4. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.

5. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.

6. Effective lines of communication between the Compliance Officer and the organization's employees.

7. Enforcement of standards through well-publicized disciplinary guidelines.

8. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence and ongoing compliance with the requirements under the Contract.

9. The requirement for prompt reporting and repayment of any overpayments identified.

10. Contractor must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Contractor must report fraud and abuse information to the County including but not limited to:

11. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),

12. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42 C.F.R. § 438.608(a), (a)(2),

13. Information about changes in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).

14. Information about a change in the Contractor's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Contractor as per 42 C.F.R. § 438.608(a)(6).

15. Contractor shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

16. Contractor shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.

17. County may suspend payments to Contractor if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. §455.23. (42 C.F.R. §438.608 (a)(8)).

18. Contractor shall report to County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

19. Contractor may adopt the County's Compliance Program.

20. Integrity Disclosures - Contractor must annually complete and submit the Form 700 Attestation https://drive.google.com/file/d/1HYkjf6TULGkexoUqEaNgdc9PHC_uXa0g/view?usp=drive_link

L. Site Inspection

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

M. Additional Financial Requirements

1. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.

2. Contractor must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the United States Department of Health and Human Services may specify.

3. Contractor agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.

4. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

N. Contractor Prohibited from Redirection of Contracted Funds

1. Contractor may not redirect or transfer funds from one funded program to another funded program under which Contractor provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.

2. Contractor may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

O. Financial Audit Report Requirements for Pass-Through Entities

1. If County determines that Contractor is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Contractor represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Contractor shall observe and comply with all applicable financial audit report requirements and standards.

2. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

3. Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the Director. The Director is responsible for providing the audit report to the County Auditor.

4. Contractor must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

P. Sanction Authority Under Welfare and Institutions Code Section 14197.7: Administrative and Monetary Sanctions and Contract Termination for Mental Health Plans (MHPS) and Drug Medi-Cal Organized Delivery System Plans

1. When a Behavioral Health Plan (BHP), such as that implemented by the County, or its subcontractor fails to meet the terms of its contract with DHCS (Contractual Obligations) or fails to comply with applicable state or federal laws or regulations, the state plan or approved waivers, or for other good cause, DHCS may impose administrative and/or monetary sanctions on the BHP. BHPs shall ensure that they and their subcontractors shall comply with all Contractual Obligations, and applicable state and federal laws and regulations, the state plan, and approved waivers.

2. If Contractor is found to be noncompliant and DHCS imposes a monetary sanction, Contractor must promptly reimburse the County upon request. Alternatively, the County may offset the sanctioned amount against any payments due or to become due under this or any other agreement.

3. Link to full Behavioral Health Information Notice (BHIN) https://www.dhcs.ca.gov/Documents/BHIN-25-023-Enforcement-Actions-for-MHPs-and-DMC-ODS-Plans.pdf

Q. Additional Reporting Requirements

The Contractor acknowledges that, during the term of this Agreement, the State may implement or require additional reporting obligations. Upon written notice from the County as an additional Exhibit or Attachment, the Contractor agrees to comply with such additional reporting requirements.

*** END OF EXHIBIT AR ***

EXHIBIT B – PAYMENTS AND RATES
BAY AREA COMMUNITY SERVICES (BACS) (FSP)
FY 2026 – 2028

In consideration of the services provided by Contractor in Exhibit A, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

In full consideration of the services provided by Contractor under this Agreement and subject to the provisions of Section 3 of this Agreement, County shall pay Contractor in the manner described below:

A. Maximum Obligation

The maximum amount that County shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Section 3 of this Agreement. Furthermore, County shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement.

In any event, the maximum amount County shall pay is FIVE MILLION TWO HUNDRED TWENTY-NINE THOUSAND NINE HUNDRED NINETY-SEVEN DOLLARS ($5,229,997).

The County will review cumulative payments for the period of July – March and amend the contract amount accordingly.

B. Payment Rate

1. In consideration of the services provided by Contractor described in Exhibit A and subject to the terms of the Agreement, County shall pay Contractor based on the following fee schedule for the contract term of July 1, 2026 to June 30, 2028.

