Department of Behavioral Health
Dawan Utecht, Mental Health Director/Public Guardian

Providing Quality Mental Health and Substance Abuse Services for the People of Fresno County

TO: Substance Use Disorder Treatment Provider

FROM: Joseph Rangel, Division Manager Contracts Division – Substance Use Disorder Services

DATE: February 6, 2015

SUBJECT: APPLICATION FOR DRUG MEDI-CAL CONTRACTS

This is to provide you with confirmation that your request for an application to contract with Fresno County Department of Behavioral Health, Contracts Division – Substance Use Disorder Services for Drug Medi-Cal services was received. Please review the attached application and fill out all forms completely. Please review the checklist on page six (6), titled "DOCUMENTATION REQUIRED" as well as the list within the Program Design section (Attachment II) and ensure that you have included all of the forms and documents required and that they are complete and in the order requested. If your application packet does not meet this requirement, it may be rejected as incomplete and returned to you. The DMC Provider form and the attached sample forms outline all documents we require for review prior to contract approval as a Drug Medi-Cal service provider in Fresno County.

Once your application is complete, submit to:

Joseph Rangel, Division Manager
Department of Behavioral Health, Contracts Division - Substance Use Disorder Services
4441 East Kings Canyon Road
Fresno, CA 93702

Upon receipt, County staff will review your application packet and will be in contact within fourteen (14) days. If you have any questions or you are in need of any further assistance, please contact your Staff Analyst at (559) 600-6053.

JR:ab

Attachments

DEPARTMENT OF BEHAVIORAL HEALTH
CONTRACTS DIVISION - SUBSTANCE USE DISORDER SERVICES
DRUG MEDI-CAL PROVIDER FORM

PROGRAM INFORMATION

Legal Business Name:		
Legal Business Address:		
City:	State:	Zip Code:
Tax Identification Number:		
Is this business or organi zation a stand-alone organization, or part of a parent organization?		
Site Address(es):		

Medical Director Name:		**License #:**
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

Program/Clinical Director Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

AGENCY/PARENT ORGANIZATION INFORMATION

Agency/Parent Organization (if other than program name)

DEPARTMENT OF BEHAVIORAL HEALTH
CONTRACTS DIVISION - SUBSTANCE USE DISORDER SERVICES
DRUG MEDI-CAL PROVIDER FORM

Status (for-profit, non-profit, 501(c)3):
Provide a brief history of the Agency/Parent Organization providing substance use disorder services:
How long has the Agency/Parent Organization been in business?
Is this Agency/Parent Organization new to Fresno County?
What other services does this Agency/Parent Organization provide?
Number of people employed in the Agency/Parent Organization?
Number of people employed in the substance use disorder services program?
What is the target population to be served by the Agency/Parent Organization?
What are the anticipated or realized referral sources for the substance use disorder program?

Name of authorized person to give or receive notices under this Agreement:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:
Any and all notices between COUNTY and CONTRACTOR(S) provided for or permitted under this Agreement or by law shall be in writing and shall be deemed duly served when personally delivered to one of the parties, or in lieu of such personal service, when deposited in the United States Mail, postage prepaid, addressed to such party.		

DEPARTMENT OF BEHAVIORAL HEALTH
CONTRACTS DIVISION - SUBSTANCE USE DISORDER SERVICES
DRUG MEDI-CAL PROVIDER FORM

Executive Director Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:
What experience does the Executive Director have in substance use disorder services? (Must demonstrate a minimum of 2-years' experience in substance use disorder services)		

Chairman of the Board Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

President Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

Chief Financial Officer Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

DEPARTMENT OF BEHAVIORAL HEALTH
CONTRACTS DIVISION - SUBSTANCE USE DISORDER SERVICES
DRUG MEDI-CAL PROVIDER FORM

Why does this agency seek to provide substance use disorder services?		
What value does the substance use disorder services add to the Agency/Parent Organization?		
How will this program fill a need for substance use disorder treatment (i.e., location, target population) in the community?		
Does the Agency/Parent Organization provide mental health services? If not, is the Agency/Parent Organization pursuing certification as a mental health facility?		
What other counties are served by the Agency/Parent Organization?		
Contact name, address, phone number and e-mail address for Accounts Receivable/Payable Department:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	E-Mail:

