Agenda Item: Agreement with Counseling Solutions for Mental Health Services

Department: Behavioral Health

Meeting Date Requested: May 21, 2019

Contact: Dorian Kittrell | Phone: 530.891.2850

Regular Agenda □ | Consent Agenda ☒

Department Summary: (Information provided in this section will be included on the agenda. Attach explanatory memorandum and other background as necessary).

Counseling Solutions is a nonprofit agency that provides mental health services to Butte County youth living in the foster care system. These services include individual counseling and case management as part of the mandated services by the State. This agreement is one of many the Department of Behavioral Health holds with local community organizations that assist the Department in meeting the required level of mental health services available to the county. The Department must manage the system of care across all direct service providers to ensure services are available based on federally mandated time and distance standards. This agreement is not measured based on the number of clients served, but instead, serves to provide additional capacity of direct service providers within the Department's system of care.

The Department recommends entering into an agreement with Counseling Solutions to provide mental health services to Medi-Cal eligible children. The term of the agreement is July 1, 2019 through June 30, 2020, not-to-exceed $337,038.

Fiscal Impact:

Funding for this agreement is provided by Federal Medi-Cal revenue. There is no impact to the County General Fund.

Personnel Impact:

Does not apply.

Action Requested:

Approve agreement and authorize the Chair to sign.

Administrative Office Review: Sang Kim, Deputy Chief Administrative Officer

Revised: April, 2019
MENTAL HEALTH SERVICES AGREEMENT BETWEEN
THE COUNTY OF BUTTE
AND
COUNSELING SOLUTIONS
FY 2019-20

LEGAL ENTITY:
COUNSELING SOLUTIONS

Contract Number 0900

Business Address: (Provider)
130 Yellowstone Drive, Suite 110
Chico, CA 95973

Legal Entity Number 0475

Provider number(s) 0475

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PROVIDER:

COUNSELING SOLUTIONS

Business Address: (Provider)

130 Yellowstone Drive, Suite 110

Chico, CA 95973

EXECUTIVE SUMMARY*

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<th>Annual Contract Amount:</th>
<th>$337,037.75</th>
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<td>Expected Annual Units of Service:</td>
<td>163,704 Minutes of Mental Health Services 28,889 Minutes of Targeted Case Management</td>
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<td>$1.75 per minute – Mental Health Services $1.75 per minute – Targeted Case Management</td>
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<td>Medi-Cal Specialty Mental Health Services for Butte County clients who meet the criteria of medical necessity.</td>
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*This summary is not to be used as a part of the attached contract for the description or provision of services, basis for payment, or terms as represented in the actual document. It is provided for information only.
COUNTY OF BUTTE
MENTAL HEALTH SERVICES AGREEMENT
FY 2019-20

THIS AGREEMENT is made and entered into by and between the County of Butte, a political subdivision of the State of California, through its Butte County Department of Behavioral Health, hereinafter referred to as "County", and

Legal Entity: COUNSELING SOLUTIONS
(thereafter referred to as "Provider")
130 Yellowstone Drive, Suite 110
Chico, CA 95973

Provider: Same as Above

WHEREAS, County believes it is in the best interest of the people of the County of Butte to provide certain mental health services for those who qualify to receive services contemplated and authorized by California Government Code 23004, 26227, 53707, and the Bronzan-McCorquodale Act, California Welfare and Institutions Code Section 5600 et seq.; and

WHEREAS, Provider is equipped, staffed, and prepared to provide these services as described in this Agreement; and

WHEREAS, these services shall be provided by Provider in accordance with all applicable Federal, State and local laws, required licenses, ordinances, rules, regulations, manuals, guidelines, and directives, which may include, but are not limited to the following: California Welfare and Institutions Code Sections 5325, 5520, 5600 et seq., 5650(a), 5651, 5664, 5655, 5670, 5670.5, 5671, 5671.5, 5672; 5705, 5709, 5710, 5716, 5719, 5721, 5722, 5751.2, 5779 through 5782, 5891; 5982; 5900 et seq., 5982, 11200 et seq., 14132.44, 14170, 14171, 14680 - 14726, and 17601 et seq.; California Code of Regulations, Title 2, Sections 50951, 50953, 50141.1, and 50141.2; California Code of Regulations, Title 9, Sections 622 through 630, 860 through 868, 1810.100 et seq., 1820.205, 1820.100, 1830.100, 1830.205, 1830.210, 1830.215, 1830.220, 1830.225, 1830.210, 1840.112, 1840.304, 1840.314 through 1840.358, 1840.344, 1850.205, 1850.206, 1850.207, 1850.208, 1850.209, 1850.210, 1850.212, and 1850.315; California Code of Regulations Title 22, Sections 50951, 50953, 50141.1, 50141.2, 51516, 70001, 71001, 72001 et seq., and 72443 et seq., Code of Federal Regulations, Title 42, Sections 422.208, 422.210, 422.113, 422.128, 431.220(a)(5), 431.244, 433.51, 438.382, 438.6, 438.10, 438.100, 438.102, 438.106, 438.108, 438.114, 438.201, 438.204, 438.206 through 438.210, 438.214, 438.236, 438.240, 438.242, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.10, 438.12, 438.228, 438.04, 438.424, 438.6, 438.604, 438.606, 438.608, 438.610, 447.50 through 447.60, 455.1, 455.101, 455.104, 455.105, 455.106, 459.100, 1002.203, 1002.3; California Government Code Sections 26227, 53703 and 8546.7; 42 United States Code Sections 290cc-2.1 through 290cc-35, 300x through 300x-9, and 1396 et seq.; California Penal Code Section 11164 et seq.; Public Contract Code Sections 10115 et seq., 12205 and 12200; Health and Safety Code 1204.1; State Department of Health Care Services' Cost Reporting/Data Collection Manual; State Department of Health Care Services' Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management; State Department of Health Care Services' Short-Doyle/Medi-Cal Automated Cost Reporting System User's Manual; policies and procedures developed by County; State's Medicaid Plan; and/or policies and procedures which have been documented in the form of Policy Letters issued by State Department of Health Care Services.

WHEREAS, the following terms, as used in this Agreement, shall have the following meanings:

A. “Beneficiary” means any person certified as eligible under the Medi-Cal Program according to Section 51000.2, Title 22, CCR;
B. “CCR” means the California Code of Regulations;
C. “Consumer” means patient/client as in “consumer of services”;
D. “Contract Maximum” shall mean the maximum financial obligation of the County to the Provider for services performed during the term of this Agreement;
E. “Contract Monitor” means the person assigned by County to monitor the provisions and requirements of the Agreement;

G. “Day(s)” means calendar day(s) unless otherwise specified;

H. “Director” means County’s Director of Behavioral Health or their authorized designee;

I. “EOB” means ‘Explanation of Balance” for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services which is the SDHCS adjusted claim data and “Explanation of Benefits’ for Medicare which is the Federal designated Fiscal Intermediary’s adjudicated Medicare claim data;

J. “FFP” means Federal Financial Participation for Short-Doyle/Medi-Cal services as authorized by Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.;

K. “Fiscal Intermediary” means County acting on behalf of the Provider and the Federally designated agency in regard to and/or Title Short-Doyle/Medi-Cal Specialty Mental Health Services;

L. “Fiscal Year” means County’s Fiscal Year which commences July 1 and ends the following June 30;

M. “I/S” means County’s Information System which may include many data systems;

N. “Interim Rate” means the Unit of Service rate as identified on the Financial Summary(ies), and is equal to or lower than Providers published charge. Interim Rate as defined in this section shall be used by County to make reimbursements throughout the term of Agreement and shall be used during the final settlement as outlined in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph L (Annual cost Report Adjustment and Settlement);

O. “HIPAA” means Health Insurance Portability and Accountability Act of 1996, which defines confidentiality of a consumer's protected health information;

P. “HITECH” means Health Information Technology for Economic and Clinical Health Act of 2009, which was enacted to promote the adoption and meaningful use of health information technology.

Q. “Legal Entity” means the legal organizational structure under California law;

R. “Prevalent non-English Language” means a language identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population (whichever is lower) in the services area;

S. “Published Charge(s)” means the Provider’s customary rate/charge approximated by Providers costs, and as approved by their Board of Directors or the Unit of Service Rate as identified on the Financial Summary(ies) in the event that the Provider does not have a published charge(s);

T. “SDHCS” means State Department of Health Care Services;

U. “SDSS” means State Department of Social Services;

V. “SFC” means Service Function Code, as defined by Director, for a particular type of mental health service;

W. “Specialty Mental Health Services” means 1) 24 hour services/Mode 5 - Hospital Inpatient, Hospital Administrative Day, Psychiatric Health Facility(PHF), Skilled Nursing Facility (SNF) Intensive, Institute for Mental Disease (IMD), Adult Crisis Residential, Jail Inpatient, Residential Other, Adult Residential, Semi-Supervised Living, Independent Living, Mental Health Rehab Center; 2) Day Services/Mode 10 – Crisis Stabilization, Vocational Services, Socialization, SNF Augmentation, Day Treatment Intensive – Half Day, Day Treatment Intensive – Full Day, Day Rehabilitation – Half Day, Day Rehabilitation – Full Day; 3) Outpatient Services/Mode 15 – Case Management, Brokerage, Intensive Care Coordination (ICC), Collateral, Professional Inpatient Visit, Outpatient Mental Health Services – Assessment, Plan Development, Therapy, Rehabilitation, Therapeutic Behavioral Services, Intensive Home Based Services (IHBS), Medication Support, Crisis Intervention; 4) Outreach Services/Mode 45; and 5) Support Services/Mode 60.

X. “State” means the State of California;

Y. “Title IV” means Title IV of the Social Security Act, 42 United States Code Section 601 et seq.;

Z. “Title XIX” means Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.;

AA. “UMDAP” means the SDHCS’s Uniform Method of Determining Ability to Pay (included as part of County’s Client Registration Payor Financial Information Insurance Authorization Form);

BB. “Units of Service (UOS)” means the type of unit used to quantify the service modalities/elements per State and Federal regulations, and the CR/DC manual. The units of service are defined as;
1) 24 Hour services (mode 5) are determined based on bed days; 2) Day Services (Mode 10) are determined by treatment days; 3) Outpatient Services (Mode 15) are determined in minutes; and 4) Outreach Services (Mode 45) are determined by direct staff hours.

CC. “W&I” means the California Welfare and Institutions Code; and

NOW, THEREFORE, Provider and County agree as follows:

1. **TERM:**

   A. The term of this Agreement shall commence on July 1, 2019 and shall continue in full force and effect through June 30, 2020.

   B. **Termination:**

      (1) This Agreement may be terminated by either party at any time without cause by giving at least thirty (30) days prior written notice to the other party.

      (2) This Agreement may be terminated by County immediately:

         (a) If County determines that:

             i. Any Federal, State, and/or County funds are not available for this Agreement or any portion thereof; or

             ii. Provider has failed to initiate delivery of services within 30 days of the commencement date of this Agreement; or

             iii. Provider has failed to comply with any of the provisions of this Agreement in accordance with County, State, and Federal regulations, laws and policy; or

         (b) In accordance with Paragraphs 31 (TERMINATION FOR INSOLVENCY), 32 (TERMINATION FOR DEFAULT), and/or 33 (TERMINATION FOR IMPROPER CONSIDERATION).

      (3) This Agreement shall terminate as of June 30, 2020

      (4) In the event that this Agreement is terminated, then:

         (a) Upon receipt of any notice of termination, whether initiated by County or Provider, County, in its sole discretion, may stop all payments to Provider hereunder until preliminary settlement based on the Annual Cost Report. Provider shall prepare an Annual Cost Report, including a statement of expenses and revenues, which shall be submitted pursuant to Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph K (Annual Cost Reports), within 60 days of the date of termination; and

         (b) Upon receipt of any notice of termination, whether initiated by County or Provider, Provider shall make immediate and appropriate plans to transfer or refer all patients/clients receiving services under this Agreement to other agencies for continuing services in accordance with the patient's/client's needs. Such plans shall be subject to prior written approval of Director or Director's designee, except that in specific cases, as determined by Provider, where an immediate patient/client transfer or referral is indicated, Provider may make an immediate transfer or referral. If Provider terminates this Agreement, upon termination date, all costs related to all such transfers or referrals as well as all costs related to all
continuing services shall not be a charge to this Agreement nor reimbursable in any way under this Agreement; and

(c) Upon receipt of any notice of termination, whether initiated by County or Provider, Provider shall forward all County patient/client chart/record information necessary to transfer clients back to the County for services on a timely basis, but no later than seven (7) days following effective contract termination date; and

(d) If Provider is in possession of any equipment, furniture, and/or removable fixtures owned by County as provided in Paragraph 41 (PURCHASES), the same shall be immediately returned to County.

C. **Suspension of Payments:**

(1) At the sole discretion of Director or Director’s designee, payments to Provider under this Agreement may be suspended for good cause. Notice of such suspension shall be provided to Provider, including a statement of the reason(s) for such suspension. Following receipt of notice, Provider may, within 15 days, request reconsideration of the Director’s decision.

(2) In the event that County suspends or withholds payment to Provider pending receipt of Provider(s) service data, Financial Summary(ies), or other data as required, Provider shall hold County harmless for any/all claims not submitted within the time frames prescribed by the County, State and Federal government. Claims, which exceed the time frames for claiming, will be considered denied and County shall have no liability for Provider’s failure to comply with County, State, and Federal time frames.

2. **OPERATION AND ADMINISTRATION:**

A. Director shall have the authority to administer this Agreement on behalf of County. Provider shall designate in writing a Contract Manager who shall function as liaison with County regarding Provider’s performance hereunder.

B. In order for the Director to administer and monitor Provider’s performance, Provider shall submit a quarterly report of costs and units of service delivered throughout the term of this Agreement. If it appears that Provider’s actual costs divided by the units of services delivered is less than or have exceeded the interim rate, then Provider shall notify County in writing within ten (10) days that an Amendment may be required to adjust the unit charge/rate as established on the Financial Summary(ies). All changes shall be made pursuant to Agreement, Paragraph 36 (ALTERATION OF TERMS).

(1) In the event that County referrals exceed the number of clients, or units of service which can be reasonably served within the allocated financial provisions as reflected in the Financial Summary(ies), the Provider shall notify the County in writing within ten (10) working days. Provider shall bear all financial responsibility for services and costs provided beyond the terms of this Agreement.

(2) Provider hereby certifies that it can provide services within the scope and limitation of this Agreement.

C. Provider agrees to furnish all space, facilities, equipment and supplies necessary for its proper operation and maintenance.

D. Provider agrees to have hours of operation which are comparable to County’s, and are no less than 40 hours per week. Only certified satellite sites may operate less than 40 hours per week.
E. Any printed material or video media shall be reviewed and approved by the Director or their designee prior to public distribution.

F. Provider shall notify clients that written translation of documents and oral interpretation services in prevalent non-English languages are available free of cost. County shall give Provider written materials regarding translation/interpretation services.

G. Providers Board of Directors shall operate according to the provisions of its Articles of Incorporation and By-laws. Said documents and any amendments shall be maintained and retained by Provider and made available for review and/or inspection by Director at reasonable times during normal business hours.

3. DESCRIPTION OF SERVICES/ACTIVITIES:

Provider shall provide specialty mental health services in the form as identified on the Financial Summary(ies) and Service Exhibit(s) for this Agreement including any addenda thereto. Services provided by Provider shall be the same regardless of the patient's/client's ability to pay or source of payment [CCR, Title 9, Chapter 11, Section 1810.436(a)(1)].

If, during Provider’s provision of services under this Agreement, there is any need for substantial deviation from the services as described in the Service Exhibit(s) for this Agreement including any addenda thereto, then Provider shall submit a written request to Director for written approval before any such substantial deviation may occur. All changes shall be made in the form of an amendment pursuant to Agreement Paragraph 36 (ALTERATION OF TERMS).

4. FINANCIAL PROVISIONS:

A. General: This Agreement provides for reimbursement as provided in this Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph I (Payment) and as shown on the Financial Summary(ies). The Provider will comply with all requirements necessary for reimbursement as established by Federal, State and local statutes, laws, ordinances, rules, regulations, manuals, policies, guidelines and directives. Under no circumstances can the total Maximum Contract Amount of this Agreement be increased or decreased without a properly executed amendment.