Maximum Obligations FSP			
Fiscal Year	**Description**	**Maximum Obligation**	**Monthly/Client FFS Rate**
July 1, 2026 – October 31, 2026	Cost Reimbursement	$784,315	-
November 1, 2026 – June 30, 2027	Fee for Service (FFS)	$1,513,016	-
	Medi-Cal FFS	$759,648	
	Non-Billable FFS/Client/Month (actual utilization)	$753,368	$1,223.00

Maximum Obligations FSP			
Fiscal Year	**Description**	**Maximum Obligation**	**Monthly/Client FFS Rate**
July 1, 2026 – June 30, 2027	Flex Funds ($3,000/Client)	$300,000	-
Total FY 2026-27 Maximum Obligation		**$2,597,331**	
July 1, 2027 – June 30, 2028	Medi-Cal FFS	$1,166,333	-
	Non-Billable FFS/Client/Month (actual utilization)	$1,166,333	$1262.26
July 1, 2027 – June 30, 2028	Flex Funds ($3,000/Client)	$300,000	-
Total FY 2027-28 Maximum Obligation		**$2,632,666**	
Total 2-Year Maximum Obligation		**$5,229,997**	

- *CARE FSP – 60 Slots & SB43 FSP – 25 Slots. The above rates are based on Contractor targeting 77 slots at any given time once fully operational.*
- *All third-party billing revenue for client services received by Contractor will either be deducted from monthly invoiced payment or repaid by check to BHRS.*

C. The Contractor acknowledges that, during the term of this Agreement, the State may implement or require additional reporting obligations. Upon written notice from the County as an additional Exhibit or Attachment, the Contractor agrees to comply with such additional reporting requirements.

D. Payments made to Contractor under the terms of this Agreement may be used for Program staff salaries, Program operations, and other direct expenses essential to the Program. No funds paid by County through this Agreement shall be spent for fundraising.

E. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

F. Modifications to the allocations in Section I.A of this Exhibit B may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Section 3 of this Agreement.

G. The Chief of San Mateo County Health or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

H. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing non unit

based, rate services under the terms of this Agreement through the end of the contract period without further payment from County.

I. In the event this Agreement is terminated prior to June 30, 2028 Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of Chief of San Mateo County Health or designee.

J. Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County. This shall include but not be limited to quality assurance (QA) audit disallowances as a result of QA Plan error or format problems with County-designed service documents.

K. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

L. Invoicing and Payment

1. Contractor shall submit monthly invoices to the County within 15 days after the close of the month in which services were rendered. Contractor will submit invoices on forms in a manner prescribed by the County. The invoice shall clearly summarize direct and indirect services (if applicable) for which claim is made.

a. Direct Services/Claims

Completed Service Reporting Forms or an electronic services file will accompany the invoice and provide back-up detail for the invoiced services. The Service Reporting Forms will be provided by County, or be in a County approved format, and will be completed by Contractor according to the instructions accompanying the Service Reporting Forms. County reserves the right to change the Service Report Forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary. The electronic services file shall be in the County approved Avatar record format.

b. Indirect Services/Claims

Indirect services (services that are not claimable on the Service Reporting Form or electronically) shall be claimed on the invoice and shall be billed according to the guidelines specified in the contract.

2. Following receipt and provisional approval of a monthly invoice, County shall make payment within 30 days. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in Exhibit C. Any Exhibit CPT, HCPCS code or rate updates will be made available to the Contractor on-line and/or via an Executive Letter by the County. Claims that are received after the fifteenth (15th) working day of the month are considered to be late submissions and may be subject to a delay in payment. Claims that are received 180 days or more after the date of service are considered to be late claims. County reserves the right to deny invoices with late claims or claims for which completed service reporting forms or electronic service files are not received. Claims may be sent to BHRS-Contracts-Unit@smcgov.org OR:

   County of San Mateo
   Behavioral Health and Recovery Services
   Attn: Contracts Unit
   2000 Alameda de las Pulgas, Suite 280
   San Mateo, CA 94403

M. Due to the County Controller's Office yearly "Black-Out Period" there will be no payments made in July or August. Payments for these months will be issued once the Controller's Office has reopened in September. This pertains to all fiscal years.

N. County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of San Mateo County Health or designee.

O. In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other agreement.

P. Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation

provided does not meet professional standards as determined by the Quality Improvement Manager of San Mateo County BHRS.

Q. Inadequate Performance

If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Section 5 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

R. Annual Financial Statements

Contractor shall submit to County year-end actual financial statement no later than ninety (90) days after the end of the fiscal year.