DEPARTMENT OF BEHAVIORAL HEALTH
CONTRACTS DIVISION - SUBSTANCE USE DISORDER SERVICES
DRUG MEDI-CAL PROVIDER FORM

DOCUMENTATION REQUIRED		
DMC Certification and Transmittal Letter (Each service site)	Attachment I	☐
NPI numbers for clinic(s) and all staff that provide substance use disorder services		☐
Program design, including hours of operation, program schedule and length of program	Attachment II	☐
Proposed outcomes and how they will be measured	Attachment III	☐
Bank reference letter	Attachment IV	☐
3 Letters of support and references for funding applications	Attachment V	☐
Program Budget	Attachment VI	☐
General and Professional Liability Insurance Certificate's • Comprehensive Auto Liability • Professional Liability • Worker's Compensation as required by California Labor Code • Commercial General Liability insurance naming County of Fresno as additional insured	Attachment VII	☐
Disclosure – Criminal History & Civil Actions	Attachment VIII	☐
Notice of Child Abuse Reporting	Attachment IX	☐
IRS Form W-9, Request for Tax Identification Number and Certification http://www.irs.gov/uac/Form-W-9,-Request-for-Taxpayer-Identification-Number-and-Certification	Attachment X	☐
California Form 590, Withholding Exemption Certificate https://www.ftb.ca.gov/forms/search/index.aspx?WT.mc_id=HP_Forms_MoreButton	Attachment XI	☐
Self-Dealing Transaction Disclosure Form	Attachment XII	☐
Disclosure of Ownership and Control Interest Statement	Attachment XIII	☐
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53	Attachment XIV	☐

OTHER DOCUMENTATION		
Youth Treatment Guidelines (if applicable) http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf	Attachment XV	☐

New DMC providers will not be approved to submit claims for payment until all forms have been reviewed and the agency has demonstrated a satisfactory understanding of the claiming process.

For more information on Drug Medi-Cal Billing and forms please visit the following URL's:

http://www.dhcs.ca.gov/services/adp/Documents/DMC_Billing_Manual.pdf
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx
http://www.dhcs.ca.gov/services/medi-cal/Documents/Consent-Basic-FINAL.PDF
http://www.dhcs.ca.gov/services/adp/Pages/DMC_Billing.aspx

State of California – Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Mr. John Doe, Executive Director
My Company Inc.
12345 N. Some Road
Somewhere, CA 12345

MEDICAL DIRECTOR: Jane Smith, MD
DRUG MEDI-CAL PROVIDER NUMBER: X X X
NATIONAL PROVIDER IDENTIFIER(S): X X X X X X X X X X
CALOMS NUMBER: XXXXXX
MEDI-CAL DOCUMENT NUMBER: XXXXXX
EFFECTIVE DATE: 1/1/2014

Dear Mr. Doe:

This letter serves as notification that the Department of Health Care Services (DHCS) has approved the application for certification in the Drug Medi-Cal (DMC) program for My Company Inc. at 12345 N. Some Road in Somewhere CA. Approved services are for the following modalities:

Type of Service	Service Function Code and Program Code	
	(20) Non-Perinatal	(25) Perinatal
Narcotic Treatment Program (NTP)		
Intensive Outpatient Program (IOP)		
Outpatient Drug Free (ODF)		
Residential		
Naltrexone		

We appreciate your assistance and cooperation during this process and your desire to provide services to Medi-Cal recipients. Participation in the DMC program is contingent upon the provider's ability to maintain compliance with state and federal laws and regulations and be DMC certified by DHCS. DHCS staff may inspect the facility and program services on a periodic basis to determine compliance with applicable statutes and/or regulations.

Please note, participation in the DMC program requires both DMC certification and an executed contract between you and either the county in which services are provided or the State. You cannot bill for DMC reimbursement without a contract. DMC certification does not entitle or guarantee a contract with your county or the State. For information on the contract process, please contact your local county alcohol and drug program administrator.