(1) Reimbursement: County agrees to reimburse Provider for SDHCS approved units of Specialty Mental Health Services during the term of this Agreement for the lesser of actual and allowable costs or Interim Rate as identified on the Financial Summary(ies), less all other revenue, interest and return resulting from services/activities, but not to exceed the Contract Maximum as shown on the Financial Summary(ies). Provider’s Published Charge shall not at any time, be less than the interim rate.

B. Compensation: The Maximum Contract Amount for the term of this Agreement as described in Paragraph 1 (TERM) shall not exceed THREE HUNDRED THIRTY-SEVEN THOUSAND THIRTY-SEVEN DOLLARS AND SEVENTY FIVE CENTS ($337,037.75) shall consist of County, State, and/or Federal funds as shown on the Financial Summary(ies). Notwithstanding any other provision of this Agreement, in no event shall County pay Provider more than this Maximum Contract Amount for Provider’s performance hereunder during the term of this Agreement.

C. Interim Rate: Notwithstanding any other provision of this Agreement, County shall not be required to pay Provider more than the Interim Rate as identified on the Financial Summary(ies). Provider’s Published Charge shall not at any time, be less than the interim rate.

D. Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services:

(1) Except as otherwise provided in this Agreement, if Provider provides Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services, then Provider shall be reimbursed as described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph A (General), Section (1) (Reimbursement).
(a) Provider may appeal a denied or modified request for service authorization with the County concerning the processing or payment of a Provider’s claim, by submitting a written appeal request. Written appeals shall be submitted within 30 days of the date of receipt of the non-approval of payment or within 30 calendar days of the County’s failure to act on the request in accordance with the time frames within the County’s Provider Appeal Process described in section (b) below.

(b) County, in accordance with W&I 14680, and Title 9, CCR has established a Provider Appeal Process. County’s appeal process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 51 (NOTICES) of this Agreement.

(2) Notwithstanding any other provision of this Agreement, if Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services, are provided hereunder, such services shall comply with and be compensated in accordance with all applicable Federal and State reimbursement requirements.

(3) If Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services are provided under this Agreement, Provider authorizes County to serve as the fiscal intermediary for claiming and reimbursement for such Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services to act on Provider’s behalf with SDHCS and/or SDSS in regard to claiming reimbursement for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services.

(4) Provider shall be solely liable and responsible for all data and information submitted by Provider to County in support of all claims for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services submitted by County as the fiscal intermediary to, SDHCS and/or SDSS and for any subsequent State approvals or denials of such claims that may be based on data and information submitted by Provider. Provider shall process all Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services data, or other data within the time frame prescribed by the County, State and/or Federal governments. County shall have no liability for Provider’s failure to comply with County, State and/or Federal time frames.

(5) Provider shall hold County harmless from and against any loss to Provider resulting from any such State denials, unresolved EOB claims, and/or any County, Federal and/or State audit disallowances for such Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services.

(6) Notwithstanding any other provision of this Agreement, Provider shall be totally liable and responsible for: (1) the accuracy of all data and information on all claims for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services which Provider inputs into the data systems, (2) the accuracy of all data and information which Provider provides to County for submission to SDHCS, and (3) ensuring that all Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services are performed appropriately within Medi-Cal guidelines including, but not limited to, administration, utilization review, documentation, and staffing.

(7) County is the State Designated fiscal intermediary for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services. Provider shall comply with all written instructions from County with regard to any such Title XIX Short-Doyle/Medi-Cal claiming and documentation. Provider shall certify in writing that all necessary documentation exists prior to submission of the Short-Doyle Medi-Cal claim to SDHCS for the Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services. Claim(s) shall only include those services entered by Provider or County into the data systems as services provided by Provider to be claimed by County to Short-Doyle/Medi-Cal. Claim(s) for purposes of this Paragraph (7) may be either direct data systems entry by Provider or submission of Providers Service Activity Logs for entry by County into County’s data systems.
Provider shall verify in writing each month that the services entered into the data systems have been accurately entered and represent the total number of units delivered by Provider for that month. Provider will use data systems generated reports to compare with source documentation to determine the accuracy of the monthly service entries. County shall provide to Provider, data systems-generated reports within 15 days following the receipt of Provider’s corresponding Service Activity Logs or monthly Data Summary Sheet.

Provider shall maintain an audit file of all records, including, but not limited to, all time studies or service activity logs prepared by Provider, documenting Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services as instructed by County for a period of ten years from the final date of the SDHCS Mental Health Plan contract period in which such services were provided under or until final resolution of any audits, whichever occurs later.

County may modify the claiming systems for either Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services, at any time in order to comply with changes in, or interpretations of, State or Federal laws, rules, regulations, manuals, guidelines, and directives. County shall notify Provider in writing of any modification(s) which would impact Provider and the reason for the modification(s) within thirty days of County's receipt of State or Federal notification for the implementation of the modification(s).

For Federal audit exceptions, Federal audit appeal processes shall be followed. County recovery of Federal overpayment shall be made in accordance with all applicable Federal laws, regulations, manuals, guidelines, and directives.

For State audit exceptions, County shall immediately recover any overpayment from Provider as soon as the State notifies the County of the overpayment due from County.

For County audit exceptions, County shall notify Provider in writing of the Audit Settlement. The Provider shall have 30 calendar days from receipt of notification of the Audit settlement to appeal the Audit Settlement. If Provider intends to appeal said notice, either in whole or in part, the County’s Provider Appeal Process shall be followed. The County’s Provider Appeal Process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 51 (NOTICES) of this Agreement.

The Provider shall have 30 calendar days from receipt of notification of the Audit settlement to appeal the Audit Settlement. If Provider intends to appeal said notice, either in whole or in part, the County’s Provider Appeal Process shall be followed. The County’s Provider Appeal Process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 51 (NOTICES) of this Agreement.

Overpayment Recovery shall be handled in accordance with County Policy. Provider shall pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

E. Shift of Funds:

(1) County, State, and/or Federal funds shall be limited to and shall not exceed the respective amounts shown on the Financial Summary(ies).

(2) Control of funds shall be for each budget line item identified on the Financial Summary(ies) within this Agreement. With Director’s prior written approval, Provider may shift funds, on a dollar-for-dollar basis, from one budget line item to another budget line item identified on the Financial Summary(ies) within this Agreement and within the applicable Fiscal Year.
Butte County Department of Behavioral Health/ Full Scope Medi-Cal MHS COUNSELING SOLUTIONS  FY 2019-20
Mental Health Services Contract

(3) Provider shall make a written request in the applicable Fiscal Year for Director's approval of a shift of funds between respective budget line item identified in the Financial Summary(ies). Director shall approve or deny in writing a request to shift funds after a program review within ten working days of the receipt of Provider's written request. As described in Paragraph 36 (ALTERATION OF TERMS), a formal amendment shall be executed to reflect any SFC shifts approved by the Director.

(4) During the Cost Report Settlement process, County may shift funds between respective SFC's identified in the Financial Summary(ies) at the Director's discretion, without requiring an Amendment to the Agreement.

(5) Under no circumstances can the total Maximum Contract Amount of this Agreement be increased or decreased without a properly executed amendment.

F. Provider Requested Changes:

(1) If Provider desires any change in the terms and conditions of this Agreement, including adjustments between SFC's within the Financial Summary(ies), Provider shall request such change in writing. All changes shall be made in the form of an amendment pursuant to Agreement Paragraph 36 (ALTERATION OF TERMS).

(2) If Provider requests to increase or decrease any Maximum Contract Amount, such request and all reports, data, and other information requested by County, shall be received by County’s Director for review prior to April 1 of the Fiscal Year in which the increase or decrease has been requested by Provider.

G. Government Funding Restrictions: This Agreement shall be subject to any restrictions, limitations, or conditions imposed by State, including, but not limited to, those contained in State's Budget Act, which may in any way affect the provisions or funding of this Agreement. This Agreement shall also be subject to any additional restrictions, limitations, or conditions imposed by the Federal government that may in any way affect the provisions or funding of this Agreement.

H. Patient/Client Eligibility, UMDAP Fees, Third Party Revenue, and Interest:

(1) Provider shall not retain any fees paid by any resources for or on behalf of Medi-Cal beneficiaries without having those fees deducted from the cost of providing the specialty mental health service units specified in this Agreement.

(2) County retains contractual responsibility for determination of patient/client fees for Medi-Cal billable services via UMDAP, and for the billing and the collection of such fees. Provider will not collect fees for client services rendered under the terms of this Agreement. Provider may be asked to facilitate the completion of UMDAP forms with clients and submit the forms to the County.

(3) Initial and ongoing Medi-Cal eligibility (from Butte County) of clients must be established by the Provider with documentation of an EVC (Eligibility Verification Control) number. Provider must determine ongoing Medi-Cal eligibility for each month of service and document this with an EVC number.

(4) Provider shall be Medi-Cal Certified to provide services under this Agreement to Full Scope Medi-Cal Beneficiaries where applicable as authorized by County. If during the time of treatment there is a change in Medi-Cal status, then the client will be referred back to the County for services. The Director or Director's designee may authorize services on a case-by-case basis to beneficiaries with other insurance. For the most part this means that a standard authorized beneficiary CANNOT have without prior approval:
(a) Other Insurance (in addition to Medi-Cal)
(b) Spend Down or Share of Cost
(c) Out of County Medi-Cal
(d) Healthy Families

(5) Medi-Cal, Insurance, and Private Payments

(a) County shall be responsible for all billing, including Medi-Cal, insurance claiming, and client billing for all clients having confirmed Medi-Cal eligibility and third-party insurance, Medi-Cal with spend down/share of costs, or the client presents Medi-Cal only and subsequently insurance or spend down/share of cost is identified.

(b) When clients present third-party insurance or are private pay only, the Provider begins providing services outside the contract, and the client is later identified as Medi-Cal eligible, the Provider shall cease billing all other payer sources and notify the County within three (3) working days, so the client can be referred back to the County for authorization of services.

Provider shall invoice the County for authorized services provided under this Agreement. Provider shall not bill other payer sources.

All billing, including Medi-Cal, insurance, and client billing, will be the responsibility of County.

I. Payment:

(1) For each month throughout the term of this Agreement, Provider shall submit to County a report and documentation for each applicable SFC delivered, in the form and content specified by County. Documentation shall be submitted within 10 days from the end of the month for which the services were provided, in order to meet Title XIX Short-Doyle/Medi-Cal claiming timelines. If, after the close of the monthly data entry time-frame, Provider desires to enter any data and information documenting units of services for a particular month, then Provider shall submit a request in writing setting forth the good cause reasons which prevented Provider from timely entering such particular data and information. Director or Director’s designee may, at their sole discretion, approve in writing Provider’s request to enter the data and information into the data system. County shall assume no liability for payment of claims not received within this time period.

(a) Claims Reimbursement: The County shall make provisional reimbursement to Provider based on the Interim Rate as reflected on the Financial Summary(ies) less all other revenue, interest and return collected by Provider from services/activities delivered under this Agreement, as described in Paragraph 4 (FINANCIAL PROVISIONS), for the SDHCS approved specialty mental health services. Provider’s Published Charge shall not at any time, be less than the interim rate. Provisional reimbursement shall be based upon specialty mental health services actually provided as shown on County’s data systems reports. Provider certifies that all units of service claimed by Provider on a provisional reimbursement basis are true and accurate claims for reimbursement. County is making these provisional payments to Provider prior to receiving FFP reimbursement for payment or notification from SDHCS to County of approved specialty mental health services claimed by the County to the State on behalf of the Provider.
i. Final reimbursement/settlement to Provider shall be based upon SDHCS approved units of service, the cost report settlement for those approved units settled to the lesser of allowable costs or Interim Rate as described in Paragraph 4 (FINANCIAL PROVISIONS), and SDHCS’s Medi-Cal Reconciliation. Provider’s Published Charge shall not at any time, be less than the interim rate.

ii. Further, Provider agrees to hold harmless both the State and beneficiary in the event County cannot or will not pay for services performed by Provider pursuant to this Agreement.

(2) On the basis of this monthly claim and after County and County Auditor review and approve the monthly claim, Provider shall receive from County provisional reimbursement of Provider’s claimed amount for, actual and allowable costs for all cost reimbursed services and activities, less all revenue, interest, and return resulting from services/activities provided hereunder, including, but not limited to any other revenue, interest, and return as described in Subparagraph H (Patient/Client Eligibility, UMDAP Fees, Third Party Revenue, and Interest).

The monthly claim and subsequent payment shall be made in accordance with County policies and procedures and terms of this Agreement. If a claim is not submitted as required by County, then payment shall be withheld until County is in receipt of a complete and correct claim and such claim has been reviewed and approved by County Director or County Director’s designee.

(3) All monthly claims shall be subject to adjustment based upon the data systems reports, EOB data, Audits or Disallowances, and/or Provider’s Annual Cost Report, which shall supersede and take precedence over all claims.

(4) All monthly claims shall be based on specialty mental health services actually provided as shown on County’s data systems reports. Provider certifies that all units of services reported by Provider into the County data system are true and accurate claims for reimbursement.

(5) Claims for Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services, provided to eligible Medi-Cal beneficiaries, will be paid to Provider, only for the period of time Provider is certified as a Title XIX Short-Doyle/Medi-Cal Provider, and only to the extent required by Federal laws, regulations, manuals, guidelines, and directives.

(6) Upon receipt of ECRs (Error Correction Reports), which indicate a problem with a submitted Medi-Cal claim, County will notify Provider. County will work with Provider to identify and rectify errors, each within their contractual areas of responsibility. Provider shall have 10 days from date of letter to correct and return ECR to County. County will submit the corrected ECR to the State, no later than 45 days from receipt of corrected ECRs. County will not be liable for Provider corrections that have not been made in time to make the submission date.

J. Withholding Payment of Monthly Claim For Nonsubmission of County Data System Documentation and Other Information: County may withhold payment of any monthly claim, if any County data systems data, EOB data, Financial Summary(ies) or other information is not submitted by Provider to County in accordance with the requirements of this Agreement or within the County, State, or Federal time limits of submission. County shall give Provider written notice of its intention to withhold payment hereunder, including the reason(s) for its intended action. Thereafter, Provider shall have 15 days either to correct deficiencies, or to request reconsideration of the decision to withhold payment. County shall have no liability for Provider’s failure to comply with County, State, and Federal time frames for claiming and data submission.
K. **Annual Cost Report:**

1. For each Fiscal Year or portion thereof that this Agreement is in effect, Provider shall provide County with one copy of an accurate and complete Annual Cost Report, with a statement of expenses and revenue. The Annual Cost Report will be submitted in accordance with the instructions from County and shall be broken out into SFCs identified on the Financial Summary(ies) within each legal entity. Such report shall be due within 60 days following the end of such Fiscal Year. In the event Provider ceases to do business, the final cost report will be due no later than 60 days following the effective date of business closure. The Annual Cost Report shall be prepared by Provider in accordance with the requirements set forth in the Short-Doyle/Medi-Cal Cost Reporting System Users Manual, CR/DC Manual. Written guidelines may be provided to Provider by the Director or Director’s designee, by July 31 following the Fiscal Year for which the Annual Cost Report is to be prepared.

2. In the event that Provider is unable to complete the Annual Cost Report by the date specified within this section, then Provider shall submit to the Director a written extension request giving good cause justification and a revised completion date. The Director or Director’s designee will review each request and prepare a written response.

3. If Provider fails to submit accurate and complete Annual Cost Report by such due date, then County may not, at the sole discretion of Director or Director’s designee, make any further payments to Provider under this Agreement or at the County’s option, other current or subsequent Agreements with the County, until the accurate and complete Annual Cost Report is submitted.