Financial statements shall include accounting for all services provided through the Agreement for each applicable period, and separate accountings for each Electronic Health Record system program. Financial statements shall be in accordance with the standard health accounting principles and format. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the financial statement. The detail financial statement total should agree to the audited statements provided.

As applicable, Contractor shall also submit to County a year-end Single Audit report with the financial statement.

The annual financial statement and Single Audit Report, as applicable, shall be sent to the BHRS Fiscal Officer, Diana Lao at dlao1@smcgov.org.

S. Beneficiary Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for

payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

T. Claims Certification and Program Integrity

1. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

   The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

   "Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

   Executed at _____ California, on _____20___

   Signed _____ Title _____

   Agency _____ "

3. The certification shall attest to the following for each beneficiary with services included in the claim:

   a. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.

   b. The beneficiary was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the beneficiary.

   c. The services included in the claim were actually provided to the beneficiary.

d. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

e. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement.

f. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

g. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

4. Except as provided in Section II.B.6. of Exhibit AR relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

*** END OF EXHIBIT B ***

Updated
6/16/2025

Exhibit C: San Mateo County Mental Health Contrator Outpatient Rates, FY 2025-26

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	Psychiatrist/ Contracted Psychiatrist	Physicians Assistant	Nurse Practitioner / Certified Nurse Specialist	RN	LVN	Licensed Psychiatric Technician	Medical Assistant	Pharmacist	Psychologist / Pre-licensed Psychologist	LCSW / LPCC / MFT	Occupational Therapist	Peer Recovery Specialist	MHRS / Other Qualified Providers
		PROVIDER TYPE HOURLY RATE		$ 1,493.23	$ 669.71	$ 742.55	$ 606.53	$ 318.62	$ 273.15	$ 219.03	$ 714.77	$ 600.53	$ 388.62	$ 517.31	$ 307.00	$ 292.38
10CA **	GROUP THERAPY 26+ MIN	90853	50	$ 276.52	$ 124.02	$ 137.51						$ 111.21	$ 71.97			
14CA ***	MD NP ASSESSMENT 31+ MIN	90792	60	$ 1,493.23	$ 669.71	$ 742.55										
150CA	MEDICATION GROUP	H0034	15	$ 82.96	$ 37.21	$ 41.25	$ 33.70	$ 17.70	$ 15.17	$ 12.17	$ 39.71					$ 16.24
16CA	MEDICATION INJECTION	96372	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76						
17CA	MEDICATION SUPPORT	H0034	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69					
2CA	CRISIS INTERVENTION	H2011	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
41CA *	FAMILY THERAPY 26+ MIN	90847	50	$ 1,244.36	$ 558.09	$ 618.79						$ 500.44	$ 323.85			
51CA	CASE MANAGEMENT	T1017	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
5CA	ASSESSMENT NON MD	H0031	15		$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
6CA	PLAN DEVELOPMENT NON MD	H0032	15		$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
70CA	REHABILITATION GROUP	H2017	15	$ 82.96	$ 37.21	$ 41.25	$ 33.70	$ 17.70	$ 15.17	$ 12.17	$ 39.71	$ 33.36	$ 21.59	$ 28.74		$ 16.24
7CA	REHABILITATION	H2017	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
90832CA	INDIVIDUAL THERAPY 16-37 MINUTES	90832	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26	$ 194.31			
90834CA	INDIVIDUAL THERAPY 38-52 MINUTES	90834	45	$ 1,119.92	$ 502.28	$ 556.91						$ 450.40	$ 291.46			
90837CA *	INDIVIDUAL THERAPY 53+ MIN	90837	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53	$ 388.62			
90839CA	PSYCHOTHERAPY for CRISIS 30+ MIN	90839	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53	$ 388.62			
90840CA	PSYCHOTHERAPY for CRISIS, each addtl 30 Min (MIS ONLY)	90840	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26	$ 194.31			
90885CA ***	ASSESSMENT (ONLY CHART REVIEW) 31+ MIN	90885	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53	$ 388.62			
96110CA***	DEVELOPMENTAL SCREENING 31+ Min	96110	60	$ 1,493.23	$ 669.71	$ 742.55	$ 606.53			$ 219.03		$ 600.53	$ 388.62	$ 517.31		
96112CA	DEVELOPMENTAL TESTING, 31+ Min	96112	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53		$ 517.31		
96113CA	DEVELOPMENTAL TESTING, each attl 30 Min (MIS ONLY)	96113	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26		$ 258.65		
96116CA	NEUROBEHAVIORAL STATUS EXAM, 31+ Min	96116	60	$ 1,493.23	$ 669.71	$ 742.55	$ 606.53					$ 600.53	$ 388.62			
96121CA	NEURO STATUS EXAM, each addl hr (MIS ONLY)	96121	60	$ 1,493.23	$ 669.71	$ 742.55	$ 606.53					$ 600.53	$ 388.62			
96125CA***	Standard Cognitive Performance Testing 31+ MIN	96125	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53				
96127CA***	Brief Behavioral Assessment 31+ MIN	96127	60	$ 1,493.23	$ 669.71	$ 742.55	$ 606.53			$ 219.03		$ 600.53	$ 388.62			