Should you have any questions regarding your certification, or if you need additional assistance, please contact the Provider Enrollment Division at (916) 323-1945,
or submit your questions via email to DHCSDMCRecert@dhcs.ca.gov.

Visit our webpage at http://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx
for more information about the DMC program.

Provider Enrollment Division

Cc: Dawan Utecht, Director
Fresno County Department of Behavioral Health
4441 East Kings Canyon Road
Fresno, CA 93702-3604

Susan Holt, Deputy Director
Fresno County Department of Behavioral Health
4441 East Kings Canyon Road
Fresno, CA 93702-3604

Joseph Rangel, Division Manager
Fresno County Department of Behavioral Health – Contracts Division
4441 East Kings Canyon Road
Fresno, CA 93702-3604

Jim Irwin, Senior Staff Analyst
Fresno County Department of Behavioral Health
4463 East Kings Canyon Road
Fresno, CA 93702-3604

PROGRAM DESIGN

Include hard copies of all forms and policies for the following, including those under the Company Information section on the next page:

Program design:

- Organizational chart
- Board policies, staff training, personnel manual/policy
- Referrals - anticipated sources
- Intake procedures - assessments, treatment planning and updating
  (Include all form templates)
  - Questionnaires must include, but are not limited to:
    - Identification of behaviors that place the participant at risk for substance use disorders;
    - Identification of family behavior that places the participant at risk for substance use disorders; and
    - Procedures linking participant and their families that display at risk behaviors for substance use disorders to assessment services.
  - Assessments must include, but are not limited to:
    - Medical questionnaire for the participant and linkages to a physician for medical services as needed.
    - Pregnant female participants shall be specifically identified and linked to appropriate services;
    - Psychosocial assessment of the participant, the impact that substance use disorder has had on them and the inherent strengths and resiliency in the participant to manage the substance use disorder more appropriately;
    - A diagnosis of the participant that indicates he/she needs this type and level of care, including any behavior indicating the participant may have a dual diagnosis. Linkages to mental health services shall occur for those participants who have a co-occurring disorder or symptoms;
      - Criteria that define how the participant is appropriate for intensive outpatient services:
    - The Addiction Severity Index (ASI) and the American Society of Addiction Medicine (ASAM) shall be the standardized assessment and placement instrument used. For adolescent treatment services the ASI Adolescent Scale and ASAM Adolescent Patient Placement Criteria 2nd edition (PPC II) shall be the standardized assessment placement instrument used.

- Program schedule and structure of program - Group counseling (maximum of ten (10) and minimum of four (4) participants) and individual counseling
- Hours of operations per site.
- Length of program
- Discharge planning for the participant
- Continuing Care - Linkages to other physical, mental, and social services the participant may need.
- Social/recreational services

For more help please review the State of California Alcohol and Other Drug Programs Certification Standards, March 2004: http://www.dhcs.ca.gov/provgovpart/Documents/AOD_Certification_Standards.pdf

http://www.dhcs.ca.gov/provgovpart/Pages/Facility_Certification.aspx

Company Information:

- **Licenses, Permits and Certificates**
  Provide copies of all appropriate licenses, permits, registrations, accreditations, and certificates required by Federal, State (including Alcohol and Other Drugs ["AOD"] permits and/or certifications), and local laws, regulations, guidelines and directives for the operations of the facility and for the provisions of services hereunder, i.e., occupancy permit, business license, Narcotic Treatment Program License, State Department of Health Care Services License to provide Residential Services, and fire clearance for each location.

- **Contract Signature Authorization**
  A statement on agency letter head, signed by one of the officers of the agency's Board of Directors, identifying one or more persons who are authorized by the agency's Board of Directors to sign contracts for the agency.

- **Counseling Staff to be Certified or Licensed**
  DMC staff advised the agency's Executive Director/Representative that Counseling staff shall be State Certified or enrolled in a Counselor Certification Program to obtain Certification as an Alcohol and Drug Counselor, as specified in the California Code of Regulations, Division 4, Title 9, Chapter 8, Section 13000. Provide a list of all counseling staff that includes their job title and hire date.