4. In the event that Provider does not submit accurate and complete Annual Cost Report by the one-hundredth day, then all amounts covered by the outstanding Annual Cost Report and paid by County to Provider in the Fiscal Year for which the Annual Cost Report is outstanding shall be due by Provider to County. Provider shall pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

L. **Annual Cost Report Adjustment and Settlement:** Based on the Annual Cost Report submitted pursuant to Subparagraph K (Annual Cost Report), at the end of each Fiscal Year or portion thereof that this Agreement is in effect the cost of all specialty mental health services shall be adjusted as follows:

1. **Reimbursement** - to the lesser of actual and allowable costs or interim rate, for SDHCS approved units of service, not to exceed the applicable Maximum Contract Amount as shown in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation), as reflected in the Financial Summary(ies), provided that reimbursement for services shall be consistent with the amounts authorized by State law and State’s Medicaid Plan. Provider’s Published Charge shall not at any time, be less than the interim rate.

2. Once submitted with signed Letter of Certification the Annual Cost Report shall be considered “provider certified” as to expenses and units of service. County shall review Provider Annual Cost Report before submission to the State and may modify certain aspects of the report as required by the State and Federal law, the State Cost Report Manual or the Contractual agreement. These modifications may include Medi-Cal units, funding sources, and/or charges. County shall not change expenses or total units of service unless instructed to do so by Provider.

Upon County approval Provider Annual Cost Report shall be deemed as final and not subject to change except by audit exception, which may include expenses or units later disallowed during a County, State, and/or Federal audit. Provider shall notify County promptly in writing if any time Provider becomes aware of errors in the submitted Annual Cost Report.
Provider shall have 30 calendar days from receipt of notification of settlement to appeal the settlement. All Cost Report appeals shall be handled in accordance with County’s Provider Appeal Process. The County’s Provider Appeal Process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 51 (NOTICES), of this Agreement.

M. Post-Contract Audit Settlement:

(1) In the event that a post-contract audit conducted by County, State, and/or Federal personnel, determines that the amounts paid by County to Provider for any Mental Health Services furnished hereunder are more than the amounts allowable pursuant to this Agreement, then the difference shall be due by Provider to County.

(2) For Cost Reimbursed services, if the post-contract audit conducted by County, State, and/or Federal personnel determines that the amounts paid by County to Provider for any Cost Reimbursed SDHCS Approved SFC units furnished hereunder are less than the allowable pursuant to this Agreement, then the difference shall be paid by County to Provider, provided that in no event shall County’s Maximum Contract Amount for the applicable Fiscal Year, as shown in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation).

N. Audit Appeals After Post-Contract Audit Settlement: For County audit exceptions, County shall notify Provider in writing of the Audit Settlement. The Provider shall have 30 calendar days from receipt of notification of the Audit Settlement to appeal Audit Settlement. All appeals for County audit exceptions shall be handled in accordance with County’s Provider Appeal Process. The County’s Provider Appeal Process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 51 (NOTICES), of this Agreement. If Provider appeals any audit report, the appeal shall not prevent the post-contract audit settlement pursuant to Subparagraph M (Post-Contract Audit Settlement).

O. Payments Due to County/Method of Payment: Within 10 calendar days after written notification by County to Provider of any amount due by Provider to County, Provider shall notify County as to which of the following six payment options Provider requests be used as the method by which such amount shall be recovered by County. Any payments due to the County shall be: (1) paid in one cash payment by Provider to County, (2) offset against prior year(s) liability(ies), (3) deducted from future claims over a period not to exceed three months, (4) deducted from any amounts due from County to Provider whether under this Agreement or otherwise, (5) paid by cash payment(s) by Provider to County over a period not to exceed three months, or (6) a combination of any or all of the above. Regardless of Provider preferred method, final determination of payment option shall be at the sole discretion of the Director.

In the event of early contract termination, for good cause, due to Providers failure to comply with provisions of this Agreement, County, at the Director’s discretion, may immediately withhold any amount due by Provider to County from future claims.

P. Interest Charges on Delinquent Payments: If Provider, without good cause as determined in the sole judgment of Director or Director’s designee, fails to pay County any amount due to County under this Agreement within 60 days after the due date, then Director or Director’s designee, in their sole discretion and after written notice to Provider, may assess interest charges at a rate equal to County’s General Fund Rate, as determined by County’s Auditor-Controller, per day on the delinquent amount due commencing on the 61st day after the due date. Provider shall have an opportunity to present to Director information bearing on the issue of whether there is a good cause justification for Provider’s failure to pay County within 60 days after the due date. The interest charges shall be: (1) paid by Provider to County by cash payment upon demand and/or (2) at the sole discretion of Director, deducted from any amounts due by County to Provider whether under this Agreement or otherwise.

Q. Financial Solvency: Provider shall maintain adequate provisions against the risk of insolvency.
R. **Limitation of County's Obligation Due to Nonappropriation of Funds:** Should County, during this or any subsequent fiscal year impose budgetary restrictions, which appropriate less than the amount provided for in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation) of this Agreement, County shall reduce services under this Agreement consistent with such imposed budgetary reductions. County shall notify Provider of any such changes in allocation of funds at the earliest possible date.

5. **COUNTY’S OBLIGATION FOR CURRENT AND FUTURE FISCAL YEARS:** Notwithstanding any other provision of this Agreement, this Agreement shall not be effective and binding upon the parties unless and until County’s Board of Supervisors appropriates funds for purposes hereof in County’s Budget for County’s current Fiscal Year.

6. **PRIOR AGREEMENT(S) SUPERSEDED:** The parties agree that the provisions of prior Agreement(s), related to the same services provided within this Agreement, and all Amendments thereto, shall be entirely superseded as of June 30, 2019, for services delivered after this date, by the provisions of this Agreement.

7. **STAFFING:** Provider shall operate throughout the term of this Agreement with staff, including, but not limited to, professional staff, that approximates the type and number as indicated in Providers Financial Summary(ies), including any addenda thereto as approved in writing by Director, and as required by W&I and CCR. All staff providing services under this Agreement shall be qualified and shall possess all appropriate licenses in accordance with W&I Section 5751.2 and all other applicable requirements of the California Business and Professions Code, W&I, CCR, CR/DC Manual, SDHCS Policy Letters, and function within the scope of practice as dictated by licensing boards/bodies. (1) If vacancies occur in any of Provider’s staff that would reduce Provider’s ability to perform any services under the Agreement, Provider shall promptly notify Director of such vacancies; (2) During the term of this Agreement, Provider shall have available and shall provide upon request to authorized representatives of County, a list of all persons by name, title, professional degree, and experience, who are providing any services under this Agreement; and (3) All new Provider staff shall attend County’s new staff training sessions. Provider shall contact County Behavioral Health Compliance officer for pre-schedule dates and times.

Provider shall obtain background checks for all employees, agents (including subcontractors), students, or volunteers (“Assigned Personnel”) who will be providing direct care to clients. Assigned Personnel must be cleared through Fingerprint Criminal Record Background Checks completed by the Department of Justice (DOJ) prior to such person providing services under this agreement (or if already providing direct care to clients when this provision is added by amendment to the agreement, as soon as possible thereafter). Provider shall be responsible for the costs of obtaining the Criminal Record Background Checks from the DOJ.

Provider shall not assign or continue the assignment of any Assigned Personnel who have been convicted or incarcerated within the prior 10 years for any felony as specified in Penal Code § 667.5 and/or 1192.7, to provide direct care to clients.

8. **STAFF TRAINING AND SUPERVISION:** Provider shall train and maintain appropriate supervision of all persons providing services under this Agreement with particular emphasis on the supervision of para-professionals, interns, students, and clinical volunteers in accordance with Provider’s clinical supervision policy. Provider shall be responsible for the training of all appropriate staff on CR/DC Manual, and other State and County policies and procedures as well as on any other matters that County may reasonably require.

Provider shall provide training on cultural competency to all persons providing services under this Agreement for a minimum of one (1) hour per fiscal year. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Medi-Cal Members.

Provider shall ensure all staff providing services under this agreement shall do so in accordance with County’s current Continuum of Care Reform policy. County shall provide this policy to Provider.
9. PROGRAM SUPERVISION, MONITORING AND REVIEW:

A. Pursuant to W&I Section 5608 and CCR Title 9, Section 521, all services hereunder shall be provided by Provider under the general supervision of Director. Director shall have the right to monitor and specify the kind, quality, appropriateness, timeliness, amount of services, and the criteria for determining the persons to be served. Upon notification from the County Contract Monitor of deficiencies, Provider shall respond in writing to the particular County Contract Monitor within the time specified in the notification either acknowledging the reported deficiencies or presenting contrary evidence, and in addition, submitting a plan for immediate correction of all deficiencies.

Provider shall be required to comply with County’s Federal Healthcare Compliance Program, which may exceed standards and requirements set forth by State and Federal entities. Refer to Paragraph 10 (FEDERAL HEALTHCARE COMPLIANCE PROGRAM) of this Agreement for more information.

In the event of a State audit of this Agreement, if State auditors disagree with County's written instructions to Provider in its performance of this Agreement, and if such disagreement results in a State disallowance of any of Provider's costs hereunder, then County shall be liable for Provider's disallowed costs as determined by State.

B. To assure compliance with this Agreement and for any other reasonable purpose relating to performance of this Agreement, and subject to the provisions of state and federal law, authorized County, State, and/or Federal representatives and designees shall have the right to enter Provider’s premises (including all other places where duties under this Agreement are being performed), with or without notice, to: inspect, monitor and/or audit Provider's facilities, programs and procedures, or to otherwise evaluate the work performed or being performed; review and copy any records and supporting documentation pertaining to the performance of this Agreement; and elicit information regarding the performance of this Agreement or any related work. The representatives and designees of such agencies may examine, audit and copy such records at the site at which they are located. Provider shall provide access to facilities and shall cooperate and assist County, State, and/or Federal representatives and designees in the performance of their duties. Unless otherwise agreed upon in writing, Provider must provide specified data upon request by County, State, and/or Federal representatives and designees within ten (10) state working days for monitoring purposes.

Failure to comply with the terms of this Subparagraph B may constitute breach of this agreement if not corrected, and may result in Withholding payment per the terms of Subparagraph J (Withholding Payment of Monthly Claim For Nonsubmission of County Data System Documentation and Other Information). In the event that Provider does not correct deficiencies within the required timeframe, then the Director at their sole discretion may request Provider to immediately return any and all amounts paid by County to Provider for the services performed under this Agreement. Provider shall be required to pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

10. FEDERAL HEALTHCARE COMPLIANCE PROGRAM:

A. In entering into this Agreement, Provider acknowledges the County’s Program for Compliance with Federal Healthcare Programs (Compliance Program) and agrees to comply, and to require its employees who are considered “Covered Individuals” to comply with all policies and procedures of the Compliance Program including, without limitation, the County’s Ethics and Compliance Program contained within Butte County Department of Behavioral Health (BCDBH) document “Our System of Caring” provided to the Provider upon review of this Agreement. “Covered Individuals” are defined as employees of the Provider with responsibilities pertaining to the ordering, provision, documentation, coding, billing of services payable by a Federal Healthcare program for which County seeks reimbursement from Federal Healthcare programs.
B. Provider agrees to provide copies of the COUNTY booklet “Our System of Caring” to all Covered Individuals who are its employees and to obtain signed certifications from each individual that they have received, read, understand, and agree to abide by its requirements. Provider will submit the signed certifications to COUNTY’s Compliance Officer within thirty (30) days after the effective date of this agreement for all current employees who are Covered Individuals, and within thirty (30) days after the start date of any newly hired employees who are Covered Individuals.

C. Provider agrees that all of its employees who are Covered Individuals, both current and all newly hired, will be required to attend a complete compliance training session, provided either by the Provider or County, as required by the County’s Program for Compliance with the Federal Healthcare Program.

D. Provider shall not enter into an agreement with any provider who is, or at any time has been, excluded from participation in any federally funded healthcare program, including, without limitation, Medicare or Medicaid. For more information and instructions concerning exclusion from participation in a federally funded program is provided for in Paragraph 48 (PROVIDERS EXCLUSION FROM PARTICAPATION IN A FEDERALLY FUNDED PROGRAM).

11. COUNTY’S QUALITY ASSURANCE PLAN: The County or its agent will evaluate Provider’s performance under this Agreement on not less than an annual basis. Such evaluation will include assessing Provider's compliance with all contract terms and performance standards. Provider deficiencies which County determines are severe or continuing and that may place performance of the Agreement in jeopardy if not corrected will be reported to the Board of Supervisors. The report will include improvement/corrective action measures taken by the County and Provider. If improvement does not occur consistent with the corrective action measures, County may terminate this Agreement or impose other penalties as specified in this Agreement.

12. RECORDS AND AUDITS:

A. Records:

(1) Direct Services and Indirect Services Records: Provider shall maintain a record of all direct services and indirect services rendered by all the various professional, para-professional, intern, student, volunteer and other personnel to fully document all services provided under this Agreement and in sufficient detail to permit review for fiscal audits, program compliance and beneficiary complaints [CCR, Title 9, Chapter 11, section 1810.436(a)(3)]. All such records shall be retained, maintained, and made immediately available for inspection, program review, and/or audit during County’s normal business hours by authorized representatives and designees of County, State, and/or Federal governments during the term of this Agreement and during the applicable period of records retention following discharge of the patient/client or termination of services (except that records of emancipated minors shall be kept at least one year after such minor has reached the age of 18 years and any case no less than a period of ten years from the final date of the SDHCS Mental Health Plan contract period in which such services were provided under, or until County, State, or Federal audit findings applicable to such services are fully resolved, whichever is later. Such access shall include regular and special reports from Provider. In the event any records are located outside Butte County, Provider shall pay County for all travel, per diem, and other costs incurred by County for any inspection, program review, and/or audit at such other location.

Failure to comply with the terms of this Paragraph 12 (RECORDS AND AUDITS) may constitute breach of this agreement if not corrected, and may result in withholding payment per the terms of Subparagraph J (Withholding Payment of Monthly Medi-Cal Claim For Nonsubmission of County Data System Documentation and Other Information). In the event that Provider does not correct deficiencies within the required timeframe, then the Director at their sole discretion may request Provider to immediately return any and all amounts paid by County to Provider for the provision of services under this agreement.
Provider shall be required to pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

In addition to the requirements in this Paragraph 12, Provider shall comply with any additional patient/client record requirements described in the Service Exhibit(s) and shall adequately document the delivery of all services described in the Service Exhibit(s).

(a) **Patient/Client Records (Direct Services):**

Provider shall maintain treatment and other records of all direct services (i.e., 24-hour services, day services, case management brokerage, specialty mental health services, medication support and crisis intervention) in accordance with all applicable County, State and Federal requirements on each individual patient/client.

Service contacts shall be documented for each client served. This documentation shall become part of the client record. Client records shall be reviewed by County quality assurance staff periodically.

Provider guarantees that each Medi-Cal eligible patient/client referred by County will be provided services within two weeks (10 working days) of the referral date. If provider is unable to provide services within this time frame, Provider will notify the County by phone and in writing so other arrangements can be made.

Each client receiving services under the terms of this Agreement, and not currently receiving other services from County shall have completed:

i. **Client Registration and Payor Financial Information**

ii. **Consent for Treatment Form**

iii. **Initial Assessment** within 30 days of Intake, and once per year thereafter.

iv. **Episode Summary - Episode Opening** to be completed as soon as feasible, but no later than the end of the month after the client enters the Provider’s program. Episode Closing to be submitted no later than the end of the month of the last billable date of service.

v. **Client Plan** Completed no later than 60 days from the date of Intake for new clients and no later than 30 days from the date of Episode Opening for clients currently receiving services from County or another contract provider. All Client Plans are rewritten yearly.

vi. **Performance Outcome Measures**, as directed by County, which may include CANS, PSC 35 and MORS at Intake, and at discharge from all County services. Performance Outcome Measures are updated every 6 months.