Updated
6/16/2025

Exhibit C: San Mateo County Mental Health Contrator Outpatient Rates, FY 2025-26

96132CA	NEURO PSYCH TEST EVAL, 31+ MIN	96132	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53				
96133CA	NEURO PSYCH TEST EVAL, Each Addl Hour (MIS ONLY)	96133	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53				
96136CA	PSYCH or NEURO TEST ADMIN, 16+ MIIN	96136	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26				
96137CA	PSYCH or NEURO TEST ADMIN , Each Addl 30 Min (MIS ONLY)	96137	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26				
99212CA	MEDICATION VISIT 10-19 MINUTES	99212	15	$ 373.31	$ 167.43	$ 185.64										
99213CA	MEDICATION VISIT 20-29 MINUTES	99213	25	$ 622.18	$ 279.05	$ 309.39										
99214CA	MEDICATION VISIT 30-39 MINUTES	99214	35	$ 871.05	$ 390.66	$ 433.15										
99215CA	MEDICATION VISIT 40+ MIN	99215	47	$ 1,169.70	$ 524.60	$ 581.66										
99347CA	MEDICATION VISIT 20-29 MINUTES (RESIDENTIAL ONLY)	99347	25	$ 622.18	$ 279.05	$ 309.39										
99348CA	MEDICATION VISIT 30-39 MINUTES (RESIDENTAL ONLY)	99348	35	$ 871.05	$ 390.66	$ 433.15										
99349CA	MEDICATION VISIT 40-59 MINUTES (RESIDENTIAL ONLY)	99349	50	$ 1,244.36	$ 558.09	$ 618.79										
99350CA	MEDICATION VISIT 60+ MIN (RESIDENTIAL ONLY)	99350	67	$ 1,667.44	$ 747.84	$ 829.18										
99366CA	NONMD TEAM CONF. PT/FAM PRESENT	99366	60		$ 669.71	$ 742.55	$ 606.53			$ 219.03	$ 714.77	$ 600.53	$ 388.62	$ 517.31		
99367CA	MD TEAM CONF. PT/FAM NOT PRESENT	99367	60	$ 1,493.23												
99368CA	NON MD TEAM CONF PT NOT PRESENT	99368	60		$ 669.71	$ 742.55	$ 606.53			$ 219.03	$ 714.77	$ 600.53	$ 388.62	$ 517.31		
99415CA	Prolonged E&M Service, First Hour (MIS ONLY) (30+ to be billable)	99415	60	$ 1,493.23	$ 669.71	$ 742.55										
99416CA	Prolonged E&M Service, each addtl 30 min (MIS ONLY)	99416	30	$ 746.62	$ 334.85	$ 371.27										
99417CA	Prolonged E&M Service, each addtl 15 min (MIS ONLY)	99417	15	$ 373.31	$ 167.43	$ 185.64										
99484CA	MD directed BH care management 20+ MIN	99484	60	$ 1,493.23	$ 669.71	$ 742.55	$ 606.53	$ 318.62	$ 273.15	$ 219.03	$ 714.77	$ 600.53	$ 388.62			
CFTICC_CA	CHILDREN AND FAMILY TEAM ICC	H2000	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
H0025	PEER SUPPORT PREVENTION EDUCATON GROUP	H0025	15												$ 17.06	
H0033	MEDICATION ADMINISTRATION	H0033	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
H0038	PEER SUPPORT SELF HELP ENGAGE THERAPY	H0038	15												$ 76.75	