- **Verification that at least thirty percent (30%) of counseling staff is licensed or certified**
  As of April 1, 2010, at least thirty percent (30%) of staff providing counseling services in all AOD Programs Licensed and/or Certified by DHCS shall be licensed or certified pursuant to the requirements of Section 13010, Title 9, Division 4, Chapter 8, Subchapter 2, California Code of Regulations. All other counseling staff shall be registered pursuant to Section 13035 (f). Provide copies of all counseling staff licenses, certifications, and registrations.

- **Criminal Record Clearance**
  If services for youth are provided, all staff employed by the Contractor and subcontractor(s), if applicable, shall not be on active probation or parole within the last three (3) years, and must have a Live Scan fingerprint check for criminal history background through the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) prior to employment. Provide copy of clearance received from the DOJ and the FBI.

- **Medical Director's Agreement**
  The Drug Medi-Cal (DMC) Medical Director shall work onsite, one (1) day per month at each agency's certified location(s). If the agency has satellites, the agency's Medical Director shall work an additional day per month for each five (5) satellites for which the agency has been certified to provide DMC treatment services. This agreement must also contain Medical Director's responsibility, which includes but is not limited to:
  a) establishing, reviewing and maintaining medical policies and standards,
  b) assuring the quality of medical services given to all patients,
  c) assuring that at least one physician practicing at the clinic shall have admitting privileges to a general acute care hospital or a plan, as approved by DHCS, for ensuring needed hospital services. For narcotic treatment programs, this requirement is the responsibility of the program sponsor and shall be met by the program sponsor entering into an agreement with a hospital official to provide general medical care in accordance with Title 9, CCR, Section 10340,
  d) assuring that a physician has assumed medical responsibility for all patients treated by the clinic (Title 9, CCR, Section 10110).

- **Medical Director's License**
  A copy of the Medical Director's current license.

- **Facility lease(s)**
  If renting or leasing the facility where services are to be provided.

PROPOSED OUTCOMES

Include all of the following in the proposed outcomes:

Outcomes:

- Description of outcomes
- Description of policies and procedures to measure outcomes
- **Auditing/Monitoring** - Personnel files, client files, and budget/expenditures
- **Evaluations/Training** - Staff evaluations and training (including Staff Development Topics)
- **Client Retention** - Client communication and engagement

SAMPLE BANK REFERENCE

Name of Bank
{Address}
{Address}

Re: Bank Reference Letter

Name of Customer(s):_____

Date of Account Opening:_____

Average Monthly/Yearly balances maintained in US Dollars or equivalent:

_____figures.

We confirm that this relationship is maintained in a satisfactory manner.

I can be contacted at the following numbers and e-mail:

_____

Sincerely,

Bank Officer's Signature

Letters of support and references for funding applications

Letters of support are often a crucial part of your application. A letter from a credible and appropriate individual or organization, containing relevant and clear supporting information, can make all the difference to your application. Letters of support should be from organizations or individuals recognized as having expertise in your field of work but who are not biased, i.e. they do not also stand to gain directly from the grant. Funders may also ask for references from supporting organizations, the same criteria applies, although with references the funder will often request them directly rather than you sending them in with the application.

Requesting a letter of support

Once you have decided who would be best to support your application contact them to explain what is required, when you would need it and why you need it. Once they have agreed to write the letter of support, send them the following guidelines with the information below:

Be sure to give them the correct address for the funder, in particular, the name of the person the letter should be specifically addressed to (if this is required);

Give information on the project you are asking for funding for;

Be clear on the date when you need the letter of support and whether it should be sent to you or directly to the funder, give plenty of leeway;

You may also want to give some pointers in relation to the funder's priorities for funding, for example, if the funder is looking for organizations with leadership from the community they work with or for projects that reach young disadvantaged people, it would be beneficial for the letter of support to include some relevant information on this, including your expertise in this area.