(2) **Therapeutic Behavioral Services (TBS):** TBS services provided by the Provider, must be documented by the Provider as follows:

(a) **Therapeutic Behavioral Services Plan – (If Applicable)**

TBS plans are to be completed by the treating clinician in conjunction with the family, and are to be approved by the TBS Contract Monitor, or their designee, before services begin. TBS plans must be reviewed by the TBS Treatment Team each month.
(b) Expedited Authorization Process for Therapeutic Behavioral Services

i. Pursuant to *Emily Q. v. Bonta* (C.D.Cal., 2001, CV98-4181 AHM (AIJx)), Provider may request expedited authorization of TBS services if Provider determines that following the normal 14 calendar day time frame for making a decision on a County payment authorization request for TBS could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function. To request expedited authorization of TBS services, Provider shall submit an Expedited Review Request form (Attachment 1) to County.

ii. Upon receipt of an Expedited Review Request form from Provider, County shall approve, deny or modify payment authorization request for TBS and provide notice to Provider no later than three (3) working days after receipt of the request form. County may extend the three-day working day time period by up to 14 calendar days if the beneficiary requests an extension, or if the County identifies a need for additional information and documents in the County’s authorization records the need and how the extension is in the beneficiary’s interest.

iii. County shall provide a Notice of Adverse Benefit Determination (NOABD) to the Provider upon denial or modification of an Expedited Review Request for TBS within three (3) working days, or if County has extended the time frame, by up to 14 calendar days. The NOABD must be mailed by the date the applicable time frame expires.

(3) Copies of Records shall be provided to County from Provider and to Provider from County as necessary for the delivery and monitoring of services, and as specified under Paragraph 1 (TERM), Subparagraph B (Termination), Item (4)(c).

(4) Financial Records: Provider shall prepare and maintain, on a current basis, accurate and complete financial records of its activities and operations relating to this Agreement in accordance with generally accepted accounting principles, with the procedures set out in the Short-Doyle/Medi-Cal Cost Reporting System Manual, and with all guidelines, standards, and procedures which may be provided by County to Provider. The above financial records shall include, but are not limited to:

(a) Books of original entry and a general ledger.

(b) Reports, studies, statistical surveys or other information Provider used to identify and allocate indirect costs among Provider's various modes of service. “Indirect costs” shall mean those costs as described by the CR/DC Manual and all guidelines, standards, and procedures, which may be provided by County to Provider.

(c) Bronzan-McCorquodale/County statistics and total facility statistics (e.g., patient days, visits) which can be identified by type of service pursuant to the CR/DC Manual and any policies and procedures which may be provided by County to Provider.

(d) A listing of all County remittances received.

(e) Patient/client financial folders clearly documenting: Provider's determination of patient's/client's eligibility for Medi-Cal, medical insurance and any other third party payer coverage; and
(f) Records indicating the type and amount of patient/client charges incurred and payments by source and service type.

(g) Employment records.

(5) The entries in all of the above financial records must be readily traceable to applicable source documentation (e.g., remittance invoices, vendor invoices, employee timecards signed by employee and countersigned by supervisor in ink, subsidiary ledgers and journals, appointment logs, service activity logs, etc.). Any apportionment of costs shall be made in accordance with the requirements of the Short-Doyle/Medi-Cal Cost Reporting System Manual, the Federal Health Care Financing Administration's Health Insurance Manual Volume 15 (HIM 15), and CR/DC Manual. All such records shall be maintained by Provider at a location in Butte County for a minimum of no less than a period of ten years from the final date of the SDHCS Mental Health Plan contract period in which such services were provided under, or until County, State and/or Federal audit findings are fully resolved, whichever is later. During such retention period, all such records shall be immediately available and open during County’s normal business hours to authorized representatives and designees of County, State, and/or Federal governments for purposes of inspection, program review, and/or audit. Such access shall include access to individuals with knowledge of financial records and Provider’s outside auditors, and regular and special reports from Provider.

(6) Preservation of Records: If, following termination of this Agreement, Provider's facility(ies) is (are) closed or if majority ownership of Provider changes, then within forty-eight hours thereafter, Director of SDHCS and County Director shall be notified thereof by Provider in writing of all arrangements made by Provider for preservation of all the patient/client, financial, and other records referred to in this Paragraph 12.

B. Audits:

(1) Provider shall provide County and its authorized representatives access to and the right to examine, audit, excerpt, copy, or transcribe, any pertinent transaction, activity, time cards, or any other records relating to this Agreement.

Failure to comply with any/all terms of this Subparagraph B (Audits), may constitute breach of this agreement if not corrected, and may result in Withholding payment per the terms of Subparagraph J (Withholding Payment of Monthly Claim For Nonsubmission of County Data System Documentation and Other Information). In the event that Provider does not correct deficiencies within the required timeframe, then the Director at their sole discretion may request Provider to immediately return any and all amounts paid by County to Provider for the provision of services under this Agreement. Provider shall be required to pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

(2) County may, in its sole discretion, perform or require Provider to facilitate at Provider’s expense, periodic fiscal and/or program review(s) of Provider's records that relate to this Agreement and if the results of any fiscal and/or program review requires a corrective plan of action, Provider shall submit such a plan no later than 30 days of the fiscal and/or program review.

Pursuant to this section, if County requests Provider to facilitate a periodic fiscal and/or program review(s), County will notify Provider and identify which Accounting Firm has been selected to perform this function on behalf of County. Provider shall make all arrangements and ensure completion within County’s required timeframe.

(3) Audit Reports: In the event that any audit of any or all aspects of this Agreement is conducted of Provider by any Federal or State auditor, or by any auditor or accountant
employed by Provider or otherwise, then Provider shall file a copy of such audit report(s) with County Department of Behavioral Health Administrative Support Division within 30 days of Provider's receipt thereof, unless otherwise provided by applicable Federal or State law or under this Agreement. Provider shall promptly notify County of any request for access to information related to this Agreement by any other governmental agency.

(4) State Department of Health Care Services Access to Records: Provider agrees that for a period of ten years from the final date of the SDHCS Mental Health Plan contract period in which such services were provided under, Provider shall maintain and make available to the SDHCS and any other authorized state agencies, or to any of their duly authorized representatives, the contracts, books, documents and records of Provider which are necessary to verify the nature and extent of the cost of services hereunder. Furthermore, if Provider carries out any of the services provided hereunder through any subcontract with a value or cost of TEN THOUSAND DOLLARS ($10,000) or more over a twelve month period with a related organization (as that term is defined under Federal law), Provider agrees that each such subcontract shall provide for such access to the subcontract, books, documents and records of the subcontractor.

(5) Federal Access to Records: If, and to the extent that, Section 1861(v)(1)(l) of the Social Security Act (42 United States Code Section 1395x(v)(1)(l)) is applicable, Provider agrees that for a period of no less than a period of ten years from the final date of the SDHCS Mental Health Plan contract period in which such services were provided under, Provider shall maintain and make available to the Secretary of the United States Department of Health and Human Services or the Controller General of the United States, or to any of their duly authorized representatives, the contracts, books, documents and records of Provider which are necessary to verify the nature and extent of the cost of services hereunder. Furthermore, if Provider carries out any of the services provided hereunder through any subcontract with a value or cost of TEN THOUSAND DOLLARS ($10,000) or more over a twelve-month period with a related organization (as that term is defined under any applicable Federal statutes, regulations, rules, or case law), Provider agrees that each such subcontract shall provide for such access to the subcontract, books, documents and records of the subcontractor.

13. REPORTS:

A. Provider shall make reports as required by Director or by State regarding Provider's activities and operations as they relate to Provider's performance of this Agreement. In no event may County require such reports unless it has provided Provider with at least 30 days prior written notification. County shall provide Provider with a written explanation of the procedures for reporting the required information. Provider shall report to County all program, patient/client/staff, and other required information as requested, within 10 days after the end of each reporting month.

B. Income Tax Withholding: Upon Director's request, Provider shall provide County with certain documents relating to Provider's income tax returns and employee income tax withholding. These documents shall include, but are not limited to:

(1) A copy of Provider's Federal and State quarterly income tax withholding returns (i.e., Federal Form 941 and/or State Form DE-3 or their equivalents).

(2) A copy of a receipt for, or other proof of payment of, each employee's Federal and State income tax withholding, whether such payments are made on a monthly or quarterly basis.

C. Information Systems (County Data System):

(1) Provider shall be required to participate in electronic submission of data, including, but not limited to, data entry into County's data systems, as required by Director. Provider would be required to supply all necessary equipment for such electronic data submission and
comply with all rules and regulations in accordance with County’s Data Systems Minimum Technical Requirements (Attachment 2), including but not limited to HIPAA.

(2) Provider shall report to County, all program, patient/client, staff, and other data and information about Provider's services, within ten days after the end of each reporting month.

(3) Notwithstanding any other provision of this Agreement, only units of service entered by Provider into the data system designated by the Director shall be counted as delivered units of service. All units of service generated during the Start-Up Period, if any, may be entered by County into the data system. After the close of the monthly data entry time frame, no data and information relating to units of service for that month may be added without the written approval of Director or Director’s designee.

(4) If, after the close of the monthly data entry time-frame, Provider desires to enter any data and information documenting units of services for a particular month, then Provider shall submit a request in writing setting forth the good cause reasons which prevented Provider from timely entering such particular data and information. Director may, at their sole discretion, approve in writing Provider's request to enter the data and information into the data system. Notwithstanding any other provision of this Agreement, the only units of service which shall be considered reimbursable at Annual Cost Report adjustment and settlement time or otherwise shall be those units of service as entered into the data system. All good cause justifications shall meet Medi-Cal and Medi-Care requirements.

(5) County shall initially train Provider’s staff in the operation, procedures, policies, and all related use, of data systems as required by County. Provider will be required to perform subsequent trainings for Provider’s staff and to have all new staff attend County’s new staff training sessions.

(6) For the month(s) when County may need to assist Provider with data entry, Provider shall provide County on a weekly basis, but no later than 10 days after the services are provided, with all the information County deems necessary to do the billing/data entry, in a format that is acceptable to County. This information shall include, but not be limited to:

- Client Name and Number
- Date of Service
- Reporting Unit
- Procedure Code
- Procedure Description
- Duration of Service (in Hours and Minutes)
- Site of Service
- Name and number of staff who provided the service

14. CONFIDENTIALITY: PROVIDER shall maintain the confidentiality of all records and information, including, but not limited to, claims, County records, patient/client records and information, and I/S records in accordance with the Business Associate Addendum, (Attachment 3), which is incorporated into this Agreement by this reference, to the extent required by 42 USC 1320d et seq.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (Public Law 111-5, Title XIII); and 42 CFR Part 2, to comply with the applicable requirements of the law(s), including any subsequent amendments thereto relating to protected health information and in accordance with W&I Sections 5328 through 5330, inclusive; Section 14100.2 of the W&I Code and Title 42 CFR Section 431.300 et seq. regarding the confidentiality of beneficiary information, and all other applicable County, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and directives, relating to privacy/security, whichever is most restrictive. PROVIDER shall require all its officers, employees, and agents providing services hereunder to acknowledge, in writing, understanding of, and agreement to fully comply with, all
such confidentiality provisions. Provider shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all loss, damage, liability, and expense arising from any disclosure of such records and information by Provider, its officers, employees, or agents.

15. **PATIENTS'/CLIENTS' RIGHTS:** Provider shall comply with all applicable patients'/clients' rights provisions, including, but not limited to, W&I Section 5325 et seq., CCR Title 9, Section 850 et seq., and CCR Title 22. Further, Provider shall comply with all patients'/clients' rights policies provided by County. County Patients’ Rights Advocates shall be given access by Provider to all patients'/clients, patients'/clients' records, and Provider's personnel in order to monitor Provider's compliance with all applicable statutes, regulations, manuals and policies.

16. **REPORTING OF PATIENT/CLIENT ABUSE AND RELATED PERSONNEL REQUIREMENTS:**

A. **Elders and Dependent Adults Abuse:** Provider, and all persons employed or subcontracted by Provider, shall comply with W&I Section 15630 et seq. and shall report all known or suspected instances of physical abuse of elders and dependent adults under the care of Provider either to an appropriate County adult protective services agency or to a local law enforcement agency, as mandated by W&I Sections 15630, 15631 and 15632. Provider, and all persons employed or subcontracted by Provider, shall make the report on such abuse, and shall submit all required information, in accordance with W&I Sections 15630, 15633 and 15633.5.

B. **Minor Children Abuse:** Provider, and all persons employed or subcontracted by Provider, shall comply with California Penal Code (hereafter "PC") Section 11164 et seq. and shall report all known or suspected instances of child abuse to an appropriate child protective agency, as mandated by California PC 11164, 11165.8 and 11166. Provider, and all persons employed or subcontracted by Provider, shall make the report on such abuse, and shall submit all required information, in accordance with PC Sections 11166 and 11167.

C. **Provider Staff:**

(1) Provider shall assure that any person who enters into employment as a care custodian of elders, dependent adults or minor children, or who enters into employment as a health or other practitioner, prior to commencing employment, and as a prerequisite to that employment, shall sign a statement on a form provided by Provider in accordance with the above code sections to the effect that such person has knowledge of, and will comply with, these code sections.

(2) Provider shall assure that clerical and other nontreatment staff who are not legally required to directly report suspected cases of abuse, consult with mandated reporters upon suspecting any abuse.

(3) For the safety and welfare of elders, dependent adults, and minor children, Provider shall, to the maximum extent permitted by law, ascertain arrest and conviction records for all current and prospective employees and shall not employ or continue to employ any person convicted of any crime involving any harm to elders, dependent adults, or minor children.

(4) Provider shall not employ or continue to employ, or shall take other appropriate action to fully protect all persons receiving services under this Agreement concerning, any person whom Provider knows, or reasonably suspects, has committed any acts which are inimical to the health, morals, welfare, or safety of elders, dependent adults or minor children, or which otherwise make it inappropriate for such person to be employed by Provider.

17. **NONDISCRIMINATION IN SERVICES:**

A. Provider shall not discriminate in the provision of services hereunder because of race, religion, national origin, ancestry, sex, age, marital status, sexual preference, or physical or mental disability or medical conditions, in accordance with requirements of Federal and State law. For
the purpose of this Paragraph 17, discrimination in the provision of services may include, but is not limited to, the following: denying any person any service or benefit or the availability of a facility; providing any service or benefit to any person which is different, or is provided in a different manner or at a different time, from that provided to others; subjecting any person to segregation or separate treatment in any matter related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment quota, eligibility, membership, or any other requirement or condition which persons must meet in order to be provided any service or benefit. Provider shall take affirmative action to ensure that intended beneficiaries of this Agreement are provided services without regard to ability to pay or source of payment, race, religion, national origin, ancestry, sex, age, marital status, sexual preference or physical or mental disability, or medical conditions. (CCR, Title 9, Chapter 11, Section 1810.436(a)(2).

B. Provider shall establish and maintain written complaint procedures under which any person applying for or receiving any services under this Agreement may seek resolution from Provider of a complaint with respect to any alleged discrimination in the rendering of services by Provider’s personnel. Such procedures shall also include a provision whereby any such person, who is dissatisfied with Provider's resolution of the matter, shall be referred by Provider to Director for the purpose of presenting the complaint of the alleged discrimination. Such complaint procedures shall also indicate that if such person is not satisfied with County's resolution or decision with respect to the complaint of alleged discrimination, such person may appeal the matter to the State, if appropriate.

C. If direct services (i.e., 24-hour services, case management services, day services, and outpatient services) are provided hereunder, Provider shall have admission policies which are in accordance with CCR Title 9, Sections 526 and 527, and which shall be in writing and available to the public. Provider shall not employ discriminatory practices in the admission of any person, assignment of accommodations, or otherwise. Any time any person applies for services under this Agreement, such person shall be advised by Provider of the complaint procedures described in the above paragraph. A copy of such complaint procedures shall be posted by Provider in a conspicuous place, available and open to the public, in each of Provider's facilities where services are provided under this Agreement.

18. NONDISCRIMINATION IN EMPLOYMENT:

A. Provider certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated equally by it without regard to, or because of, race, religion, national origin, ancestry, sex, age, marital status, sexual preference, physical or mental disability, or political affiliation, and in compliance with all applicable Federal and State anti-discrimination laws and regulations.

B. Provider shall take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to race, religion, national origin, ancestry, sex, age, marital status, sexual preference, physical or mental disability, or political affiliation. Such action shall include, but is not limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

C. Provider shall deal with its subcontractors, bidders, or vendors without regard to or because of race, religion, ancestry, national origin, sex, age, marital status, sexual preference, physical or mental disability, or political affiliation.

D. Provider shall allow County representatives access to its employment records during regular business hours to verify compliance with the provisions of this Paragraph 18 when so requested by Director.

E. If County finds that any of the above provisions has been violated, the same shall constitute a
material breach of this Agreement upon which County may immediately terminate or suspend this Agreement. While County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Provider has violated State or Federal anti-discrimination laws or regulations shall constitute a finding by County that Provider has violated the anti-discrimination provisions of this Agreement.

F. In the event that Provider violates any of the anti-discrimination provisions of this Paragraph 18, County shall be entitled, at its option, to the sum of FIVE HUNDRED DOLLARS ($500) pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

19. FAIR LABOR STANDARDS: Provider shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its officers, employees, and agents, from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for services performed by Provider's employees for which County may be found jointly or solely liable.

20. INDEMNIFICATION AND INSURANCE:

A. Indemnification: Provider shall indemnify, defend and hold harmless County, and their elected and appointed officers, employees, and agents, from and against any and all liability and expense, including defense costs and legal fees, arising from or connected with claims and lawsuits for damages or workers' compensation benefits relating to Provider's operations or its services, which result from bodily injury, death, personal injury, or property damage, including physical damage or loss of Provider's property in the care, custody or control of Provider. Provider shall not be obligated to indemnify for liability and expense arising from the active negligence of the County.

B. Insurance: Without limiting Provider indemnification, Provider shall procure and maintain for the duration of this contract, insurance against claims for injuries to persons or damages to property that may arise from, or be in connection with the performance of the work hereunder by Provider, Provider's agents, representatives, employees, and subcontractors. At the very least, Provider shall maintain the insurance coverage, limits of coverage and other insurance requirements as described in Insurance requirements for County Contracts (Attachment 4) to this contract. Certificates evidencing the maintenance of Provider's insurance coverage shall be filed with County. Said certificates must be on file before payment for services will be released.

21. WARRANTY AGAINST CONTINGENT FEES: Provider warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon any agreement or understanding for any commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Provider for the purpose of securing business. For Provider's breach or violation of this warranty, County may, in its sole discretion, deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

22. CONFLICT OF INTEREST:

A. No County employee whose position in County enables such employee to influence the award or administration of this Agreement or any competing agreement, and no spouse or economic dependent of such employee, shall be employed in any capacity by Provider or have any direct or indirect financial interest in this Agreement. No officer or employee of Provider who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.
B. Provider shall comply with all conflict of interest laws, ordinances and regulations now in effect or hereafter to be enacted during the term of this Agreement. Provider warrants that it is not now aware of any facts, which create a conflict of interest. If Provider hereafter becomes aware of any facts, which might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to County. Full written disclosure shall include, without limitation, identification of all persons implicated and complete description of all relevant circumstances.

23. **UNLAWFUL SOLICITATION:** Provider shall require all of its employees to acknowledge, in writing, understanding of and agreement to comply with the provisions of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of California Business and Professions Code (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to insure that there is no violation of such provisions by its employees. Provider shall utilize the attorney referral service of all those bar associations within the County of Butte that have such a service.

24. **INDEPENDENT STATUS OF PROVIDER:**

A. This Agreement is by and between County and Provider and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between County and Provider. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Provider shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Agreement all compensation and benefits. County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of Provider.

C. Provider understands and agrees that all persons performing services pursuant to this Agreement are, for purposes of workers’ compensation liability, the sole employees of Provider and not employees of County. Provider shall be solely liable and responsible for furnishing any and all workers’ compensation benefits to any person as a result of any injuries arising from or connected with any services performed by or on behalf of Provider pursuant to this Agreement.

D. Provider shall obtain and maintain on file an executed Provider’s Employee Acknowledgment of Employer (Attachment 5), for each of its employees performing services under this Agreement. Such Acknowledgments shall be executed by each such employee on or immediately after the commencement date of this Agreement but in no event later than the date such employee first performs services under this Agreement.

25. **DELEGATION AND ASSIGNMENT:** Provider shall not delegate its duties or assign its rights under this Agreement, or both, either in whole or in part, without the prior written consent of County, and any prohibited delegation or assignment shall be null and void. Any payments by County to any delegatee or assignee on any claim under this Agreement, in consequence of any such consent, shall be subject to set off, recoupment, or other reduction for any claim which Provider may have against County.

26. **SUBCONTRACTING:**

A. No performance of this Agreement, or any portion thereof, shall be subcontracted by Provider without the prior written consent of County as provided in this Paragraph 26. Any attempt by Provider to subcontract any performance, obligation, or responsibility under this Agreement, without the prior written consent of County, shall be null and void and shall constitute a material breach of this Agreement. Notwithstanding any other provision of this Agreement, in the event of any such breach by Provider, this Agreement may be terminated forthwith by County. Notwithstanding any other provision of this Agreement, the parties do not in any way
intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

B. If Provider desires to subcontract any portion of its performance, obligations, or responsibilities under this Agreement, Provider shall make a written request to County for written approval to enter into the particular subcontract. Provider's request to County shall include:

(1) The reasons for the particular subcontract.
(2) A detailed description of the services to be provided by the subcontract.
(3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the degree of competition involved.
(4) A description of the proposed subcontract amount and manner of compensation, together with Provider's cost or price analysis thereof.
(5) A copy of the proposed subcontract which shall contain the following provision: "This contract is a subcontract under the terms of the prime contract with the County of Butte and shall be subject to all of the provisions of such prime contract."
(6) A copy of the proposed subcontract, if in excess of $10,000 and utilizes State funds, shall also contain the following provision: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7)."

The Provider will also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

(7) Any other information and/or certifications requested by County.

C. County shall review Provider's request to subcontract and shall determine, in its sole discretion, whether or not to consent to such request on a case-by-case basis.

D. Provider shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and legal fees, arising from or related to Provider's use of any subcontractor, including any officers, employees, or agents of any subcontractor, in the same manner as required for Provider, its officers, employees, and agents, under this Agreement.

E. Notwithstanding any County consent to any subcontracting, Provider shall remain fully liable and responsible for any and all performance required of it under this Agreement, and no subcontract shall bind or purport to bind County. Further, County approval of any subcontract shall not be construed to limit in any way Provider's performance, obligations, or responsibilities, to County, nor shall such approval limit in any way any of County's rights or remedies contained in this Agreement. Additionally, County approval of any subcontract shall not be construed in any way to constitute the determination of the allowability or appropriateness of any cost or payment under this Agreement.

F. In the event that County consents to any subcontracting, such consent shall be subject to County's right to terminate, in whole or in part, any subcontract at any time upon written notice to Provider when such action is deemed by County to be in its best interest. County shall not be liable or responsible in any way to Provider, to any subcontractor, or to any officers, employees, or agents of Provider or any subcontractor, for any liability, damages, costs, or expenses arising from or related to County's exercise of such right.
G. In the event that County consents to any subcontracting, each and all of the provisions of this Agreement and any amendment thereto shall extend to, be binding upon, and inure to the benefit of, the successors or administrators of the respective parties.

H. In the event that County consents to any subcontracting, such consent shall apply to each particular subcontract only and shall not be, or be construed to be, a waiver of this Paragraph 26 or a blanket consent to any further subcontracting.

I. In the event that County consents to any subcontracting, Provider shall be solely liable and responsible for any and all payments and/or other compensation to all subcontractors and their officers, employees, and agents. County shall have no liability or responsibility whatsoever for any payment and/or other compensation for any subcontractors or their officers, employees, and agents.

J. Provider shall deliver to the County Contract Monitor a fully executed copy of each subcontract entered into by Provider pursuant to this Paragraph 26, on or immediately after the effective date of the subcontract but in no event later than the date any services are performed under the subcontract.

K. In the event that County consents to any subcontracting, Provider shall obtain and maintain on file an executed Subcontractor’s Employee Acknowledgment of Employer (Attachment 6) for each of the subcontractor’s employees performing services under the subcontract. Such Acknowledgments shall be delivered to the County Contract Monitor or immediately after the commencement date of the particular subcontract but in no event later than the date such employee first performs any services under the subcontract.

L. County shall have no liability or responsibility whatsoever for any payment or other compensation for any subcontractor or its officers, employees, and agents.

M. Director is hereby authorized to act for and on behalf of County pursuant to this Paragraph 26, including, but not limited to, consenting to any subcontracting.

27. GOVERNING LAW, JURISDICTION AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Provider agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Butte, California. Further, this Agreement shall be governed by, and construed in accordance with, all laws, regulations, and contractual obligations of County under its agreement with the State.

28. COMPLIANCE WITH APPLICABLE LAW:

A. Provider shall comply with all applicable Federal and State statutes and regulations, including, but not limited to, Title XIX of the Social Security Act, HIPAA, State, and local laws, ordinances, rules, regulations, manuals, guidelines, Americans with Disabilities Act (ADA) standards, and directives applicable to its performance hereunder or whichever is most restrictive. Further, all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference [CCR, Title 9, Chapter 11, section 1810.436(a)(5)].

B. Provider shall indemnify and hold harmless County from and against any and all liability, damages, costs or expenses, including, but not limited to, defense costs and attorneys' fees, arising from or related to any violation on the part of Provider, its officers, employees, or agents, of any such Federal, State or local laws, ordinances, rules, regulations, manuals, guidelines, ADA standards, or directives.

C. Provider shall maintain in effect an active compliance program in accordance with the recommendations set forth by the Department of Health and Human Services, Office of the Inspector General.
29. **THIRD PARTY BENEFICIARIES:** Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

30. **LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES:**

   A. Provider shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certificates (including, but not limited to, certification as a Short-Doyle/Medi-Cal provider if Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services are provided hereunder), as required by all Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines, and directives, which are applicable to Provider's facility(ies) and services under this Agreement. Provider shall further ensure that all of its officers, employees, and agents, who perform services hereunder, shall obtain and maintain in effect during the term of this Agreement all licenses, permits, registrations, accreditations, and certificates which are applicable to their performance hereunder. A copy of each such license, permit, registration, accreditation, and certificate (including, but not limited to, certification as a Short-Doyle/Medi-Cal provider if Title XIX Short-Doyle/Medi-Cal Specialty Mental Health Services are provided hereunder) as required by all applicable Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines and directives shall be provided, in duplicate, to County's Contract Monitor.

   B. If Provider is a participant in the Short-Doyle/Medi-Cal program, Provider shall keep fully informed of all current Short-Doyle/Medi-Cal Policy Letters, including, but not limited to, procedures for maintaining Medi-Cal certification of all its facilities.

31. **TERMINATION FOR INSOLVENCY:**

   A. County may terminate this Agreement immediately in the event of the occurrence of any of the following:

   (1) Insolvency of Provider. Provider shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Provider is insolvent within the meaning of the Federal Bankruptcy Code.

   (2) The filing of a voluntary or involuntary petition regarding Provider under the Federal Bankruptcy Code.

   (3) The appointment of a Receiver or Trustee for Provider.

   (4) The execution by Provider of a general assignment for the benefit of creditors.

   B. The rights and remedies of County provided in this Paragraph 31 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

32. **TERMINATION FOR DEFAULT:**

   A. County may, by written notice of default to Provider, terminate this Agreement immediately in any one of the following circumstances:

   (1) If, as determined in the sole judgment of County, Provider fails to perform any services within the times specified in this Agreement or any extension thereof as County may authorize in writing; or

   (2) If, as determined in the sole judgment of County, Provider fails to perform and/or comply with any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in either of
these two circumstances, does not cure such failure within a period of five days (or such longer period as County may authorize in writing) after receipt of notice from County specifying such failure.

B. In the event that County terminates this Agreement as provided in Subparagraph A, County may procure, upon such terms and in such manner as County may deem appropriate, services similar to those so terminated, and Provider shall be liable to County for any reasonable excess costs incurred by County, as determined by County, for such similar services.

C. The rights and remedies of County provided in this Paragraph 32 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

33. **TERMINATION FOR IMPROPER CONSIDERATION:** County may, by written notice to Provider, immediately terminate the right of Provider to proceed under this Agreement if it is found that consideration, in any form, was offered or given by Provider, either directly or through an intermediary, to any County officer, employee or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment or extension of the Agreement or the making of any determinations with respect to the Provider’s performance pursuant to the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Provider as it could pursue in the event of default by the Provider.

Provider shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made to the County Department of Behavioral Health Director.

Among other items, such improper consideration may take the form of cash, discounts, and service, the provision of travel or entertainment, or tangible gifts.

34. **SEVERABILITY:** If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

35. **CAPTIONS AND PARAGRAPH HEADINGS:** Captions and paragraph headings used in this Agreement are for convenience only and are not a part of this Agreement and shall not be used in construing this Agreement.

36. **ALTERATION OF TERMS:** Other than the shifting funds by County during the Cost Report Settlement process, no addition to, or alteration of, the terms of the body of this Agreement, or the SFC’s within the Financial Summary(ies) or Service Exhibit(s) hereto, whether by written or oral understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the form of a written amendment to this Agreement which is formally approved and executed by the parties in the same manner as this Agreement.

37. **ENTIRE AGREEMENT:** The body of this Agreement; Financial Summary(ies),

<table>
<thead>
<tr>
<th>Service Exhibit(s)</th>
<th>Exhibit A - Mental Health Services</th>
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</thead>
<tbody>
<tr>
<td>Exhibit B - Crisis Intervention</td>
<td></td>
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<tr>
<td>Exhibit C - Targeted Case Management</td>
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</table>

Attachment(s) 1, 2, 3, 4, 5, 6, 7, 8 and 9 attached hereto and incorporated herein by reference including any addenda thereto, which are hereby incorporated herein by reference but not attached shall construe the complete and exclusive statement of understanding between the parties which supersedes all previous agreements, written or oral, and all other communications between the parties relating to the subject matter of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or schedule, or the contents or description of any service or other work, or otherwise, between the body of this Agreement and the other referenced documents, or between such other documents, such conflict or inconsistency shall be
resolved by giving precedence first to the body of this Agreement then to such other documents according to the following priority:

A. Financial Summary(ies)
B. Service Exhibit(s)
C. Attachments.

38. **WAIVER:** No waiver by County of any breach of any provision of this Agreement shall constitute a waiver of any other breach of such provision. Failure of County to enforce at any time, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this Paragraph 38 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

39. **EMPLOYMENT ELIGIBILITY VERIFICATION:** Provider warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others and that all its employees performing services hereunder meet the citizenship or alien status requirements set forth in Federal statutes and regulations. Provider shall obtain, from all covered employees performing services hereunder, all verification and other documentation of employment eligibility status required by Federal statutes and regulations as they currently exist and as they may be hereafter amended. Provider shall retain all such documentation for the period prescribed by law. Provider shall indemnify, defend, and hold harmless County, its officers and employees from and against any employer sanctions and any other liability which may be assessed against Provider or County in connection with any alleged violation of any Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

40. **PUBLIC ANNOUNCEMENTS AND LITERATURE:** In public announcements and literature distributed by Provider for the purpose of apprising patients/clients and the general public of the nature of its treatment services, Provider shall clearly indicate that the services, which it provides under this Agreement, are in whole or in part funded by the Butte County Department of Behavioral Health.

41. **PURCHASES:**

A. **Purchase Practices:** Provider shall fully comply with all Federal, State and County laws, ordinances, rules, regulations, manuals, guidelines, and directives, in acquiring all furniture, fixtures, and equipment. Such items shall be acquired at the lowest possible price or cost if funding is provided for such purposes hereunder. Failure to comply with the terms of this Paragraph 41, PURCHASES, may constitute breach of this agreement if not corrected, and may result in withholding payment per the terms of Subparagraph J (Withholding Payment of Monthly Claim For Nonsubmission of County Data System Documentation and Other Information). In the event that Provider does not correct deficiency’s within the required timeframe, then the Director at their sole discretion may request Provider to immediately return any and all amounts paid by County to Provider for the purchase of such furniture, removable fixtures, and equipment. Provider shall be required to pay County according to the method described in Subparagraph O (Payments Due to County/Method of Payment).

B. **Proprietary Interest of County:** In accordance with all applicable Federal, State and County laws, ordinances, rules, regulations, manuals, guidelines and directives, County shall retain all proprietary interest, except the use during the term of this Agreement, in all furniture, fixtures, and equipment, purchased or obtained by Provider using any County funds. Upon the expiration or termination of this Agreement, the discontinuance of the business of Provider, the failure of Provider to comply with any of the provisions of this Agreement, the bankruptcy of Provider or its giving an assignment for the benefit of creditors, or the failure of Provider to satisfy any judgment against it within thirty days of filing, County shall have the right to take immediate possession of all such furniture, removable fixtures, and equipment, without any claim for reimbursement whatsoever on the part of Provider. County, in conjunction with Provider, shall attach identifying labels on all such property indicating the proprietary interest of County.
C. **Inventory Records, Controls and Reports:** Provider shall maintain accurate and complete inventory records and controls for all furniture, fixtures, and equipment, purchased or obtained using any County funds. Within ninety days following the execution of this Agreement, Provider shall provide Director with an accurate and complete inventory report of all furniture, fixtures, and equipment, purchased or obtained using any County funds. The inventory report shall be prepared by Provider on a form or forms designated by Director, certified and signed by an authorized officer of Provider, and one copy thereof shall be delivered to County within thirty days of any change in the inventory. Within five days after the expiration or termination of the Agreement, Provider shall submit to County six copies of the same inventory report updated to the expiration or termination date of the Agreement, certified and signed by an authorized officer of Provider, based on a physical count of all items of furniture, fixtures, and equipment, as of such expiration or termination date.

D. **Protection of Property in Provider's Custody:** Provider shall maintain vigilance and take all reasonable precautions, to protect all furniture, fixtures, and equipment, purchased or obtained using any County funds, against any damage or loss by fire, burglary, theft, disappearance, vandalism or misuse. In the event of any burglary, theft, disappearance, or vandalism of any item of furniture, fixtures, and equipment, Provider shall immediately notify the police and make a written report thereof, including a report of the results of any investigation, which may be made. In the event of any damage or loss of any item of furniture, fixtures, and equipment, from any cause, Provider shall immediately send Director a detailed, written report. Provider shall contact County Department of Behavioral Health's Administrative Support Division for instructions for disposition of any such property, which is worn out or unusable.

E. **Disposition of Property in Provider's Custody:** Upon the termination of the funding of any program covered by this Agreement, or upon the expiration or termination of this Agreement, or at any other time that County may request, Provider shall: (1) provide access to and render all necessary assistance for physical removal by County or its authorized representatives of any or all furniture, fixtures, and equipment, purchased or obtained using any County funds, in the same condition as such property was received by Provider, reasonable wear and tear excepted; or (2) at Director's option, deliver any or all items of such property to a location designated by Director. Any disposition, settlement or adjustment connected with such property shall be in accordance with all applicable Federal, State and County laws, ordinances, rules, regulations, manuals, guidelines and directives.

42. **AUTHORIZATION WARRANTY:** Provider represents and warrants that the person executing this Agreement for Provider is an authorized agent who has actual authority to bind Provider to each and every term, condition, and obligation of this Agreement and that all requirements of Provider have been fulfilled to provide such actual authority.

43. **RESTRICTIONS ON LOBBYING:**
(Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

A. **Certification and Disclosure Requirements**

1. A Provider who receives a contract which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000, shall file a certification (in the form set forth in **Attachment 8**, consisting of one page, entitled “Certification Regarding Lobbying”, incorporated by this reference) that the Provider has not made, and will not make, any payment prohibited by Paragraph 43.

2. Provider shall file a disclosure (in the form set forth in **Attachment 9**, entitled “Disclosure of Lobbying Activities” Standard Form-LLL, incorporated by this reference) if such Provider has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or any amendment of that contract, which would be prohibited under Paragraph 43 if paid for with appropriated funds.
3. Provider shall require that the language of this certification be included in the award of documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

4. Provider shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed under this Paragraph 43, Subparagraph A, Section (1) and Subparagraph A, Section (2) herein. An event that materially affects the accuracy of the information reported includes:
   a. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
   b. A change in the person(s) or individual(s) influencing or attempting to influence a covered federal action; or
   c. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

44. **CERTIFICATION OF DRUG-FREE WORK PLACE**: Provider certifies and agrees that Provider and its employees shall comply with County’s policy of maintaining a drug-free workplace. Provider and its employees shall not manufacture, distribute, dispense, possess, or use any controlled substances as defined in 21 United States Code Section 812, including, but not limited to, marijuana, heroin, cocaine, and amphetamines, at any of Provider’s facilities or work sites or County’s facilities or work sites. If Provider or any of its employees is convicted of or pleads nolo contendere to any criminal drug statute violation occurring at any such facility or work site, then Provider, within five days thereafter, shall notify Director in writing.

45. **MAINTENANCE STANDARDS FOR SERVICE DELIVERY SITES**: Provider shall assure that all locations where services are provided under this Agreement are operated at all times in accordance with all County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulations relating to the property. County’s periodic monitoring visits to Provider’s facility(ies) shall include a review of compliance with this Paragraph 45.

46. **CHILD SUPPORT COMPLIANCE PROGRAM**:
   A. **Provider’s Acknowledgement of County’s Commitment to Child Support Enforcement**: The Provider acknowledges that the County places a high priority on the enforcement of child support laws and the apprehension of child support evaders.
   B. **Provider’s Warranty of Adherence to County’s Child Support Compliance Program**:
      (1) The Provider acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through Purchase Order or Agreement are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.
      (2) As required by the County and without limiting the Provider’s duty under this Agreement to comply with all applicable provisions of law, the Provider warrants that it is now in compliance and shall during the term of this Agreement maintain compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings
Assignment for Child or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

47. PROVIDER RESPONSIBILITY AND DEBARMENT:
   
   A. A responsible Provider is a Provider who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County’s policy to conduct business only with responsible providers.

   B. The Provider is hereby notified that, in accordance with County Policy, if the County acquires information concerning the performance of the Provider on this or other Agreements which indicates that the Provider is not responsible, the County may, in addition to other remedies provided in the Agreement, debar the Provider from bidding on County contracts for a specified period of time not to exceed 3 years, and terminate any or all existing contracts the Provider may have with the County.

   C. The County may debar a Provider if the Board of Supervisors finds, in its discretion, that the Provider has done any of the following: (1) violated any term of an Agreement with the County; (2) committed any act or omission which negatively reflects on the Provider’s quality, fitness or capacity to perform a contract with the County or any other public entity, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or offense which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against the County or any other public entity.

   D. If there is evidence that the Provider may be subject to debarment, the County will notify the Provider in writing of the evidence, which is the basis for the proposed debarment and will advise the Provider of the scheduled date for a debarment hearing before the Provider Hearing Board.

   E. The Provider Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Provider and/or the Provider’s representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Provider Hearing Board shall prepare a proposed decision, which shall contain a recommendation regarding whether the provider should be debarred, and, if so, the appropriate length of time of the debarment. If the Provider fails to avail itself of the opportunity to submit evidence to the Provider Hearing Board, the Provider may be deemed to have waived all rights of appeal.

   F. A record of the hearing, the proposed decision and any other recommendation of the Provider Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny or adopt the proposed decision and recommendation of the Hearing Board.

   G. These terms shall also apply to subcontractors/subconsultants of County Providers.

48. PROVIDER’S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM:

   Provider hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Provider will notify Director in writing within thirty (30) calendar days from receipt of the fully executed Agreement of: (1) any event that would require Provider or a staff member’s mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Provider or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

   Provider shall screen all potential employees or contractors prior to providing services related to this Agreement to ensure that they are not designated as “Ineligible” or “Excluded” as defined hereunder. Screening shall be conducted against the California “Medi-Cal Suspended and Ineligible List”, the United States, Health and Human Services, Office of Inspector General “List of Excluded Individuals/Entities”,

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the Social Security Administration Death Master File, the National Plan and Provider Enumeration System (NPPES), and the System for Award Management (SAM).

Provider shall screen all staff employed or retained to provide services related to this Agreement monthly. Screening shall be conducted against the California “Medi-Cal Suspended and Ineligible List”, the United States, Health and Human Services, Office of Inspector General “List of Excluded Individuals/Entities”, and the System for Award Management (SAM). Provider shall notify Director in writing that Provider and Provider’s staff are eligible to participate in Federally funded programs. This notification shall be performed by completing Attachment 7, Attestation Regarding Federally Funded Programs.

Provider and staff shall be required to disclose to the Director immediately any debarment, exclusion or other event that makes any individual an Ineligible or Excluded person. If the Provider becomes aware that a staff member has become an Ineligible or Excluded person, Provider shall remove such individual from responsibility for, or involvement with, COUNTY business operations related to this Agreement.

There are a variety of different reasons why an individual or entity may be excluded from participating in a Federally funded health care program. Sometimes, the exclusion is mandatory and in other cases the OIG has the discretion not to exclude.

The mandatory basis for exclusion include: (1) felony convictions for program related crimes, including fraud or false claims, or for offenses related to the dispensing or use of controlled substances; or (2) convictions related to patient abuse.

Permissive exclusions may be based on: (1) conviction of a misdemeanor related to fraud or financial misconduct involving a government program; (2) obstructing an investigation; (3) failing to provide access to documents or premises as required by federal healthcare program officials; (4) conviction of a misdemeanor related to controlled substances; (5) failing to disclose information about the entity itself, its subcontractors or its significant business transactions; (6) loss of a state license to practice a healthcare profession; (7) default on a student loan given in connection with education in a health profession; (8) charging excessive amounts to a Federally funded health care program or furnishing services of poor quality or which are substantially in excess of the needs of the patients; (9) paying a kickback or submitting a false or fraudulent claim. Persons controlling or managing excluded entities who knew of the conduct leading to the exclusion can themselves be excluded, and entities, which are owned and controlled by excluded individuals, can also be excluded.

Provider shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Provider or its staff members from such participation in a Federally funded health care program.

Failure by Provider to meet the requirements of this Paragraph 48 shall constitute a material breach of Agreement upon which County may immediately terminate or suspend this Agreement.

49. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (“HIPAA”). Provider understands and agrees that it is a “Covered Entity” under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients’ medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Provider understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Provider’s behalf. Provider has not relied, and will not in any way rely, on County for legal advice or other representations with
respect to Provider's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

Provider and County understand and agree that each is independently responsible for HIPAA compliance and agree to take all necessary and reasonable actions to comply with the requirements of HIPAA law and implementing regulations related to Transactions and Code Sets, Privacy, and Security. Each party further agrees to indemnify and hold harmless the other party (including their officers, employees and agents), for its failure to comply with HIPAA.

50. PROVIDER'S DISCLOSURE OF OWNERSHIP:

A. Pursuant to 42 C.F.R. § 455.104, all County contractors/subcontractors/network providers must disclose ownership information set forth in in subsection B(1).

B. The County's Provider must be required to submit updated disclosures to the County upon submitting the provider application, before entering into or renewing contracts, and within 35 days after any change in the Provider's ownership or upon request of the County.

(1) Disclosures to be Provided:

(a) The name and address of any person (individual or corporation) with an ownership or control interest in the Provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;

(b) Date of birth and Social Security Number (in the case of an individual);

(c) Other tax identification number (in the case of a corporation with an ownership or control interest in the Provider, of 5 percent or more interest);

(d) Whether the person (individual or corporation) with an ownership or control interest in the Provider is related to another person with ownership or control interest in the same or any other Provider of the County as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Provider has a 5 percent or more interest is related to another person with ownership or control interest in the Provider as a spouse, parent, child, or sibling;

(e) The name of any other disclosing entity in which the Provider or subcontractor has an ownership or control interest; and

(f) The name, address, date of birth, and Social Security Number of any managing employee of the Provider.

51. NOTICES: All notices or demands required or permitted to be given under this Agreement shall be in writing and shall be delivered with signed receipt or mailed by first class, registered or certified mail, postage pre-paid, addressed to the parties at the following addresses and to the attention of the persons named. Director shall have the authority to execute all notices or demands which are required or permitted by County under this Agreement. Addresses and persons to be notified may be changed by either party by giving ten days prior written notice thereof to the other party and will not require an amendment to the Agreement.
52. CONTRACT RESOLUTION PROCESS: In the event Provider and County have a difference of opinion with regard to this Agreement, Provider shall initially work with the assigned County Contract Monitor. If satisfaction is not received, the County’s Problem Resolution Process shall be followed. Provider may contact County’s Department of Behavioral Health Administrative Support Division at the address and/or phone number as shown in Paragraph 51 NOTICES above, to obtain a copy of the County’s Provider Problem Resolution Process. All differences of opinion shall be handled at the lowest possible level within the two agencies and with cooperative spirit.

53. APPLICABLE LAW AND FORUM: This Contract shall be construed and interpreted according to California law and action to enforce the terms of this Contract for the breach thereof shall be brought and tried in the County of Butte.

54. INTELLECTUAL PROPERTY: All work provided by the Provider shall be the sole property of the County. Provider shall have no proprietary interest in the programs or data they develop for the County or those programs or data developed during periods of time that are subsequently billed to the County. Provider understands that work performed in the described manner is accomplished for the benefit of the County and becomes the sole property of the County. The compensation provided to Provider by this agreement shall be deemed fair and adequate compensation for all work performed. The Provider agrees that the products of this work, its “Intellectual Property”, is by rights the sole possession of the County. Intellectual Property is defined as “The ownership of ideas and control over the tangible or virtual representation of those ideas, including but not limited to program names and phone numbers.”

55. GOVERNING AGREEMENT COMPLIANCE: By signing this Agreement, Provider acknowledges that, as a sub-recipient of Federal and State funding, Provider is obligated to adhere to all terms and conditions defined in the governing agreement(s) including those incorporated by reference, in effect at the time services are provided between County and SDHCS, under the Mental Health Plan agreement, and any future terms and conditions contained in any subsequent agreements or amendments to those agreements. Such terms and conditions are in reference to “subcontractor”, and are available at www.buttecounty.net.
Behavioral Health, Contractor Resources, Mental Health Plan, incorporated by reference as if incorporated herein. Noncompliance with the aforementioned terms and conditions may result in termination of this Agreement by giving written notice as detailed in Paragraph 32 TERMINATION FOR DEFAULT.

http://www.buttecounty.net/behavioralhealth/ContractorResources.aspx

County shall notify in writing the Provider contacts listed in Paragraph 51 NOTICES, of any amendments of the governing agreements. The amendments will then be posted on the Contractor Resources webpage referenced above for review.
IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

______________________________      Date
Trishanne Lininger, Administrator
Counseling Solutions

______________________________      Date
Dorian Kittrell, Director
Butte County Department of Behavioral Health

______________________________      Date
Steve Lambert, Chair
Butte County Board of Supervisors

Reviewed for Contract Policy Compliance, General Services by: ________________________________

Approved as to form, County Counsel by: ___________________________________________

Provider: Counseling Solutions
Budget: 5411000  534030
Monitor: Kennelly/Perez
**PROVIDER NAME:** Counseling Solutions  
**Financial Summary**  
**Period:** July 1, 2019 - June 30, 2020

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SERVICE EXHIBIT A
MENTAL HEALTH SERVICES
(MODE OF SERVICE 15)

1. **GENERAL:** Mental health services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the consumer’s goals.

For patients/clients who are seriously emotionally disturbed children and adolescents, mental health services provide a range of services to assist the patient/client to gain the social and functional skills necessary for appropriate development and social integration.

Services may either be face-to-face or by telephone contact with the patient/client or significant support persons and may be provided anywhere in the community. In the unusual circumstance where the patient/client and/or significant other is not present, plan development activities hereunder may be provided without a face-to-face or telephone contact.

Provider shall be certified by BCDBH as a Short-Doyle/Medi-Cal Mental Health Provider.

In addition to the other staffing requirements of this Agreement, Provider shall assure that these services are provided with the minimum qualified staff and staffing ratio, if any, as required by State regulation.

The definition of Service Function Code (SFC) unit for the purpose of determining the number of units of service provided by Provider hereunder shall be as established by the Director. Billing restrictions for these services shall apply as legislated.

2. **PERSONS TO BE SERVED:** Provider shall provide services to children/adolescents and their families with full scope Medi-Cal from Butte County who meet the criteria of medical necessity.

3. **SERVICE DELIVERY SITE(S):** Provider will provide the majority of services at an approved site, though a portion of services may be delivered off-site each day.

4. **QUALITY IMPROVEMENT:** Provider shall comply with all applicable provisions of WIC, CCR, Code of Federal Regulations, SDHS policies and procedures, SDMH policies and procedures, and BCDBH quality improvement policies and procedures. Provider shall establish and maintain a complete and integrated quality improvement system.

In conformance with these provisions, Provider shall adopt and comply with the quality improvement programs and responsibilities set forth in the BCDBH's Quality Management Plan. Provider agrees to provide and deliver a random sampling of charts as requested by County for Quality Assurance/Utilization Review on a monthly basis. A copy of Provider's procedures to comply with BCDBH's Quality Management Plan shall be submitted to BCDBH's Contract Monitor for review prior to Provider's submission of any billings for services hereunder.

5. **PROGRAM ELEMENTS AND SERVICES:** Provider shall provide services to consumers in accordance with this Agreement and any addenda thereto for the term of this Agreement. Services shall include, as checked below:

   X   A. Assessment and Evaluation – Assessment - A clinical analysis of the history and current status of the patient's/client's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and the use of testing procedures.
Evaluation – An appraisal of the patient’s/ client’s community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues may be addressed where appropriate.

X B. Collateral – Contact with one or more significant support persons in the life of the patient/client which may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the patient’s/client’s condition and involving them in service planning and implementation of service plan(s). Family counseling when the consumer is not present or therapy which is provided on behalf of the patient/client can be considered collateral.

X C. Therapy (Individual, Group, Family) – Therapeutic interventions consistent with the patient’s/ client’s goals which focus primarily on symptom reduction as a means to improve functional impairments. This service activity may be delivered to an individual patient/client or group of patients/clients, and may include family therapy.

X D. Rehabilitation services, including but not limited to, assistance in restoring a patient’s/ client’s or group of patient’s/ client’s functional skills, daily living skills, social skills, grooming and personal hygiene skills, meal preparation skills, medication compliance, development of support systems, counseling of the patient/client and/or family, training in leisure activities integral to achieving the patient’s/ client’s goals/desired results/personal milestones, and medication education.

X E. Plan development, including but not limited to, development of coordination client plans or service plans, approval of plans, verification of medical necessity, and monitoring of the patient’s/client’s progress.

X F. TBS – the planning and monitoring of TBS services needed for clients. Provider will not be delivering TBS shadowing services. State requirements for tracking services relative to the delivery of TBS necessitate the ability to code for these TBS supportive services.

X G. Intensive Home Based Services (IHBS) – are mental health rehabilitation services. IHBS are individualized, strength-based interventions designed to improve mental health conditions that interfere with a patient’s/ client’s functioning and are aimed at helping the patient’s/ client’s family build skills necessary for successful functioning in the home and community and improving the patient’s/ client’s family ability to help the child/youth successfully function in the home and community.
1. **GENERAL:** Crisis Interventions are services to or on behalf of a beneficiary for a condition which requires a more timely response than a regularly scheduled visit.

   Services may either be face-to-face or by telephone contact with the patient/client or significant support persons and may be provided anywhere in the community.

   Provider shall be certified by COUNTY as a Short-Doyle/Medi-Cal Mental Health Provider.

   In addition to the other staffing requirements of this Agreement, Provider shall assure that these services are provided with the minimum qualified staff and staffing ratio, if any, as required by State regulation.

   The definition of Service Function Code (SFC) unit for the purpose of determining the number of units of service provided by Provider hereunder shall be as established by the Director. Billing restrictions for these services shall apply as legislated.

2. **PERSONS TO BE SERVED:** Provider shall provide services to children/adolescents and their families with full scope Medi-Cal from Butte County who meet the criteria of medical necessity.

3. **SERVICE DELIVERY SITE(S):** Provider will provide the majority of services at an approved site, though a portion of services may be delivered off-site each day.

4. **QUALITY IMPROVEMENT:** Provider shall comply with all applicable provisions of W&I, CCR, Code of Federal Regulations, SDHS policies and procedures, and COUNTY quality improvement policies and procedures. Provider shall establish and maintain a complete and integrated quality improvement system.

   In conformance with these provisions, Provider shall adopt and comply with the quality improvement programs and responsibilities set forth in the COUNTY’s Quality Management Plan. Provider agrees to provide and deliver a random sampling of charts as requested by County for Quality Assurance/Utilization Review on a monthly basis. A copy of Provider’s procedures to comply with COUNTY’s Quality Management Plan shall be submitted to COUNTY’s Contract Monitor for review prior to Provider’s submission of any billings for services hereunder.

5. **PROGRAM ELEMENTS AND SERVICES:** Provider shall provide services to consumers in accordance with this Agreement and any addenda thereto for the term of this Agreement. Services shall include, as checked below:

   - **X** Crisis Intervention means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by SDMH or a Mental Health Plan (COUNTY) to provide crisis stabilization. (Title 9, Section 1810.209).
SERVICE EXHIBIT C

TARGETED CASE MANAGEMENT

(MODE OF SERVICE 15)

1. GENERAL: Targeted Case Management means services that assist a patient/client to access needed medical, educational, social, prevocational, rehabilitative, or other community services.

Services may either be face-to-face or by telephone contact with the patient/client or significant support persons and may be provided anywhere in the community.

PROVIDER shall be certified by COUNTY as a Short-Doyle/Medi-Cal Mental Health Provider.

In addition to the other staffing requirements of this Agreement, PROVIDER shall assure that these services are provided with the minimum qualified staff and staffing ratio, if any, as required by State regulation.

The definition of SFC unit for the purpose of determining the number of units of service provided by PROVIDER hereunder shall be as established by the Director. Billing restrictions for these services shall apply as legislated.

2. PERSONS TO BE SERVED: PROVIDER shall provide services to children/adolescents and their families with full scope Medi-cal from Butte County who meet the criteria of medical necessity.

3. SERVICE DELIVERY SITE(S): PROVIDER will provide the majority of services at an approved site, though a portion of services may be delivered off-site each day.

4. QUALITY IMPROVEMENT: PROVIDER shall comply with all applicable provisions of WIC, CCR, Code of Federal Regulations, SDHS policies and procedures, SDMH policies and procedures, and COUNTY quality improvement policies and procedures. PROVIDER shall establish and maintain a complete and integrated quality improvement system.

In conformance with these provisions, PROVIDER shall adopt and comply with the quality improvement programs and responsibilities set forth in the COUNTY’s Quality Management Plan. PROVIDER agrees to provide and deliver a random sampling of charts as requested by County for Quality Assurance/Utilization Review on a monthly basis. A copy of PROVIDER’s procedures to comply with COUNTY’s Quality Management Plan shall be submitted to COUNTY’s Contract Monitor for review prior to PROVIDER’s submission of any billings for services hereunder.

5. PROGRAM ELEMENTS AND SERVICES: PROVIDER shall provide services to consumers in accordance with this Agreement and any addenda thereto for the term of this Agreement. Services shall include, as checked below:

   X A. “Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress and plan development. (Title 9 Section 1810.249).

   X B. Intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for and coordination of services, including urgent services.
(1) **Assessing**
- Assessing client’s and family’s needs and strengths
- Assessing the adequacy and availability of resources
- Reviewing information from family and other sources
- Evaluating effectiveness of previous interventions and activities

(2) **Service Planning and Implementation**
- Developing a plan with specific goals, activities and objectives
- Ensuring the active participation of client and individuals involved and clarifying the roles of the individuals involved
- Identifying the interventions/course of action targeted at the client’s and family’s assessed needs

(3) **Monitoring and Adapting**
- Monitoring to ensure that identified services and activities are progressing appropriately
- Changing and redirecting actions targeted at the client’s and family’s assessed needs, not less than every 90 days

(4) **Transition**
- Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

Services shall include, but not be limited to:

1. Case management charts shall be maintained to identify each patient/client and the services provided;

2. Case managers shall meet regularly with patient/clients to assure that they are receiving the appropriate type(s) of service;

3. Case managers shall act as an advocate on behalf of patients/clients or arrange for such advocacy whenever needed;

4. Case managers shall coordinate with local agencies and community resources to avoid duplication of services; and

5. Case managers shall establish specific linkages with local agencies and community resources.
ATTACHMENT 1
EXPEDITED REVIEW REQUEST

EXPEDITED REVIEW REQUEST
Mental Health Plan Payment Authorization
For Therapeutic Behavioral Science
Mental Health Plan Name: ___________________

Initial Authorization Request _____ Reauthorization Request _____

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<tr>
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</tr>
<tr>
<td>Beneficiary Medi-Cal Number</td>
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<th>Provider Certification:</th>
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I certify under penalty of perjury that an expedited review of the accompanying MHP payment authorization request is necessary because the standard 14 day authorization timeframe could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, regain maximum function.

Signature of Provider____________________________                              Date _________________

Examples of Reasons for an Expedited Request

Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.

The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.
ATTACHMENT 2
COUNTY’S DATA SYSTEM MINIMUM TECHNICAL REQUIREMENTS

In accordance with Provider/Contractor provision of services under this agreement and access to the County Information Systems (County Data System) hereinafter referred to as BHIS:

Each clinical Provider/Contractor for Butte County Department of Behavioral Health, hereafter BCDBH, or any Provider/Contractor that handles any Protected Health Information (PHI), Personally Identifiable Information (PII) or Personal Information (PI) of clients or employees of BCDBH shall follow the requirements set forth in this Attachment.

Provider/Contractor shall supply all necessary equipment and software for such electronic data submission, and shall comply with all rules and regulations identified in this Attachment.

Access to the BHIS is for the use of authorized users only. This connectivity grants consent to County for active monitoring of system usage.

A. CONNECTIVITY

1. County staff will provide Provider/Contractor with a secure VPN connection to appropriate Behavioral Health Information Systems. Any costs associated with telecommunications connectivity shall be at the Provider/Contractor’s expense. Provider/Contractor shall be responsible for their own equipment maintenance and software support, following completion of initial setup.

B. USER ACCOUNTS

1. Each contract user of County or BCDBH resources must use their own, unique credentials to access resources such as VPN, Avatar, Email, network resources or any system that contains or holds PHI, PII, PI or may allow access to other systems which hold the same. These credentials shall not be shared or used by anyone other than the individual they were created for.
2. Password requirements are a minimum of 8 characters in length including upper case, lower case, a number and an allowable symbol for any County or BCDBH resource. Passwords shall be changed every 90 days.
3. Provider/Contractor shall also use unique accounts with complex passwords on their own systems, computers, servers or devices.
4. When a contract user no longer needs access to County or BCDBH resources, the Contractor or Provider shall notify BCDBH IT within 24 hours to disable that unique credential set.
5. When the Provider/Contractor needs to have additional users provided access to County or BCDBH resources, the Contractor or Provider shall fill out applicable account request forms and return them to BCDBH IT prior to any access being provided.
6. Each computer must be running a legitimate and licensed operating system and along with any software that is used to access BCDBH resources.
7. Only Microsoft operating systems that are currently supported and receive patches and security updates shall be allowed to connect to County or DBH resources. Providers/Contractors shall not use unsupported operating systems.
8. DBH IT shall provide to each Provider/Contractor by Email a list of approved operating systems and software that is acceptable and functional to use when connecting to BCDBH resources. This may be sent out annually or as necessary. Provider/Contractor may request an updated list at any time. It is strongly recommended that a Contractor or Provider request this prior to making significant changes to their systems.
   a. Operating System
   b. Web Browser
   c. Java
   d. Report Viewer
e. Antivirus / Antimalware
f. Other

9. The Provider/Contractor shall be given 60 day notice by Email when required or mandatory operating system or software upgrades must occur.

10. The Provider/Contractor shall ensure all operating system and application security updates, patches and service packs are installed within 30 days of release by each vendor.

11. The Provider/Contractor shall ensure that all computer systems connecting to County or BCDBH network resources shall have a BCDBH IT approved “endpoint protection”, including antivirus and antimalware applications installed with vendor definitions that are updated within 30 days of release.

12. Should the Provider/Contractor not comply with the BCDBH IT requirements after a 60 day notice, all connectivity to County or BCDBH resources may be terminated until compliance is achieved.

13. The Provider/Contractor must meet all HIPAA, HITECH, 42CFR and Medicare/Medical regulatory and contractual requirements. BCDBH IT may request to review and audit administrative, technical and physical safeguards for any system and user that connects to or uses County or BCDBH network resources. A 10 day notice shall be provided prior to the audit. Upon completion of the audit, BCDBH IT will submit a report on findings.
   a. Upon completion of an audit, BCDBH IT shall assist the Provider/Contractor in identifying elements of their computer system that are not in compliance and provide recommended changes necessary to achieve compliance. The Provider/Contractor is solely responsible for actual remediation.
   b. The Provider/Contractor must implement corrective action on any found deficiencies with 60 days of notification.

14. Per applicable law and regulation, the Provider/Contractor must conduct an annual “Risk Assessment” of their systems, technology, offices and environment. This Risk Assessment must be provided to BCDBH within 5 days upon request.

15. Per applicable law and regulation, the Provider/Contractor must create or update an annual “Business Continuity Plan” and a “Disaster Recovery Plan”. Both the Business Continuity Plan and the Disaster Recovery Plan must be provided to BCDBH upon request.

16. The Provider/Contractor shall encrypt any portable device or media such as but not limited to laptops, tablets, thumb drives, USB external drives, etc. that contains or may contain BCDBH PHI, PII, PI or other protected information.

17. It is strongly recommended that the Provider/Contractor use a wired network connection (CAT5, CAT5e or CAT6). A “wireless” network connection is strongly discouraged due to security issues and consistent, solid connectivity. If a “wireless” network connection is used, the Provider/Contractor must use an industry accepted secure, unbreakable wireless security protocol. The protocol WEP is not acceptable. An unsecured or unencrypted wireless connection is also not acceptable.

18. Protected Health Information relating to clients or consumers of Butte County services may not be sent by or stored in personal or “public” email systems such as Yahoo, Google, etc. or in cloud-based systems. Some Provider/Contractors may be provided Butte County email accounts at the discretion of Butte County Behavioral Health IT.

19. The Provider/Contractor is solely responsible for the operation and support of their own computer, operating system, network and Internet connectivity. BCDBH IT’s responsibility is as follows:
   a. DBH IT shall ensure that a working VPN and Avatar account exists.
   b. DBH IT may assist in connecting to Butte County’s VPN and Avatar system at the discretion of the BCDBH IT Program Manager.
   c. DBH IT may assist in providing limited phone or Email support and may answer questions within the scope of supporting the connection to County or BCDBH resources.

20. BCDBH IT is not liable for any damage, loss of data, configuration changes, software incompatibilities (etc.) associated with the above activities or with any activities or actions on the part of the Provider/Contractor.
21. Provider/Contractor's inability to use the necessary County or BCDBH network resources caused by unsupported or unapproved operating systems, other software conflicts, misconfiguration of their computer(s) or network(s) in general, infection by viruses or malware, poor, problematic or no Internet access is solely the responsibility of the Provider/Contractor.

The following is to be used for informational purposes and may change as noted in the contract language above. It is available to Provider/Contractor's upon request or may be sent out to them annually or as needed.

**BCDBH IT Approved System Requirements**

- **Operating System**
  - Microsoft Windows 7 until 12/31/19 at which time it expires and will not be allowed
  - Microsoft Windows 10 Builds 1803 or higher. Build 1803 expires on 11/12/19. All Builds prior to 1803 are no longer supported and thus will not be allowed.

- **Web Browser**
  - Internet Explorer 11

- **Java**
  - Minimum: Java 8 Update 131 or higher as long as it works with the Avatar EHR.

- **Netsmart Report Viewer**
  - Report Reader (CSMRprtV.exe Version 11.5)

- **Antivirus / Antimalware / Endpoint Protection (any of the following)**
  - AegisLab
  - AhnLab-V3
  - Avast
  - AVG
  - Avira (no cloud)
  - BitDefender
  - Comodo
  - CrowdStrike Falcon
  - Cybereason
  - Fortinet
  - F-Prot
  - F-Secure
  - Kaspersky
  - Malwarebytes
  - McAfee
  - Microsoft Windows Defender (Windows 10)
  - Panda
  - SentinelOne
  - Sophos
  - Symantec
  - TrendMicro
  - ViRobot
  - Webroot
  - ZoneAlarm by Check Point
This Business Associate Addendum (Addendum) supplements and is made a part of the contract (Contract) by and between County of Butte (COUNTY), a covered entity and Counseling Solutions, a BUSINESS ASSOCIATE, and is effective as of the date of the Contract.

RECITALS

A. COUNTY wishes to disclose certain information to BUSINESS ASSOCIATE pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI) as defined below.

B. COUNTY and BUSINESS ASSOCIATE intend to protect the privacy and provide for the security of PHI disclosed to BUSINESS ASSOCIATE pursuant to the Contract in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health (HITECH) Act, Public Law 111-005, and regulations promulgated there under by the U.S. Department of Health and Human Services ("HIPAA Regulations") and other applicable laws.

C. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require COUNTY to enter into a contract containing specific requirements with BUSINESS ASSOCIATE prior to the disclosure of PHI, as set forth in, but not limited to Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR") and continued in this Addendum.

Definitions

(a) Unless otherwise noted, the following terms used in this Addendum shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

(b) 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 party to this Addendum, shall mean Counseling Solutions.

(c) 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 Addendum, shall mean the County of Butte (COUNTY).


Obligations and Activities of Business Associate

BUSINESS ASSOCIATE agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Contract or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Contract;
(c) Report to COUNTY any use or disclosure of protected health information not provided for by the Contract of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware. Reports are to be made by BUSINESS ASSOCIATE to COUNTY as follows: 1) by telephone within 24-hours of discovery of suspected breach or security incident; and 2) by written notice, in a form prescribed by the COUNTY, within three (3) business days of discovery of suspected breach or security incident.

BUSINESS ASSOCIATE agrees that COUNTY will be responsible for breach notification obligations resulting from BUSINESS ASSOCIATE'S breach of COUNTY'S unsecured protected health information. BUSINESS ASSOCIATE agrees to assist COUNTY in responding to, providing notification of, and mitigating any negative consequences of BUSINESS ASSOCIATE'S breach of COUNTY'S unsecured protected health information. BUSINESS ASSOCIATE is to contact Sesha Zinn, Compliance Officer at 530.891.2850 regarding notifications, written communications, and breach response activities required by this Addendum.

This section shall apply only to COUNTY data under BUSINESS ASSOCIATE'S care, custody or control. BUSINESS ASSOCIATE will be responsible for breach notification obligations arising from the breach of BUSINESS ASSOCIATE’S protected health information.

BUSINESS ASSOCIATE agrees to defend, indemnify, hold harmless and release COUNTY, its officers, agents and employees from and against any and all actions, claims, damages, disabilities or expenses that may be asserted by any person or entity, arising out of or in connection with the negligent acts or omissions or willful misconduct by BUSINESS ASSOCIATE or BUSINESS ASSOCIATE’S officers, agents and employees, which results in a breach of COUNTY's unsecured protected health information.

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of BUSINESS ASSOCIATE agree to the same restrictions, conditions, and requirements that apply to BUSINESS ASSOCIATE with respect to such information;

(e) Make protected health information in a designated record set available to the individual who is the subject of the protected health information or the authorized representative of the individual who is the subject of the protected health information, as necessary to satisfy COUNTY'S obligations under 45 CFR 164.524;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the COUNTY pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy COUNTY'S obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the individual who is the subject of the protected health information or the authorized representative of the individual who is the subject of the protected health information, as necessary to satisfy COUNTY'S obligations under 45 CFR 164.528;

(h) To the extent BUSINESS ASSOCIATE is to carry out one or more of COUNTY'S obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the COUNTY in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.
Permitted Uses and Disclosures by Business Associate

(a) BUSINESS ASSOCIATE may only use or disclose protected health information as necessary to perform the services set forth in the Scope of Work included in the Contract.

(b) BUSINESS ASSOCIATE may use or disclose protected health information as required by law.

(c) BUSINESS ASSOCIATE agrees to make uses and disclosures and requests for protected health information consistent with COUNTY’S minimum necessary policies 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 if done by covered entity except for the specific uses and disclosures set forth below, to the extent those specific uses and disclosures are permitted by the Contract.

(e) BUSINESS ASSOCIATE may use protected health information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.

(f) BUSINESS ASSOCIATE may disclose protected health information for the proper management and administration of BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE, provided the disclosures are required by law, or BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of the information has been breached.

(g) BUSINESS ASSOCIATE may provide data aggregation services relating to the health care operations of the COUNTY.

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) COUNTY shall notify BUSINESS ASSOCIATE of any limitation(s) in the COUNTY’S notice of privacy practices under 45 CFR 164.520, to the extent that such limitation may affect BUSINESS ASSOCIATE’S use or disclosure of protected health information.

(b) COUNTY shall notify BUSINESS ASSOCIATE of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect BUSINESS ASSOCIATE’S use or disclosure of protected health information.

(c) COUNTY shall notify BUSINESS ASSOCIATE of any restriction on the use or disclosure of protected health information that COUNTY has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect BUSINESS ASSOCIATE’S use or disclosure of protected health information.

Permissible Requests by Covered Entity

COUNTY shall not request BUSINESS ASSOCIATE to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by COUNTY. BUSINESS ASSOCIATE is permitted uses and disclosures of protected health information for data aggregation or management and administration and legal responsibilities of the BUSINESS ASSOCIATE, if such uses or disclosures are permitted by the Contract.
Term and Termination

(a) Term. The Term of this Addendum shall be effective as of the effective date of the Contract, and shall terminate concurrent with the termination of the Contract, or on the date COUNTY terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. BUSINESS ASSOCIATE authorizes termination of the Contract by COUNTY if the COUNTY determines BUSINESS ASSOCIATE has violated a material term of the Contract and BUSINESS ASSOCIATE has not cured the breach or ended the violation within the time specified by COUNTY.

(c) Obligations of Business Associate Upon Termination.

Upon termination of the Contract for any reason, BUSINESS ASSOCIATE shall return to COUNTY (or, if agreed to by COUNTY in writing, destroy) all protected health information received from COUNTY, or created, maintained, or received by BUSINESS ASSOCIATE on behalf of the COUNTY, that the BUSINESS ASSOCIATE still maintains in any form. BUSINESS ASSOCIATE shall retain no copies of the protected health information.

If returning or destroying COUNTY protected health information is not feasible, and retention has been approved by the COUNTY in writing, or if the Contract authorizes BUSINESS ASSOCIATE to use or disclose protected health information for its own management and administration or to carry out its legal responsibilities and the BUSINESS ASSOCIATE needs to retain protected health information for such purposes after termination of the Contract, the following shall apply:

Upon termination of the Contract for any reason, BUSINESS ASSOCIATE, with respect to protected health information received from COUNTY, or created, maintained, or received by BUSINESS ASSOCIATE on behalf of COUNTY, shall:

1. Retain only that protected health information which is necessary for BUSINESS ASSOCIATE to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to COUNTY (or, if agreed to by COUNTY in writing, destroy) the remaining protected health information that the BUSINESS ASSOCIATE still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as BUSINESS ASSOCIATE retains the protected health information;
4. Not use or disclose the protected health information retained by BUSINESS ASSOCIATE other than for the purposes for which such protected health information was retained, and subject to the same conditions which applied prior to termination;
5. Return to COUNTY (or, if agreed to by COUNTY in writing, destroy) the protected health information retained by BUSINESS ASSOCIATE when it is no longer needed by BUSINESS ASSOCIATE for its proper management and administration or to carry out its legal responsibilities; and
6. BUSINESS ASSOCIATE shall obtain and return to COUNTY (or, if agreed to by COUNTY in writing, destroy or ensure the destruction of) all COUNTY protected health information created, received or maintained by any of BUSINESS ASSOCIATE’S subcontractors.

(d) Survival. The obligations of BUSINESS ASSOCIATE under this Section shall survive the termination of the Contract.

Miscellaneous

(a) Regulatory References. A reference in this Addendum to a section in the HIPAA Rules means the section as in effect or as amended.
(b) **Amendment.** The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) **Interpretation.** Any ambiguity in this Addendum shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum.

<table>
<thead>
<tr>
<th>County of Butte—Covered Entity</th>
<th>Counseling Solutions—Business Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: __________________</td>
<td>Signature: __________________</td>
</tr>
<tr>
<td>Name: Dorian Kittrell</td>
<td>Name: Trishanne Lininger</td>
</tr>
<tr>
<td>Title: Director</td>
<td>Title: Administrator</td>
</tr>
<tr>
<td>Date: ________________________</td>
<td>Date: ______________________________</td>
</tr>
</tbody>
</table>
ATTACHMENT 4
STANDARD INSURANCE REQUIREMENTS

INSURANCE REQUIREMENTS FOR MOST CONTRACTS
Not for Professional Services or Construction Contracts

*Please provide a copy of Attachment 4 to your insurance agent.

Contractor shall procure and maintain for the duration of this contract, insurance against claims for injuries to persons or damages to property that may arise from or be in connection with the performance of the work hereunder by Contractor, Contractor’s agents, representatives, employees and subcontractors. Before the commencement of work Contractor shall submit Certificates of Insurance and Endorsements evidencing that Contractor has obtained the following forms of coverage:

A. MINIMUM SCOPE AND LIMITS OF INSURANCE - Coverage shall be at least as broad as:

1) Commercial General Liability (CGL): Insurance Services Office (ISO) Form CG 00 01 covering CGL on an “occurrence” basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2) Automobile Liability: ISO’s Commercial Automobile Liability coverage form CA 00 01.
   a. Commercial Automobile Liability: Covering any auto (Code 1) for corporate/business owned vehicles, or if Contractor has no owned autos, covering hired (Code 8) and non-owned autos (Code 9), with limits no less than $1,000,000 per accident for bodily injury and property damage.
   b. If no transportation services of any type are provided, and use of a motor vehicle is strictly limited to travel to and from work or work sites, evidence of Personal Auto Policy coverage with limits no less than $100,000 per person, $300,000 each accident, $50,000 property damage may be provided in lieu of Commercial Automobile Liability Insurance.

3) Workers’ Compensation Insurance: As required by the State of California, with Statutory Limits and Employer’s Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury disease. (Not required if Contractor provides written verification he or she has no employees.)

If Contractor maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or higher limits maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the County.

B. OTHER INSURANCE PROVISIONS - The insurance policies are to contain, or be endorsed to contain, the following provisions:

1) The County of Butte, its officers, employees and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Contractor, including materials, parts or equipment furnished in connection with such work or operations. General Liability coverage can be provided in the form of an endorsement to Contractor’s insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 26, CG 20 33, or CG 20 38 and CG 20 37 forms if later revisions used).

2) For any claims related to this contract, Contractors insurance coverage shall be primary insurance coverage at least as broad as ISO Form CG 20 01 04 13 as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees and volunteers shall be excess of Contractor’s insurance and shall not contribute with it.
3) Each insurance policy required above shall state that coverage shall not be canceled, except with notice to the County.

C. WAIVER OF SUBROGATION: Contractor hereby grants to County a waiver of any right to subrogation which any insurer of said Contractor may acquire against the County by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the County has received a waiver of subrogation endorsement from the insurer.

The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the County for all work performed by the Contractor, its employees, agents and subcontractors.

D. SELF-INSURED RETENTIONS: Self-insured retentions must be declared to and approved by the County. The County may require Contractor to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County.

E. ACCEPTABILITY OF INSURERS: Insurance is to be placed with insurers authorized to conduct business in the state with a current A.M. Best’s rating of no less than A:VII, unless otherwise acceptable to the County.

F. VERIFICATION OF COVERAGE: Contractor shall furnish County with original certificates of insurance including all required amendatory endorsements (or copies of the applicable policy language affecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements before work begins. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor’s obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

G. SPECIAL RISKS OR CIRCUMSTANCES: County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

H. SUBCONTRACTORS: Contractor shall include all subcontractors as insured under its policies or require all subcontractors to be insured under their own policies. If subcontractors are insured under their own policies, they shall be subject to all the requirements stated herein, including providing the County certificates of insurance and endorsements before beginning work under this contract.
ATTACHMENT 5
PROVIDER’S EMPLOYEE
ACKNOWLEDGEMENT OF EMPLOYER

I understand that ________________________________________, is my sole employer for purposes of this employment.

I rely exclusively upon ________________________________________, for payment of all salary and any and all other benefits payable to me or on my behalf during the period of this employment.

I understand and agree that I am not an employee of Butte County for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Butte during the period of this employment.

I understand and agree that I do not have and will not acquire any rights or benefits pursuant to any contract between my employer, _______________________, and the County of Butte.

ACKNOWLEDGED AND RECEIVED:

NAME: ____________________________________________

DATE: ____________________________________________

NAME: ____________________________________________

Print

When completed, this form must be maintained on file by PROVIDER in accordance with all applicable County, State and Federal requirements and made available for inspection and/or audit by authorized representatives of County, State and/or Federal governments.
ATTACHMENT 6
SUBCONTRACTOR’S EMPLOYEE
ACKNOWLEDGEMENT OF EMPLOYER

I understand that ________________________________ is my sole employer for purposes of this employment.

I rely exclusively upon ________________________________, for payment of all salary and any and all other benefits payable to me or on my behalf during the period of this employment.

I understand and agree that I am not an employee of Butte County for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Butte during the period of this employment.

I understand and agree that I do not have and will not acquire any rights or benefits pursuant to any contract between my employer, ________________________________, and the County of Butte.

ACKNOWLEDGED AND RECEIVED:

NAME: ________________________________

DATE: ________________________________

NAME: ________________________________

Print

When completed, this form must be maintained on file by PROVIDER in accordance with all applicable County, State and Federal requirements and made available for inspection and/or audit by authorized representatives of County, State and/or Federal governments.
ATTACHMENT 7
ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

In accordance with the Mental Health Services Agreement’s Paragraph 48 (PROVIDER’S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned certify that I am not presently excluded from participation in federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any federally funded health care program, nor am I otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I further certify as the official responsible for the administration of Counseling Solutions, (hereinafter “Provider”) that all of its officers, employees, agents and/or sub-contractors are not presently excluded from participation in any federally funded health care programs, nor is there an investigation presently pending or recently concluded of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federally funded health care program, nor are any of its officers, employees, agents and/or sub-contractors otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I understand and certify that I will notify County’s Behavioral Health Director immediately, in writing of:

- Any event that would require Provider or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against Provider, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federally funded healthcare program payment may be made.

Name and Title of authorized official  Trishanne Lininger, Administrator
Please Print Name and Title

Signature of authorized official ___________________________ Date ______________
ATTACHMENT 8

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor

Printed Name of Person Signing for Contractor

Contract / Grant Number

Signature of Person Signing for Contractor

Date

Title
<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
<th>2. Status of Federal Action:</th>
<th>3. Report Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] a. contract</td>
<td>[ ] a. bid/offer/application</td>
<td>[ ] a. initial filing</td>
</tr>
<tr>
<td>b. grant</td>
<td>b. initial award</td>
<td>b. material change</td>
</tr>
<tr>
<td>c. cooperative agreement</td>
<td>c. post-award</td>
<td>For Material Change Only:</td>
</tr>
<tr>
<td>d. loan</td>
<td></td>
<td>Year _____ quarter _____</td>
</tr>
<tr>
<td>e. loan guarantee</td>
<td></td>
<td>date of last report _____</td>
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<tr>
<td>f. loan insurance</td>
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</tbody>
</table>

4. Name and Address of Reporting Entity:
   - Prime [ ]
   - Subawardee [ ]

   Tier [ ], if known:

   Congressional District, if known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

   Congressional District, if known:

6. Federal Department/Agency

7. Federal Program Name/Description:
   CDFA Number, if applicable: [ ]

8. Federal Action Number, if known:
   Award Amount, if known: [ ]

9. [ ]

10.a. Name and Address of Lobbying Registrant (if individual, last name, first name, MI):

   b. Individuals Performing Services (including address if different from 10a. (Last name, First name, MI)):

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.

   Signature: ____________________________
   Print Name: ____________________________
   Title: ____________________________
   Telephone No.: ____________________________
   Date: ____________________________

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Standard Form-LLL (Rev. 7-97)