Updated
6/16/2025

Exhibit C: San Mateo County Mental Health Contrator Outpatient Rates, FY 2025-26

ICC_CA	INTENSIVE CARE COODINATION	T1017	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
IHBS2CA	IHBS CRISIS INTERVENTION	H2011	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
IHBS41CA*	IHBS FAMILY THERAPY 26+ MIN	90847	50	$ 1,244.36	$ 558.09	$ 618.79						$ 500.44	$ 323.85			
IHBS5CA	IHBS ASSESSMENT NON MD	H0031	15		$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
IHBS6CA	IHBS PLAN DEVELOPMENT NON MD	H0032	15		$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29		$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
IHBS7CA	IHBS REHABILITATION	H2017	15	$ 373.31	$ 167.43	$ 185.64	$ 151.63	$ 79.66	$ 68.29	$ 54.76	$ 178.69	$ 150.13	$ 97.15	$ 129.33		$ 73.09
IHBS90832	IHBS INDIVIDUAL THERAPY 16-37 MIN	90832	30	$ 746.62	$ 334.85	$ 371.27						$ 300.26	$ 194.31			
IHBS90834	IHBS INDIVIDUAL THERAPY 38-52 MIN	90834	45	$ 1,119.92	$ 502.28	$ 556.91						$ 450.40	$ 291.46			
IHBS90837*	IHBS INDIVIDUAL THERAPY 53+ MIN	90837	60	$ 1,493.23	$ 669.71	$ 742.55						$ 600.53	$ 388.62			
T1013	SIGN LANG OR ORAL INTERPRETIVE	T1013	15	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72
T1013M	MEDICAL SIGN LANG OR ORAL INTERPRETIVE (14CA, 16CA, 99212CA-99215CA, 99347CA-99350CA)	T1013	15	$ 20.72	$ 20.72	$ 20.72	$ 20.72			$ 20.72						
T1013X	SIGN LANG OR ORAL INTERPRETIVE (6CA, 7CA, 51CA, 70CA, CFTICC_CA, ICC_CA, IHBS6CA, IHBS7CA)	T1013	15	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72	$ 20.72		$ 20.72
T2021 *	Therapy substitute, 15 minutes (MIS ONLY)	T2021	15	$ 373.31	$ 167.43	$ 185.64						$ 150.13	$ 97.15			
T2021G **	Therapy substitute, 15 minutes (MIS ONLY)	T2021	15	$ 82.96	$ 37.21	$ 41.25						$ 33.36	$ 21.59			
T2024 ***	Assessment substitute, 15 minutes (MIS ONLY)	T2024	15	$ 373.31	$ 167.43	$ 185.64				$ 54.76		$ 150.13	$ 97.15	$ 129.33		

Attachment H
Health Insurance Portability and Accountability Act (HIPAA)
Business Associate Requirements

DEFINITIONS

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations (CFR) sections 160.103, 164.304, and 164.501. All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.

a. ***Business Associate.*** "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the parties to this agreement shall mean Contractor.
b. ***Covered Entity.*** "Covered entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement shall mean County.
c. **HIPAA Rules**. "HIPAA rules" shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 CFR part 160 and part 164, as amended and supplemented by Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009.
d. ***Designated Record Set***. "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
e. ***Electronic Protected Health Information***. "Electronic Protected Health Information" (EPHI) means individually identifiable health information that is transmitted or maintained in electronic media; it is limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.
f. ***Individual***. "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
g. ***Privacy Rule***. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
h. ***Protected Health Information***. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in Section 160.103 and is limited to the information created or received by Business Associate from or on behalf of County.
i. ***Required By Law***. "Required by law" shall have the same meaning as the term "required by law" in Section 164.103.
j. ***Secretary***. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.
k. ***Breach***. The acquisition, access, use, or disclosure of PHI in violation of the Privacy Rule that compromises the security or privacy of the PHI and subject to the exclusions set forth in Section 164.402. Unless an exception applies, an impermissible use or disclosure of PHI *is presumed* to be a breach, unless it can be demonstrated there is a low

probability that the PHI has been compromised based upon, at minimum, a four-part risk assessment:

1. Nature and extent of PHI included, identifiers and likelihood of re-identification;
2. Identity of the unauthorized person or to whom impermissible disclosure was made;
3. Whether PHI was actually viewed or only the opportunity to do so existed;
4. The extent to which the risk has been mitigated.

l. ***Security Rule***. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

m. ***Unsecured PHI.*** "Unsecured PHI" is protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in relevant HHS guidance.

n. ***Security Incident***. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. "Security Incident" includes all incidents that constitute breaches of unsecured protected health information.