What to include in a letter of support

Addressing the letter

Enter your address on the top right of the letter (preferably organization address rather than a personal one) and the funder's address below it on the left as normal. Ensure that the specific contact person's name is used in the address and that the letter is written directly to them (e.g. Dear Ms. X). Personalizing the letter is important. Add the date as usual.

Intent of letter

Under the address and date add a clear title for the letter, such as "*Re: Support for funding request from [organization name]"*.

Open with a sentence to summarize the intent of the letter, e.g. "*This letter is to support the funding application from [organization name], an organization we have worked with for the last 5 years, for their project to improve employment prospects of people with learning disabilities in West Fresno*".

Who you are

Explain who you are, information about your organization and the work it does (with relevance to the funding application you are supporting) and your particular position within it.

Relationship with organization

Explain your relationship with the organization. Perhaps you have given a grant previously, represent a beneficiary group or have worked in partnership with them. Give specific details of this relationship, including whether this is a past or present relationship, how long you have known them and in what capacity. This could also include your experiences of working with them, for example, if they communicate well with you and take in to account your feedback?

Need for the project

Back up the need for the organization's work by including some information about why the project is needed, what are the needs of the relevant community that are not currently being addressed, that you have experience of? Include how awarding this grant will benefit the local community, and the larger community as a whole, if applicable.

Organization's ability and track record

Explain what evidence you have which proves the organization's ability to perform carry out the project they are seeking funding for. Try to give solid facts rather than anecdotal evidence. This could include information such as whether they manage projects effectively, include stakeholders in developing and running projects, monitor their work and adapt accordingly. Include any past experiences, and be certain to mention the organization's positive effect on their beneficiary group.

Close

End the letter on a high by expressing some enthusiasm or excitement about the prospect of the project being funded and going ahead and the difference you feel it will make.

Offer to provide more information, if required and direct contact details (personal email address, direct telephone number).

Include your position at your organization in your sign-off.

Budget How To

The common cost categories for creating a program evaluation budget are:

1. Staffing
2. Materials and supplies
3. Equipment
4. Travel

Staffing

In the section on selecting a team, you may have considered the different types of staff that you would like to involve. You may have selected staff from varying levels of your organization and from different types of outside agencies. It is important to know what impact these selections will have on the budget.

Planning for staffing costs is often much more than establishing a pay rate. You will also need to know:

- The related costs for benefits, which may vary based on the type of staff member you hire and the length of time that that staff member works for you
- The amount of time each existing employee will spend on the evaluation project

While this may seem tedious or difficult to track, understand the actual cost of staff time helps you to better understand how your budget money is allocated and may provide insight on future allocations.

Materials and Supplies

There are numerous types of items that can fall under the category of materials and supplies, for example:

- Clerical supplies
- Copy paper
- Food for meetings and other events

Below are some strategies to consider when estimating and ordering evaluation supplies:

A) Event/Activity Estimate

It can be hard to predict the changing needs and costs for even the most well-developed program evaluation. One way to think about the costs for your materials and supplies is to estimate per event or activity. Because you are developing a budget for a project that has a relatively set start and end point, it may be possible to develop your expenditure amount using the event or activity method.

B) Separate evaluation supply budget

Although it is possible to use existing office materials and supplies, it is advisable to draw from a separate budget for evaluation materials and supplies. Having to delineate an office supply order by either evaluation or regular office expenses can become tedious and challenging, especially if your budget technician is managing multiple accounts.

Equipment

Equipment costs typically include items that need to be purchased for the program evaluation, but can potentially be used for other projects at a later date. These items might include computers, computer software, tape recorders, and transcribing equipment.

Keep in mind that it is important to check in with your budget personnel about their policies regarding expenditure categories. In many cases, including grant applications, it is expected that your equipment costs be listed separately from your material and supplies expenses. The equipment category may be a place where you can use existing resources and save on costs, depending on the budget policies at your organization.