OBLIGATIONS AND ACTIVITIES OF CONTRACTOR AS BUSINESS ASSOCIATE

a. Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
b. Business Associate agrees to use appropriate safeguards to comply with Subpart C of 45 CFR part 164 with respect to EPHI and PHI, and to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to make uses and disclosures requests for Protected Health Information consistent with minimum necessary policy and procedures.
d. Business Associate may not use or disclose protected health information in a manner that would violate subpart E of 45 CFR part 164.504 if used or disclosed by Covered Entity.
e. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
f. Business Associate agrees to report to County any use or disclosure of Protected Health Information not authorized by this Agreement.
g. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of County, agrees to adhere to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
h. If Business Associate has Protected Health Information in a Designated Record Set, Business Associate agrees to provide access, at the request of County, and in the time and manner designated by County, to Protected Health Information in a Designated Record Set, to County or, as directed by County, to an Individual in order to meet the requirements under Section 164.524.

i. If Business Associate has Protected Health Information in a Designated Record Set, Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the County directs or agrees to make pursuant to Section 164.526 at the request of County or an Individual, and in the time and manner designed by County.
j. Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of County, available to the County at the request of County or the Secretary, in a time and manner designated by the County or the Secretary, for purposes of the Secretary determining County's compliance with the Privacy Rule.
k. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for County to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
l. Business Associate agrees to provide to County or an Individual in the time and manner designated by County, information collected in accordance with Section (k) of this Schedule, in order to permit County to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
m. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Business Associate creates, receives, maintains, or transmits on behalf of County.
n. Business Associate shall conform to generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.
o. Business Associate shall ensure that any agent to whom it provides EPHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such EPHI.
p. Business Associate shall report to County any Security Incident within three (3) business days of becoming aware of such incident. Business Associate shall also facilitate breach notification(s) to the appropriate governing body (i.e. HHS, OCR, etc.) as required by law. As appropriate and after consulting with County, Business Associate shall also notify affected individuals and the media of a qualifying breach.
q. Business Associate understands that it is directly liable under the HIPAA rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of Protected Health Information that are not authorized by this Attachment, the underlying contract as or required by law.

PERMITTED USES AND DISCLOSURES BY CONTRACTOR AS BUSINESS ASSOCIATE

Except as otherwise limited in this Schedule, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, County as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by County.

OBLIGATIONS OF COUNTY

a. County shall provide Business Associate with the notice of privacy practices that County produces in accordance with Section 164.520, as well as any changes to such notice.
b. County shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.
c. County shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that County has agreed to in accordance with Section 164.522.

PERMISSIBLE REQUESTS BY COUNTY

County shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if so requested by County, unless the Business Associate will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of Business Associate.

DUTIES UPON TERMINATION OF AGREEMENT

a. Upon termination of the Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from County, or created, maintained, or received by Business Associate on behalf of County, that Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
b. In the event that Business Associate determines that returning or destroying Protected Health Information is infeasible, Business Associate shall provide to County notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protection Health Information.

MISCELLANEOUS

a. **Regulatory References**. A reference in this Schedule to a section in the HIPAA Privacy Rule means the section as in effect or as amended, and for which compliance is required.
b. **Amendment**. The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for County to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

c. **Survival**. The respective rights and obligations of Business Associate under this Schedule shall survive the termination of the Agreement.
d. **Interpretation**. Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits County to comply with the Privacy Rule.
e. **Reservation of Right to Monitor Activities**. County reserves the right to monitor the security policies and procedures of Business Associate.