Travel

Travel costs typically include:

- Expenses for staff to attend local meetings
- Car or airfare costs
- Parking
- Meals

Depending on the size and scope of your outreach project, you may also need to consider:

- Day-to-day travel related to data collection, especially for research projects which involve a lot of qualitative approaches such as interviews, focus groups, and event observations
- Travel expenses of team members who work remotely from various locations
- Off-site training sessions to build your team's expertise for the project
- Advisory board meetings in other locations and related expenses
- Travel related to conferences or workshops, as specified in your program evaluation's communication plan

Drug Medi-Cal Insurance Requirement

Within thirty (30) days from the date PROVIDER executes the Agreement, PROVIDER shall provide certificates of insurance and endorsement to the County of Fresno, Department of Behavioral Health - Substance Use Disorder Services, Attn: Principal Staff Analyst, 515 S. Cedar Ave, Fresno CA 93702.

Each PROVIDER, at its sole expense, shall maintain in full force and effect the following insurance policies throughout the term of this Agreement:

A. Commercial General Liability

Commercial General Liability Insurance with limits of not less than One Million Dollars ($1,000,000) per occurrence and an annual aggregate of Two Million Dollars ($2,000,000). This policy shall be issued on a per occurrence basis. COUNTY may require specific coverages including completed operations, products liability, contractual liability, Explosion-Collapse-Underground, fire legal liability or any other liability insurance deemed necessary because of the nature of this contract.

B. Automobile Liability

Comprehensive Automobile Liability Insurance with limits for bodily injury of not less than Two Hundred Fifty Thousand Dollars ($250,000.00) per person, Five Hundred Thousand Dollars ($500,000.00) per accident and for property damages of not less than Fifty Thousand Dollars ($50,000.00), or such coverage with a combined single limit of Five Hundred Thousand Dollars ($500,000.00). Coverage should include owned and non-owned vehicles used in connection with this Agreement.

C. Professional Liability

If PROVIDER(S) employs licensed professional staff, (e.g., Ph.D., R.N., L.C.S.W., M.F.T.) in providing services, Professional Liability Insurance with limits of not less than One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate.

D. Worker's Compensation

A policy of Worker's Compensation insurance as may be required by the California Labor Code.

PROVIDER(S) shall obtain endorsements to the Commercial General Liability insurance naming the County of Fresno, its officers, agents, and employees, individually and collectively, as additional insured, but only insofar as the operations under this Agreement are concerned. Such coverage for additional insured shall apply as primary insurance and any other insurance, or self-insurance, maintained by COUNTY, its officers, agents and employees shall be excess only and not contributing with insurance provided under PROVIDER(S)' policies herein. This insurance shall not be cancelled or changed without a minimum of thirty (30) days advance written notice given to COUNTY.

All policies shall be with admitted insurers licensed to do business in the State of California. Insurance purchased shall be purchased from companies possessing a current A.M. Best, Inc. rating of AFSC VII or better.

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): XX/XX/XXXX

PRODUCER
My Helpful Insurance Agency
License #1234567
0123 Sesame Street, Suite 444
Somewhere, CA 98765

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
My Company Inc.
4321 Some Road
Somewhere, CA 98765

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: My Insurance Company	23456
INSURER B: State Fund Compensation	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	X	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC	XXXXXXXXXX	XX/XX/XX	XX/XX/XX	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1000000 $ XXXXXX $ XXXX $ $ 3000000 $ 3000000
A	X	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	XXXXXXXXXX	XX/XX/XX	XX/XX/XX	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 500000 $ $ $
		GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
		EXCESS/UMBRELLA LIABILITY [ ] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] RETENTION $				EACH OCCURRENCE AGGREGATE	$ $
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	XXX	XX/XX/XX	XX/XX/XX	WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1000000 $ 1000000 $ 1000000
		OTHER					

Sample

Sample

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Additional Insured: County of Fresno, its officers, agents and employees, individually and collectively

CERTIFICATE HOLDER

Fresno County Department of Behavioral Health
4441 East Kings Canyon
Fresno, CA 93702

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

DISCLOSURE – CRIMINAL HISTORY & CIVIL ACTIONS

The applicant is required to disclose if any of the following conditions apply to them, their owners, officers, corporate managers and partners:

- Within the three-year period preceding the application, they have been convicted of, or had a civil judgment rendered against them for:
    - fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction;
    - violation of a federal or state antitrust statute;
    - embezzlement, theft, forgery, bribery, falsification, or destruction of records; or
    - false statements or receipt of stolen property
- Within a three-year period preceding their application, they have had a public transaction (federal, state, or local) terminated for cause or default.

Disclosure of the above information will not automatically eliminate an applicant from consideration. The information will be considered as part of the determination of whether to award the contract and any additional information or explanation that an applicant elects to submit with the disclosed information will be considered. If it is later determined that the applicant failed to disclose required information, any contract awarded to such applicant may be immediately voided and terminated for material failure to comply with the terms and conditions of the award.

Any applicant who is awarded a contract must sign an appropriate Certification Regarding Debarment, Suspension, and Other Responsibility Matters, see pages 2 & 3 of this attachment, Additionally, the applicant awarded the contract must immediately advise the County in writing if, during the term of the agreement: (1) applicant becomes suspended, debarred, excluded or ineligible for participation in federal or state funded programs or from receiving federal funds as listed in the excluded parties list system (http://www/epls/gov); or (2) any of the above listed conditions become applicable to applicant. The applicant will indemnify, defend and hold the County harmless for any loss or damage resulting from a conviction, debarment, exclusion, ineligibility or other matter listed in the signed Certification Regarding Debarment, Suspension, and Other Responsibility Matters.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS--PRIMARY COVERED TRANSACTIONS

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the department or agency to which this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms covered transaction, debarred, suspended, ineligible, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

6. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

CERTIFICATION

(1) The prospective primary participant certifies to the best of its knowledge and belief, that it, its owners, officers, corporate managers and partners:

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

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

(c) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Signature: _____ Date: _____

_____ _____

(Printed Name & Title) (Name of Agency or Company)

NOTICE OF CHILD ABUSE REPORTING LAW

The undersigned hereby acknowledges that Penal Code section 11166 and the contractual obligations between County of Fresno (COUNTY) and PROVIDER(S) related to provision of alcohol and drug abuse treatment services for Fresno County residents, require that the undersigned report all known or suspected child abuse or neglect to one or more of the agencies set forth in Penal Code (P.C.) section (§) 11165.9.

For purposes of the undersigned's child abuse reporting requirements, "child abuse or neglect" includes physical injury inflicted by other than accidental means upon a child by another person, sexual abuse as defined in P.C. §11165.1, neglect as defined in P.C. §11165.2, willful cruelty or unjustifiable punishment as defined in P.C. §11165.3, and unlawful corporal punishment or injury as defined in P.C. §11165.4.

A child abuse report shall be made whenever the undersigned, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the undersigned knows or reasonably suspects has been the victim of child abuse or neglect. (P.C §11166.) The child abuse report shall be made to any police department or sheriff's department (not including a school district police or security department), or to any county welfare department, including Fresno County Department of Children and Family Services' 24 Hour CARELINE. (See PC §11165.9.)

For purposes of child abuse reporting, a "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. The pregnancy of a child does not, in and of itself, constitute a basis for reasonable suspicion of sexual abuse. (P.C. §11166(a)(1).)

Substantial penalties may be imposed for failure to comply with these child abuse reporting requirements.

Further information and a copy of the law may be obtained from the department head or designee.

I have read and understand the above statement and agree to comply with the child abuse reporting requirements.

_____ _____

SIGNATURE DATE

0980fadx

SELF-DEALING TRANSACTION DISCLOSURE FORM

In order to conduct business with the County of Fresno (hereinafter referred to as "County"), members of a contractor's board of directors (hereinafter referred to as "County Contractor"), must disclose any self-dealing transactions that they are a party to while providing goods, performing services, or both for the County. A self-dealing transaction is defined below:

"A self-dealing transaction means a transaction to which the corporation is a party and in which one or more of its directors has a material financial interest"

The definition above will be utilized for purposes of completing this disclosure form.

INSTRUCTIONS

(1) Enter board member's name, job title (if applicable), and date this disclosure is being made.

(2) Enter the board member's company/agency name and address.