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a, b, or c)

- ☐ a. Has no employees
- ☐ b. Employs fewer than 15 persons
- ☐ c. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Name of 504 Person:	
Name of Contractor(s):	Bay Area Community Services, Inc.
Street Address or P.O. Box:	390 40th Street
City, State, Zip Code:	Oakland, CA 94609

I certify that the above information is complete and correct to the best of my knowledge

Signature:	Signed by: Jamie Alamanza 2CFE83C6436342A...
Title of Authorized Official:	CEO
Date:	5/26/2026

*Exception: DHHS regulations state that: "If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

ATTACHMENT T

DISASTER AND EMERGENCY RESPONSE PLAN

AGENCY NAME:

ADDRESS:

NAME OF PRIMARY POINT OF CONTACT:

TELEPHONE NUMBER(S):

EMAIL ADDRESS:

LAST UPDATED:

I. SUUMMARY OF DISASTER AND EMERGENCY RESPONSE PLAN ("PLAN")

(The Plan summary sets for the major processes, procedures and goals of the Plan, including a general description of the agency's plans for response and recovery in the immediate aftermath of a national, state, or local disaster or emergency and the agency's plans for the continuation of Services under the Agreement during and after the disaster or emergency.)

II. KEY PERSONNEL AND CONTACT INFORMATION

Name/Title	Role in Plan Implementation	Work Phone	Cell Phone	Work Email	Personal Email

III. EMERGENCY RESPONSE PLAN

(Detailed description of the agency's plan to respond to and recover from the emergency. This includes key matters that need to be addressed and acted on immediately in the event of an emergency to ensure the on-going viability of the agency. May include a description of the agency's plans to address leadership/succession, in the event that agency's leaders are unavailable or incapacitated; securing and establishing alternate facilities and equipment in the event that the agency's primary facilities or equipment are unavailable; access to telecommunications and information technology and other matters appropriate to the agency and its mission.)

IV. CONTINUITY OF OPERATIONS

(This is a detailed description of the agency's plan to ensure the ongoing continuation of services under the Agreement during and after a disaster or emergency. Recognizing that each disaster or emergency will be unique and will pose diverse challenges and constraints that may be impossible to fully anticipate, this section should include a description of the agency's plans for ensuring that staff needed to provide the services set forth in the Agreement are available and able to provide the services and that the agency has identified a process for securing the equipment and supplies needed to perform such services. The agency should attempt to identify, to the extent feasible, the additional personnel, equipment and supply costs that it would incur in providing such ongoing continuity of services to the County.)

V. PLAN PRACTICE AND EXERCISING

(The agency should describe its process to ensure that agency staff is informed of, and trained on, the Plan. This may include a general description of the training materials that are prepared and provided to agency staff and any initial and follow-on training that may be provided.)

VI. OTHER MATTERS

(In this section, the agency will discuss other emergency response-related matters unique to the agency and its mission.)

SAN MATEO COUNTY HEALTH

DECLARATION OF NOTICE OF CONFIDENTIALITY

As an employee, contractor, or associate of San Mateo County Health, I agree to the following as evidenced by my signature affixed below:

I will not disclose or otherwise discuss San Mateo County Health's patients or clients, their conditions, treatments or status, even if they are known to me personally, with anyone, except to carry out my assigned duties associated with their proper care or treatment.

I will not release information to anyone concerning the financial, medical, or social status of San Mateo County Health patients or clients which has not first been authorized according to written San Mateo County Health policies, federal or state regulation, or otherwise properly ordered by legal authorities.

I will not, at any time or under any circumstances, disclose to or share with anyone the San Mateo County Health computer systems User Identifications or passwords assigned to me.

I will not tamper with any of the San Mateo County Health computer systems to gain unauthorized access to the network or information contained there.

I will take all reasonable care to prevent the unauthorized use, disclosure or availability of confidential and/or proprietary information through unattended screen displays or by mishandling of system generated output, regardless of its form.

I acknowledge that San Mateo County Health retains the right to monitor and/or review, at any time and without cause, any access to San Mateo County Health computer systems for evidence of tampering or misuse, and may, at its sole discretion, suspend or terminate my computer privileges to any San Mateo County Health computer systems pending administrative review.

I agree to adhere to policies concerning the San Mateo County Health computer systems and understand that any misconduct and/or breaches of confidentiality expressly described herein may be grounds for immediate suspension of computer privileges. In addition, San Mateo County Health's administrative actions, up to and including termination of employment or contract may result. Additionally, violation of any applicable civil or criminal statutes by the disclosure of confidential material or information or other misuse of a computer system will be prosecuted to the fullest extent of the law.

Signed by:
Jamie Alamanza
2CFE83C0438342A...
Employee or Contractor Signature

5/26/2026
Date Signed

Jaime Alamanza
Print Employee or Contractor
First Name, Middle Name, and Last Name

Supervisor Signature

CEO
Employee or Contractor Title

Location/Contract Agency