(3) Describe in detail the nature of the self-dealing transaction that is being disclosed to the County. At a minimum, include a description of the following:

   a. The name of the agency/company with which the corporation has the transaction; and

   b. The nature of the material financial interest in the Corporation's transaction that the board member has.

(4) Describe in detail why the self-dealing transaction is appropriate based on applicable provisions of the Corporations Code.

(5) Form must be signed by the board member that is involved in the self-dealing transaction described in Sections (3) and (4).

SELF-DEALING TRANSACTION DISCLOSURE FORM

(1) Company Board Member Information:			
Name:		**Date:**	
Job Title:			

(2) Company/Agency Name and Address:

(3) Disclosure (Please describe the nature of the self-dealing transaction you are a party to):

(4) Explain why this self-dealing transaction is consistent with the requirements of Corporations Code 5233 (a):

(5) Authorized Signature			
Signature:		Date:	

Exhibit
Page **1** of **2**

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of entity	D/B/A			
Address (number, street)		City	State	ZIP code
CLIA number	Taxpayer ID number (EIN)	Telephone number ( )		

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under "Remarks" on page 2. Identify each item number to be continued.

		YES	NO
A.	Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XX?	❒	❒
B.	Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?	❒	❒
C.	Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)	❒	❒

III. A. List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remarks."

NAME	ADDRESS	EIN

B. Type of entity: ❒ Sole proprietorship ❒ Partnership ❒ Corporation
❒ Unincorporated Associations ❒ Other (specify) _____

C. If the disclosing entity is a corporation, list names, addresses of the directors, and EINs for corporations under "Remarks."

D. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership, or members of Board of Directors) If yes, list names, addresses of individuals, and provider numbers. ❒ ❒

NAME	ADDRESS	PROVIDER NUMBER

Exhibit
Page 2 of 2

	YES	NO
IV. A. Has there been a change in ownership or control within the last year? ..... If yes, give date. _____	❒	❒
B. Do you anticipate any change of ownership or control within the year?..... If yes, when? _____	❒	❒
C. Do you anticipate filing for bankruptcy within the year?..... If yes, when? _____	❒	❒
V. Is the facility operated by a management company or leased in whole or part by another organization?..... If yes, give date of change in operations. _____	❒	❒
VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?.....	❒	❒
VII. A. Is this facility chain affiliated? ..... (If yes, list name, address of corporation, and EIN.)	❒	❒

Name		EIN	
Address (number, name)	City	State	ZIP code

B. If the answer to question VII.A. is NO, was the facility ever affiliated with a chain?
(If yes, list name, address of corporation, and EIN.)

Name		EIN	
Address (number, name)	City	State	ZIP code

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the agency, as appropriate.

Name of authorized representative (typed)	Title
Signature	Date

Remarks

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

CONTRACTORS are required to comply with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. section 2000d, and 45 C.F.R. Part 80) and Executive Order 12250 of 1979 which prohibits recipients of federal financial assistance from discrimination against persons based on race, color, national origin, sex, disability or religion. This is interpreted to mean that a limited English proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of comprehensive and quality bilingual services.

Policies and procedures for ensuring access and appropriate use of trained interpreters and material translation services for all LEP consumers, including, but not limited to, assessing the cultural and linguistic needs of its consumers, training of staff on the policies and procedures, and monitoring its language assistance program is required.

In compliance with the State mandated Culturally and Linguistically Appropriate Services standards as published by the Office of Minority Heath, CONTRACTOR'S must submit to COUNTY for approval, within sixty (60) days from the date of contract execution, a plan to address all fifteen (15) national cultural competency standards as set forth in the "National Standards for Culturally and Linguistically Appropriate Services (CLAS)" (seeing following page).

I have read and understand that within sixty (60) days of contract execution the program will be required to submit a CLAS Plan addressing all fifteen (15) National Standards for Culturally and Linguistically Appropriate Services.

_____	_____	_____
Printed Name	Signature	Date

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Youth Treatment Guidelines

CONTRACTORS that provide adolescent substance use disorder treatment services are required to follow the Youth Treatment Guidelines.

The Youth Treatment Guidelines are available at:

http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf