AGREEMENT BETWEEN THE COUNTY OF TEHAMA AND ZND RESIDENTIAL, INC.

This agreement is entered into between the County of Tehama, through its Health Services Agency, ("County") and ZND Residential, Inc. ("Contractor") for the provision of Mental Health Services.

1. RESPONSIBILITIES OF CONTRACTOR

Contractor agrees to provide Mental Health Services for Full-Scope Medi-Cal beneficiaries eligible for enrollment in the Tehama County (COUNTY 52 Medi-Cal) Mental Health Plan. Services to uninsured or non-Medi-Cal eligible individuals may be reimbursed under this agreement on a case-by-case basis if the Contractor receives written authorization from County prior to providing such services provided however, that only medically necessary services shall be provided or billed under this contract. Without limiting the generality of the foregoing, educationally related mental health services are not covered by this contract, and County shall not be obligated to pay for such services under the contract. Further, this contract shall not cover services provided to any individual placed in Contractor's facility pursuant to an Individualized Education Plan, and County shall not be obligated to pay for such services under the contract.

Contractor agrees to provide specialized treatment services for adolescents who are certified to require Short Term Residential Therapeutic Programs (STRTP) upon request of County (subject to availability of staff) including:

1. One-on-one supervision with client and staff as necessary for special needs client.
2. Additional treatment for the client requiring clinical therapeutic intervention by licensed professional staff, or clinical therapeutic intervention by unlicensed professional staff who are under direct clinical supervision of licensed professional staff.
3. Nighttime supervision for the client requiring extensive supervision and/or crisis intervention.
4. Group and individual outpatient psychotherapy sessions, delivered by a licensed mental health clinician.
5. Milieu therapy and other specified therapeutic services as deemed necessary in accordance with the youth's treatment plan.

7. Aftercare services for clients meeting criteria for return to community living. Aftercare services shall include medication support services, and other specified therapeutic services as deemed necessary in accordance with youth's return.
8. Service planning, treatment planning, progress evaluation, aftercare planning, and discharge. Planning shall be scheduled between County's and Contractor's staffs to insure appropriate continuity of care, and concurrent review and service authorization.

Contractor will provide these services specifically for the client who needs maintenance through behaviors that cannot be tolerated in the regular group home setting, i.e., assaultive behavior, self-injurious or self-destructive behavior, suicidal behavior, bizarre or outrageous behavior, self-mutilation, elopement.

Contractor shall provide only those services for which a written authorization from the County has been received. Services provided without prior written authorization from the County will be the responsibility of the Contractor and will not be reimbursed by the County.

Contractor understands that court-ordered assessments, written reports, expert witness testimony, case conferences or other forensic or administrative professional activities shall not be considered reimbursable activities under this agreement.

Contractor shall comply with:

A. Applicable Medi-Cal Specialty Mental Health Services regulations, section 14680 of the Welfare and Institutions Code and the California Code of Regulations, Title 9, Division 1, Chapter 11;

B. Applicable sections of the Tehama County Mental Health Plan ("MHP") as approved by the California Department of Health Care Services, the Tehama County Mental Health Quality Assurance Plan, the Tehama County Cultural Competency Plan, and the various policies and procedures established by the Tehama County Mental Health Director for the administration of public mental health services within Tehama County, as hereafter amended; and

C. The most current Tehama County Behavioral Health Member Handbook ("Handbook") – Exhibit E.

Contractor shall be liable for State Department of Health Care Services audit exceptions due to inadequate documentation as per medical necessity requirements and shall reimburse County for any recoupments ordered by the State within sixty (60) days of the date of the State or County's notice of such recoupment order. If Contractor fails to reimburse County within such period, County may offset the unpaid amount against any sums due from County to Contractor pursuant to this agreement or any other agreement of obligation.

2. RESPONSIBILITIES OF THE COUNTY

County shall compensate Contractor as set forth in section 3 of this agreement. Contractor acknowledges TCHSA Executive Director's ("Director") responsibility for implementing, operating, managing, and overseeing the MHP and compliance with California Welfare and Institutions Code, and Title 9, California Code of Regulations ("Title 9, CCR"). Director retains the right to restrict payment under this agreement to medically necessary services that meet MHP and Title 9, CCR requirements for preauthorization and retrospective review.

County agrees to pay Contractor at the rates listed in section 3 of this agreement for authorized services. In the event that the State of California shall establish a maximum allowance for any service listed in section 1 that is lower than the rate established by this agreement the maximum allowance established by the State of California shall prevail.

County will provide Contractor with the Handbook, attached hereto as Exhibit E, and by this reference made a part hereof.

County will follow the Provider Problem Resolution Process described in the Handbook when Contractor disputes denial of payment. If a Federal or State audit exception is created due to error of omission or commission on the part of the County, the County will be held responsible for the audit exception.

3. COMPENSATION

A. County shall compensate Contractor for services rendered pursuant to the terms described in the current Handbook, attached as Exhibit E and incorporated herein. County shall pay Contractor the rates set forth in Exhibit B.

B. Board and Care shall not be the responsibility of Tehama County and shall not be billed under this Agreement.

C. The total Maximum compensation payable under this agreement shall not exceed $400,000.00 (Four Hundred Thousand Dollars and no cents) at the rates set forth in Exhibit B, pursuant to the terms and conditions of this Agreement and pursuant to any special compensation terms specified therein.

SPECIAL COMPENSATION TERMS

The following specific terms of compensation shall apply. For each client the monthly claim shall itemize the type and date of service:

Medication Visits - in increments of staff minutes so that County is able to bill the Medi-Cal program for minutes of medication support provided by an appropriately licensed medical professional.

D. Cost Reports

Effective July 1, 2022, MHPs, DMCODS/DMC counties will no longer be required to submit an annual Medi-Cal cost report. This policy change will eliminate the need for counties to collect and submit cost reports from subcontracted network providers for purposes of Medi-Cal reimbursement. However, counties may still need to collect cost information from subcontracted network providers for a variety of reasons, including, but not limited to:

MHPs and DMC-ODS/DMC counties are required to continue to collect cost reports from network providers in compliance with DHCS cost reporting policies for services rendered prior to the date Behavioral Health Payment Reform is implemented on July 1, 2023.

When cost reporting is required by state or federal law.

4. BILLING AND PAYMENT

Contractor shall submit to County a monthly invoice of rendered services by the thirtieth day following the last day of the month in which the services were delivered. County shall make payment within 30 days of the date the services were approved for payment on the basis of retrospective review described in Section 27, PAYMENT AUTHORIZATION, below. County shall not be obligated to pay for services billed later than the thirtieth day following the last day

of the month in which the services were delivered except in the case of beneficiaries covered by both Medi-Cal and a third-party payer. If a beneficiary is covered by both Medi-Cal and a third-party payer, Contractor will bill third party payer and receive an Explanation of Benefits (EOB) from the third-party payer prior to billing County. Submission to County shall be considered timely when a billing invoice (accompanied by an EOB indicating payment or denial) is submitted: (1) no later than the thirtieth day following the last day of the month in which Contractor received an EOB for the billed service from the third-party payer, and (2) no later than the 120th day following the last day of the month in which services were delivered.

When, on the basis of retrospective review, it has been determined that Contractor has failed to meet service standards or documentation standards established by the MHP and Title 9, California Code of Regulations, payment will be denied on the basis of audit exception. Payment will not be made on the basis of added, amended, or altered records presented after the date of the retrospective review.

5. TERM OF AGREEMENT

This agreement shall commence on the date of signing and shall terminate June 30, 2027, unless terminated in accordance with section 6 below.

6. TERMINATION OF AGREEMENT

If Contractor fails to perform his/her duties to the satisfaction of the County, or if Contractor fails to fulfill in a timely and professional manner his/her obligations under this agreement, or if Contractor violates any of the terms or provisions of this agreement, then the County shall have the right to terminate this agreement effective immediately upon the County giving written notice thereof to the Contractor. Either party may terminate this agreement on 30 days' written notice. County shall pay contractor for all work satisfactorily completed as of the date of notice. County may terminate this agreement immediately upon oral notice should funding cease or be materially decreased or should the Tehama County Board of Supervisors fail to appropriate sufficient funds for this agreement in any fiscal year.

The County's right to terminate this agreement may be exercised by the Health Services Agency's Executive Director.

7. ENTIRE AGREEMENT; MODIFICATION

This agreement for the services specified herein supersedes all previous agreements for these services and constitutes the entire understanding between the parties hereto. Contractor shall be entitled to no other benefits other than those specified herein. No changes, amendments or alterations shall be effective unless in writing and signed by both parties. Contractor specifically acknowledges that in entering into and executing this agreement, Contractor relies solely upon the provisions contained in this agreement and no other oral or written representation.

8. NONASSIGNMENT OF AGREEMENT

Inasmuch as this agreement is intended to secure the specialized services of Contractor, Contractor may not assign, transfer, delegate or sublet any interest herein without the prior written consent of the County.

9. EMPLOYMENT STATUS

Contractor shall, during the entire term of this agreement, be construed to be an independent contractor and nothing in this agreement is intended nor shall be construed to create an employer-employee relationship, a joint venture relationship, or to allow County to exercise discretion or control over the professional manner in which Contractor performs the services which are the subject matter of this agreement; provided always, however, that the services to be provided by Contractor shall be provided in a manner consistent with the professional standards applicable to such services. The sole interest of the County is to ensure that the services shall be rendered and performed in a competent, efficient, and satisfactory manner. Contractor shall be fully responsible for payment of all taxes due to the State of California or the Federal government, which would be withheld from compensation of Contractor, if Contractor were a County employee. County shall not be liable for deductions for any amount for any purpose from Contractor's compensation. Contractor shall not be eligible for coverage under County's Workers Compensation Insurance Plan nor shall Contractor be eligible for any other County benefit.

10. INDEMNIFICATION

Contractor shall defend, hold harmless, and indemnify Tehama County, its elected officials, officers, employees, agents, and volunteers against all claims, suits, actions, costs, expenses (including but not limited to reasonable attorney's fees of County), damages, judgments, or

decrees by reason of any person's or persons' injury, including death, or property (including property of County) being damaged, arising out of contractor's performance of work hereunder or its failure to comply with any of its obligations contained in this agreement, whether by negligence or otherwise. Contractor shall, at its own expense, defend any suit or action founded upon a claim of the foregoing. Contractor shall also defend and indemnify County against any adverse determination made by the Internal Revenue Service or the State Franchise Tax Board and/or any other taxing or regulatory agency against the County with respect to Contractor's "independent contractor" status that would establish a liability for failure to make social security or income tax withholding payments, or any other legally mandated payment.

11. INSURANCE

Contractor shall procure and maintain insurance pursuant to Exhibit A, "Insurance Requirements For Contractor," attached hereto and incorporated by reference.

12. PREVAILING WAGE

Contractor certifies that it is aware of the requirements of California Labor Code Sections 1720 et seq. and 1770 et seq., as well as California Code of Regulations, Title 8, Section 16000 et seq. ("Prevailing Wage Laws"), which require the payment of prevailing wage rates and the performance of other requirements on certain "public works" and "maintenance" projects. If the Services hereunder are being performed as part of an applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws, and if the total compensation is $1,000 or more, Contractor agrees to fully comply with and to require its subcontractors to fully comply with such Prevailing Wage Laws, to the extent that such laws apply. If applicable, County will maintain the general prevailing rate of per diem wages and other information set forth in Labor Code section 1773 at its principal office and will make this information available to any interested party upon request. Contractor shall defend, indemnify, and hold the County, its elected officials, officers, employees and agents free and harmless from any claims, liabilities, costs, penalties, or interest arising out of any failure or alleged failure of the Contractor or its subcontractors to comply with the Prevailing Wage Laws. Without limiting the generality of the foregoing, Contractor specifically acknowledges that County has not affirmatively represented to contractor in writing, in the call for bids, or otherwise, that the work to be covered by the bid or contract was not a "public work." To the fullest extent permitted by law, Contractor hereby

specifically waives and agrees not to assert, in any manner, any past, present, or future claim for indemnification under Labor Code section 1781.

Contractor acknowledges the requirements of Labor Code sections 1725.5 and 1771.1 which provide that no contractor or subcontractor may be listed on a bid proposal or be awarded a contract for a public works project unless registered with the Department of Industrial Relations pursuant to Labor Code section 1725.5, with exceptions from this requirement specified under Labor Code sections 1725.5(f), 1771.1(a) and 1771.1(n).

If the services are being performed as part of the applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws, Contractor acknowledges that this project is subject to compliance monitoring and enforcement by the Department of Industrial Relations.

13. NON-DISCRIMINATION

Contractor shall not employ discriminatory practices in the treatment of persons in relation to the circumstances provided for herein, including assignment of accommodations, employment of personnel, or in any other respect on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation.

14. GREEN PROCUREMENT POLICY

Through Tehama County Resolution No. 2021-140, the County adopted the Recovered Organic Waste Product Procurement Policy (available upon request) to (1) protect and conserve natural resources, water and energy; (2) minimize the jurisdiction's contribution to pollution and solid waste disposal; (3) comply with state requirements as contained in 14 CCR Division 7, Chapter 12, Article 12 (SB 1383); (4) support recycling and waste reduction; and (5) promote the purchase of products made with recycled materials, in compliance with the California Integrated Waste Management Act of 1989 (AB 939) and SB1382 when product fitness and quality are equal and they are available at the same or lesser cost of non-recycled products. Contractor shall adhere to this policy as required therein and is otherwise encouraged to conform to this policy.

15. COMPLIANCE WITH LAWS AND REGULATIONS

All services to be performed by Contractor under to this Agreement shall be performed in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations. Any change in status, licensure, or ability to perform activities, as set forth herein, must be reported to the County immediately.

16. LAW AND VENUE

This agreement shall be deemed to be made in and shall be governed by and construed in accordance with the laws of the State of California (excepting any conflict of laws provisions which would serve to defeat application of California substantive law). Venue for any action arising from this agreement shall be in Tehama County, California.

17. AUTHORITY

Each party executing this Agreement and each person executing this Agreement in any representative capacity, hereby fully and completely warrants to all other parties that he or she has full and complete authority to bind the person or entity on whose behalf the signing party is purposing to act.

18. NOTICES

Any notice required to be given pursuant to the terms and provisions of this agreement shall be in writing and shall be sent first class mail to the following addresses:

If to County:	Tehama County Health Services Agency Attn: Executive Director P.O. Box 400 Red Bluff, CA 96080 (530) 527-8491
If to Contractor:	ZND Residential, Inc. 2514 N. Whittier Ave Fresno, CA 93727 (559) 554-9703

Notice shall be deemed to be effective two days after mailing.

19. NON-EXCLUSIVE AGREEMENT

Contractor understands that this is not an exclusive agreement, and that County shall have the right to negotiate with and enter into agreements with others providing the same or similar services to those provided by Contractor, or to perform such services with County's own forces, as County desires.

20. STANDARDS OF THE PROFESSION

Contractor agrees to perform its duties and responsibilities pursuant to the terms and conditions of this agreement in accordance with the standards of the profession for which Contractor has been properly licensed to practice.

21. LICENSING OR ACCREDITATION

Where applicable the Contractor shall maintain the appropriate license or accreditation through the life of this contract.

22. RESOLUTION OF AMBIGUITIES

If an ambiguity exists in this Agreement, or in a specific provision hereof, neither the Agreement nor the provision shall be construed against the party who drafted the Agreement or provision.

23. NO THIRD-PARTY BENEFICIARIES

Neither party intends that any person shall have a cause of action against either of them as a third-party beneficiary under this Agreement. The parties expressly acknowledge that is not their intent to create any rights or obligations in any third person or entity under this Agreement. The parties agree that this Agreement does not create, by implication or otherwise, any specific, direct or indirect obligation, duty, promise, benefit and/or special right to any person, other than the parties hereto, their successors and permitted assigns, and legal or equitable rights, remedy, or claim under or in respect to this Agreement or provisions herein.

24. SERVICE STANDARDS

Contractor agrees to abide by the same standards of care under which county provides service through programs staffed by County employees. Standards of care are communicated to Contractor via the Handbook, orientation, site certification process, retrospective reviews by the MHP, and training as new standards of care are implemented.

25. PAYMENT AUTHORIZATION

County shall render payment as described in the current Handbook for services provided under this agreement that were authorized and that meet service standards and documentation standards established by the Tehama County MHP and Title 9, CCR. Compliance with MHP and Title 9, CCR service standards and documentation standards shall be established on the basis of retrospective reviews performed by Director or his or her designee. All claims for reimbursement under this agreement shall be submitted together with an Assurance of Compliance and Letter of Transmittal (see Handbook).

26. CODE OF CONDUCT

Tehama County Health Services Agency (TCHSA) maintains high ethical standards and is committed to complying with all applicable statutes, regulations, and guidelines. The TCHSA and each of its employees and contractors shall follow an established Code of Conduct.

PURPOSE

The purpose of the TCHSA Code of Conduct is to ensure that all TCHSA employees and contractors are committed to conducting their activities in accordance with the highest levels of ethics and in compliance with all applicable State and Federal statutes, regulations, and guidelines. The Code of Conduct also serves to demonstrate TCHSA's dedication to providing quality care to its patients.

CODE OF CONDUCT – General Statement

The Code of Conduct is intended to provide TCHSA employees and contractors with general guidelines to enable them to conduct the business of TCHSA in an ethical and legal manner;

- Every TCHSA employee and contractor is expected to uphold the Code of Conduct;
- Failure to comply with the Code of Conduct or failure to report non-compliance may subject the TCHSA employee or contractor to disciplinary action, up to or including termination of employment or contracted status.

CODE OF CONDUCT

All TCHSA employees and contractors:

- Shall perform their duties in good faith and to the best of their ability.
- Shall comply with all statutes, regulations, and guidelines applicable to Federal health care programs, and with TCHSA's own policies and procedures.
- Shall refrain from any illegal conduct. When an employee or contractor is uncertain of the meaning or application of a statute, regulation, or guideline, or the legality of a certain practice or activity, he or she shall seek guidance from his or her immediate

Supervisor, Division Director, the Quality Assurance Manager, the Compliance Auditor, the Assistant Executive Director-Programs, or the Assistant Executive Director-Administration.

- Shall not obtain any improper personal benefit by virtue of their employment or contractual relationship with TCHSA.
- Shall notify their Supervisor, Division Director, Assistant Executive Director-Administration, the Assistant Executive Director-Programs, or Agency Executive Director immediately upon receipt (at work or at home) of any inquiry, subpoena, or other agency or governmental request for information regarding TCHSA;
- Shall not destroy or alter TCHSA information or documents in anticipation of, or in response to, a request for documents by any applicable governmental agency or from a court of competent jurisdiction;
- Shall not engage in any practice intended to unlawfully obtain favorable treatment or business from any entity, physician, patient, resident, vendor, or any other person or entity in a position to provide such treatment or business;
- Shall not accept any gift of more than nominal value or any hospitality or entertainment, which because of its source or value, might influence the employee's or contractor's independent judgment in transactions involving TCHSA;
- Shall disclose to their Division Director any financial interest, official position, ownership interest, or any other relationship that they (or a member of their immediate family) has with TCHSA vendors or contractors;
- Shall not participate in any false billing of patients, governmental entities, or any other party;
- Shall not participate in preparation of any false cost report or other type of report submitted to the government;
- Shall not pay or arrange for TCHSA to pay any person or entity for the referral of patients to TCHSA, and shall not accept any payment or arrangement for TCHSA to accept any payment for referrals from TCHSA:
- Shall not use confidential TCHSA information for their own personal benefit or for the benefit of any other person or entity while employed at or under contract to TCHSA, or at any time thereafter;
- Shall not disclose confidential medical information pertaining to TCHSA's patients or clients without the express written consent of the patients or clients or pursuant to court order and in accordance with the applicable law and TCHSA applicable policies and procedures;
- Shall promptly report to the Compliance Auditor any and all violations or suspected violations of the Code of Conduct;
- Shall promptly report to the Compliance Auditor any and all violations or suspected violations of any statute, regulation, or guideline applicable to Federal health care programs or violations of TCHSA's own policies and procedures;
- Shall not engage in or tolerate retaliation against employees or contractors who report or suspect wrongdoing.

27. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Contractor acknowledges that it is a "health care provider" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. The Contractor agrees to use individually identifiable healthcare information obtained from the COUNTY only for purposes of providing diagnostic or treatment services to patients.

CONTRACTOR agrees to report to County any security incident or any use or disclosure of PHI (in any form) not provided for by this Agreement. Security incidents include attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. CONTRACTOR shall make this report by the next business day following discovery of the use, disclosure, or security incident.

28. CULTURAL COMPETENCY

Contractor shall insure that services delivered under the terms of this agreement reflect a comprehensive range of age appropriate, cost-effective, high quality intervention strategies directed so as to promote wellness, avert crises, and maintain beneficiaries within their own communities. Contractor shall make every effort to deliver services which are culturally sensitive and culturally competent and which operationalize the following values:

A. Services should be delivered in the client's primary language or language of choice since language is the primary "carrier of culture,"

B. Services should encourage the active participation of individuals in their own care, protect confidentiality at all times, and recognize the rights of all individuals regardless of race, ethnicity, cultural background, disability or personal characteristics,

C. Service delivery staff should reflect the racial, ethnic, and cultural diversity of the population being served,

D. Certain culturally sanctioned behaviors, values, or attitudes of individuals legitimately may conflict with "mainstream values" without indicating psychopathology or moral deviance,

E. Service delivery systems should reflect cultural diversity in methods of service

delivery as well as policy,

F. The organization should instill values in staff which encourage them to confront racially or culturally biased behavior in themselves and others and which encourage them to increase their sensitivity and acceptance of culturally based differences.

G. Contractor's staff shall receive cultural competency training and Contractor shall provide evidence of such training to County upon request.

29. DOCUMENTS AND RECORDS

A. Upon written request, Contractor agrees to permit County, State, and/or Federal agencies authorized by the Director, to inspect, review, and copy all records, notes, and writing of any kind in connection with the services provided by Contractor under this agreement. All such inspections and copying shall occur during normal business hours.

B. If the California Department of Health Care Services, Center for Medicare and Medicaid Services (CMS), or Office of the Inspector General of the US Department of Health and Human Services determines there is a reasonable possibility of fraud or similar risk, the State, SMC or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

C. Contractor shall preserve all records relating to the services provided pursuant to this agreement until at least ten years from the final date of the contract period or ten years from the date of completion of any audit, whichever is later.

D. At the end of the period required for record retention, Contractor shall destroy all records made pursuant to this agreement in accordance with the California Code of Regulations, the California Welfare and Institutions Code, and Contractor’s State licensing requirements.

E. Contractor shall document compliance with all contractual requirements. Such documentation shall be provided to County upon request.

30. CLINICAL RECORDS

Contractor shall maintain adequate records. Patient records must comply with all appropriate State and Federal requirements. Individual records shall contain intake information, interviews, and progress notes. Program records shall contain detail adequate for the evaluation of the service. Contractor agrees that its inability to produce records adequate for evaluation of the service shall constitute ground for audit exception and denial of Contractor's claim for payment for those services. Contractor shall provide monthly reports to the Director in conformance with the Client and Service Information (CSI) System as prescribed by the State Department of Health Care Services.

If Contractor maintains an Electronic Health Record (EHR) with Protected Health Information (PHI), and an individual requests a copy of such information in an electronic format, Contractor shall provide such information in an electronic format to enable the County to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. Section 17935(e) and the HIPAA regulations.

31. FINANCIAL RECORDS

Contractor shall maintain financial records that clearly reflect the cost of each type of service for which payment is claimed. Any apportionment of costs shall be made in accordance with generally accepted accounting principles and shall evidence proper audit trails reflecting the true cost of the services rendered. Appropriate service and financial records must be maintained and retained for ten years following the close of the fiscal year to which the records pertain, or settlement of the Short-Doyle Medi-Cal Cost Report with the State of California, whichever is longer.

32. CONFIDENTIALITY OF PATIENT INFORMATION

All information and records obtained in the course of providing services under this agreement shall be confidential and Contractor shall comply with State and Federal requirements regarding confidentiality of patient information (including but not limited to section 5328 of the Welfare and Institutions Code, and Title 45, Code of Federal Regulations, section 205.50 for MediCal-eligible patients) including all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All applicable regulations and statutes relating to patients' rights shall be adhered to. This provision shall survive the termination, expiration, or cancellation of this agreement.

33. SEVERABILITY

If any portion of this agreement or application thereof to any person or circumstance is declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal or state statute or regulation or County ordinance, the remaining provisions of this agreement, or the application thereof, shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this agreement are severable.

34. PARTICIPATION IN FEDERAL HEALTHCARE PROGRAMS

A. In entering into this agreement, Contractor acknowledges that County intends to seek reimbursement from Federal Healthcare programs for services provided directly by Contractor. Contractor acknowledges County's intent to comply with all rules and regulations pertaining to Federal Healthcare Programs. Contractor agrees to comply, and to require its employees who are considered "Covered Individuals" to comply with all policies and procedures of the Compliance Program. "Covered Individuals" are defined as employees or independent contractors of the Contractor with responsibilities pertaining to the ordering, provision, documentation, coding, or billing of services payable by a Federal Healthcare program for which County seeks reimbursement from the Federal Healthcare programs.

B. Contractor agrees to provide copies of the Code of Conduct to all Covered Individuals and to obtain (subject to review by County and/or Office of Inspector General [OIG]) signed certifications from each individual certifying that they have received, read, and understand the Code of Conduct and agree to abide by all rules and regulations pertaining to participation in Federal Healthcare programs. Contractor will submit the signed certifications to TCHSA'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 or independent contractors who are "Covered Individuals".

C. Contractor shall comply with all contractual provisions pursuant to Exhibit D, "COMPLIANCE AND PROGRAM INTEGRITY," attached hereto and

incorporated by reference.

D. Contractor shall provide assurances of compliance with current State of California and Federal regulations regulating the reimbursement and delivery of healthcare services. These assurances are in the following forms which are provided in the Handbook:

(1) Statement of Understanding and Compliance – signed by each service provider for every day he/she provides a service to a beneficiary. This Statement shall be attached to or printed on the service provider's daily time sheet, service activity log, or billing record. If Contractor does not use a daily time sheet, service activity log, or billing record, Contractor may, after approval from County (which may be obtained via email), have each service provider sign a monthly Statement of Understanding and Compliance. Contractor shall make signed Statements available to County upon request.

(2) Assurance of Compliance and Letter of Transmittal – signed by an officer of the corporation. This must accompany each claim for reimbursement.

35. AGREEMENT SUPERVISION

A. The Director, or his/her designee, shall be the County employee authorized and assigned to represent the interests of the County and to ensure that the terms and conditions of this agreement are carried out.

B. County shall monitor the kind, quality, and quantity of Contractor's services and criteria for determining the persons to be served and length of treatment for patients covered under the terms of this agreement.

36. PERSONNEL

A. Contractor shall furnish such qualified professional personnel as prescribed in Title 9 of the California Code of Regulations required for the type of services described in Section 1.

B. All Contractor's personnel (including independent contractors) shall have the appropriate current State licensure required for their given profession.

C. Contractor shall comply with all applicable Federal and/or State laws, rules, and regulations in regard to nondiscrimination in employment on the basis of race, color, ancestry, national origin, religion, sex, marital status, sexual orientation, age, medical condition, or disability (including compliance with the Federal Rehabilitation Act of 1973, section 504.

37. LICENSINDG REQUIREMENTS

Contractor shall comply with all necessary County or State licensing requirements and must obtain appropriate licenses and display same in a location that is reasonably conspicuous. Contractor shall abide by the Welfare and Institutions Code, section 5600 et. seq., Title 9 and Title 22 of the California Code of Regulations, the State Cost Reporting/Data Collection Manual (CR/DC), and State Department of Health Care Services Policy Letters.

38. TAXES

Contractor agrees to file Federal and State tax returns and pay all applicable State and Federal taxes on amounts paid pursuant to this agreement. In case County is audited for compliance regarding withholding or other applicable taxes, Contractor agrees to furnish County with proof of payment of taxes on those earnings.

39. PATIENT'S RIGHTS

Contractor shall give beneficiaries notice of their rights as contained in the Tehama County Guide to Medi-Cal Mental Health Services (available upon request from County in electronic or paper form). In addition, in all facilities providing the services described herein the Contractor shall have prominently posted in the predominant languages of the community a list of the patients' rights.

40. SUPPLEMENTATION OF WAGES

Contractor desires to comply with DSS Manual of Procedures Section 11-402.122 & .123 which allows RCL programs to use mental health funds to pay for certain payroll costs of child care and

social worker staff and not forfeit RCL points. County acknowledges that the funds in this contract may be used, in part, to supplement the wages (including taxes and benefits) of child care and social worker staff which would otherwise be paid with AFDC-FC funds. Any requirement for additional hours or positions beyond the minimum provided for under AFDC-FC policy may also be paid for with mental health funds.

41. MISCELLANEOUS PROVISION

Contractor shall comply specifically with Division 5 of the Welfare and Institutions Code, Titles 9 and 22 of the California Code of Regulations, and all statutes and regulations related thereto.

Contractor shall possess and maintain Mental Health Organizational Provider certification and comply with the California Department of Health Care Services requirements thereof, including on-site reviews at least once every three years. If Contractor is a STRTP, Contractor shall also maintain accreditation in good status, Mental Health Program Approval and Medi-Cal certification.

Contractor shall comply with all Patients' Rights statutes and regulations.

Contractor shall insure that all pertinent admissions and length of stay requests comply with utilization review regulations.

BANKRUPTCY: Contractor shall immediately notify County in the event that Contractor ceases conducting business in the normal manner, becomes insolvent, makes a general assignment for the benefits of creditors, suffers or permits the appointment of a receiver for its business or assets, or avails itself, or, becomes subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors.

42. HAZARDOUS MATERIALS

Contractor shall provide to County all Safety Data Sheets covering all Hazardous Materials to be furnished, used, applied, or stored by Contractor, or any of its Subcontractors, in connection with the services on County property. Contractor shall provide County with copies of any such Safety Data Sheets prior to entry to County property or with a document certifying that no Hazardous Materials will be brought onto County property by Contractor, or any of its Subcontractors,

during the performance of the services. County shall provide Safety Data Sheets for any Hazardous Materials that Contractor may be exposed to while on County property.

43. HARASSMENT

Contractor agrees to make itself aware of and comply with the County's Harassment Policy, TCPR §8102: Harassment, which is available upon request. The County will not tolerate or condone harassment, discrimination, retaliation, or any other abusive behavior. Violations of this policy may cause termination of this agreement.

44. TRAFFICKING VICTIMS PROTECTION ACT OF 2000

Contractor and its Subcontractors that provide services covered by this Contract shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C.7104)."

45. BYRD ANTI-LOBBYING AMENDMENT (31 USC 1352)

Contractor certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352. Contractor shall also disclose to DHCS any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

46. HATCH AC

County agrees to comply with the provisions of the Hatch Act (USC, Title 5, Part III, Subpart F., Chapter 73, Subchapter III), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

47. COUNTERPARTS, ELECTRONIC SIGNATURES – BINDING

This agreement may be executed in any number of counterparts, each of which will be an original, but all of which together will constitute one instrument. Each Party of this agreement agrees to the use of electronic signatures, such as digital signatures that meet the requirements of the California Uniform Electronic Transactions Act ((“CUETA”) Cal. Civil Code §§ 1633.1 to

1633.17), for executing this agreement. The Parties further agree that the electronic signatures of the Parties included in this agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic signature means an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record pursuant to the CUETA as amended from time to time. The CUETA authorizes use of an electronic signature for transactions and contracts among Parties in California, including a government agency. Digital signature means an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature, and shall be reasonably relied upon by the Parties. For purposes of this section, a digital signature is a type of "electronic signature" as defined in subdivision (i) of Section 1633.2 of the Civil Code. Facsimile signatures or signatures transmitted via pdf document shall be treated as originals for all purposes.

48. EXHIBITS

Contractor shall comply with all provisions of Exhibits A through E, attached hereto and incorporated by reference. In the event of a conflict between the provisions of the main body of this Agreement and any attached Exhibit(s), the main body of the Agreement shall take precedence.

IN WITNESS WHEREOF, County and Contractor have executed this agreement on the day and year set forth below.

COUNTY OF TEHAMA

Date: 10-1-25

Jayme S. Bottke, Executive Director

ZND Residential, Inc.

Date: 10/1/25

Jante Bracamontes, CFO

Contractor Number

Vendor Number

Budget Account Number

Standard Form of Agreement – Services adopted 12/08/22

Exhibit A

INSURANCE REQUIREMENTS FOR CONTRACTOR

Contractor shall procure and maintain, for the duration of the contract, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work described herein and the results of that work by Contractor, his/her agents, representatives, employees, or subcontractors. At a minimum, Contractor shall maintain the insurance coverage, limits of coverage and other insurance requirements as described below.

Commercial General Liability (including operations, products and completed operations) $1,000,000 per occurrence for bodily injury, personal injury, and property damage. If coverage is subject to an aggregate limit, that aggregate limit will be twice the occurrence limit, or the general aggregate limit shall apply separately to this project/location.

Automobile Liability

Automobile liability insurance is required with minimum limits of $1,000,000 per accident for bodily injury and property damage, including owned and non-owned and hired automobile coverage, as applicable to the scope of services defined under this agreement.

Workers' Compensation

If Contractor has employees, he/she shall obtain and maintain continuously Workers' Compensation insurance to cover Contractor and Contractor's employees and volunteers, as required by the State of California, as well as Employer's Liability insurance in the minimum amount of $1,000,000 per accident for bodily injury or disease.

Professional Liability (Contractor/Professional services standard agreement only)

If Contractor is a state-licensed architect, engineer, contractor, counselor, attorney, accountant, medical provider, and/or other professional licensed by the State of California to practice a profession, Contractor shall provide and maintain in full force and effect while providing services pursuant to this contract a professional liability policy (also known as Errors and Omissions or Malpractice liability insurance) with single limits of liability not less than $1,000,000 per claim and $2,000,000 aggregate on a claims made basis. However, if

coverage is written on a claims-made basis, the policy shall be endorsed to provide coverage for at least three years from termination of agreement.

If Contractor maintains higher limits than the minimums shown above, County shall be entitled to coverage for the higher limits maintained by Contractor.

All such insurance coverage, except professional liability insurance, shall be provided on an "occurrence" basis, rather than a "claims made" basis.

Endorsements: Additional Insureds

The Commercial General Liability and Automobile Liability policies shall include, or be endorsed to include "Tehama County, its elected officials, officers, employees and volunteers" as an additional insured.

The certificate holder shall be "County of Tehama."

Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions of $25,000 or more must be declared to, and approved by, the County. The deductible and/or self-insured retentions will not limit or apply to Contractor's liability to County and will be the sole responsibility of Contractor.

Primary Insurance Coverage

For any claims related to this project, Contractor's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be excess of Contractor's insurance and shall not contribute with it.

Coverage Cancellation

Each insurance policy required herein shall be endorsed to state that "coverage shall not be reduced or canceled without 30 days' prior written notice certain to the County."

Acceptability of Insurers

Contractor's insurance shall be placed with an insurance carrier holding a current A.M. Best & Company's rating of not less than A:VII unless otherwise acceptable to the County. The County reserves the right to require rating verification. Contractor shall ensure that the insurance carrier shall be authorized to transact business in the State of California.

Subcontractors

Contractor shall require and verify that all subcontractors maintain insurance that meets all the requirements stated herein.

Material Breach

If for any reason, Contractor fails to maintain insurance coverage or to provide evidence of renewal, the same shall be deemed a material breach of contract. County, in its sole option, may terminate the contract and obtain damages from Contractor resulting from breach. Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County may deduct from sums due to Contractor any premium costs advanced by County for such insurance.

Policy Obligations

Contractor's indemnity and other obligations shall not be limited by the foregoing insurance requirements.

Verification of Coverage

Contractor shall furnish County with original certificates and endorsements effecting coverage required herein. All certificates and endorsements shall be received and approved by the County prior to County signing the agreement and before work commences. However, failure to do so shall not operate as a waiver of these insurance requirements.

The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications at any time.

Exhibit B

PAYMENT TERMS

I. COUNTY shall pay CONTRACTOR as per the following instructions:

A. CONTRACTOR shall submit claims in accordance with the applicable billing requirements. COUNTY shall reimburse CONTRACTOR within thirty (30) days upon receipt of invoice (Attachment 2) from CONTRACTOR.

B. Net negotiated rates for services are as defined in Fiscal Year 2025-26 Rates below:

Group Name	Group Description	Hourly Rate
CNS Group	Certified Nurse Specialists	$467.89
LPHA Group	LPHAs {MFT LCSW LPCC)/ Intern or Waivered LPHAs {MFT LCSW LPCC)	$244.88
LVN Group	Licensed Vocational Nurses	$200.77
MA Group	Medical Assistants	$138.01
MD Group	Licensed Physicians	$940.90
MHRS Group	Mental Health Rehab Specialists	$184.23
NP Group	Nurse Practitioners	$467.89
OT Group	Occupational Therapists	$325.96
OTHER Group	Other Qualified Practitioners	$184.23
PA Group	Physicians Assistants	$421.99
PEER Group	Peer Support Specialists	$193.44
PHARM Group	Pharmacists	$450.39
PSY Group	Psychologists {Licensed or Waivered)	$378.40
PT Group	Licensed Psychiatric Technicians	$172.11
RN Group	Registered Nurses	$382.18

C. Rates for services rendered by CONTRACTOR shall be reviewed annually and amended by mutual agreement of CONTRACTOR and COUNTY at the beginning of each fiscal year. In the event mutual agreement for rates is not reached between parties hereto, this Agreement shall terminate upon written notice from COUNTY or CONTRACTOR.

D. Payment of claims is contingent upon authorization for treatment by COUNTY or designee as the Managed Care Provider.

Exhibit C

SCOPE OF WORK

The County of Tehama, on behalf of the Department of Behavioral Health (DBH), intends to engage several Short-Term Residential Therapeutic Program (STRTP) contractors under a master agreement to provide outpatient specialty mental health to youth placed in their STRTP licensed and Mental Health Program Application (MHPA) approved homes.

A. Background

On October 11, 2015 and September 25, 2016, Assembly Bills 403 and 1997 were signed into law, respectively, to implement provisions of the Continuum of Care Reform (CCR). The provisions were founded on the collective belief among stakeholders involved in California's child welfare system that all children served by the foster care system need, deserve, and have an ability to be part of a loving family, and not to grow up in a congregate setting. Assembly Bill 403 created a new youth residential licensing category – the Short-Term Residential Therapeutic Program (STRTP – to replace the former group home Rate Classification Level (RCL) structure. With this change, youth and non-minor dependents would receive short-term, specialized, and intensive treatment, and 24-hour care and supervision within the STRTP home in which they were placed. Assembly Bill 1997 further adopted the requirement for all STRTPs to provide and ensure access to specialty mental health services to youth and non-minor dependents placed in their care. This would allow for the timely provision of services and greater care coordination for foster youth in the system.

STRTPs are required to obtain and maintain STRTP licensure through the California Department of Social Services (CDSS) and Mental Health Program Application (MHPA) approval and Medi-Cal site certification through either the Department of Health Care Services (DHCS) or their home county, if it is a delegate county. In order to provide Medi-Cal billable services within Tehama County, STRTPs are required to obtain and maintain Medi-Cal site certification.

B. Target Population

Tehama County youth, presumptive transfer youth, and AB1051 youth placed within the care of the STRTP.

Entry Criteria

A licensed STRTP may accept youth, including non-minor dependents, for placement who meet all of the following criteria:

1. Youth does not require inpatient care in a licensed health facility,

2. Youth has been assessed by a licensed mental health professional as meeting the applicable criteria for placement in a STRTP program,

3. A determination has been made by the Interagency Placement Committee (IPC) that the youth should be placed in a STRTP.

Referrals shall be submitted to the program from the Tehama County DSS and Probation Department. The STRTP may also receive referrals from out-of-county DSS and Probation Departments.

AB 1051 changes to the presumptive transfer process would necessitate an individual contract between the STRTP and county of responsibility for all out of county youth placed in the home. Out-of-county youth covered by the Master STRTP Agreement are those:

1. Youth from a county which has signed onto the Tehama County DBH county-to-county agreement; or

2. Youth who have had an exemption granted by Tehama County DBH for the youth to be presumptively transferred.

Additionally, Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall ensure that American Indian youth receive specialty mental health services in accordance with the Federal Indian Child Welfare Act (25 U.S.C. Sec 1901 et seq.).

C. Description of Services

The intended benefit of the STRTP program is to increase ease of access and availability of mental health services for youth placed within the care of the STRTP.

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall provide a level of service and support that will reflect each participant's unique and individual needs.

A. Services Start Date

The County intends to select one (1) or more bidder(s) to provide the requested services under the development of a master agreement expected to be effective July 1, 2025.

Site certification/recertification must be completed no later than September 1, 2025.

B. Summary of Services

i. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall provide these services to all individuals in the program. Services will include but are not limited to the following:

a. Provide support to the youth's family and other members of the youth's social network to help them manage the symptoms and illness of the youth and reduce the level of family and social stress associated with the illness.

b. Make appropriate referrals and linkages to services that are beyond that of the selected bidder(s)' services under this agreement or as appropriate when discharging/transitioning a youth from your program.

c. Coordinate services with any other community mental health and non-mental health providers as well as other medical

d. Assist person served/family with accessing all entitlements or benefits for which they are eligible (i.e. Managed Care Plan benefits, Medi-Cal, SSI, Section 8 vouchers etc.).

e. Develop family support and involvement whenever possible.

f. Refer individuals to supported education and employment opportunities, as appropriate.

g. Provide or link to transportation services when it is critical to initially access a support service or gain entitlements or benefits.

h. Provide or refer to peer support activities, as appropriate.

i. Ensure that clinically appropriate Evidence-Based Practices are utilized in service delivery at all levels of care.

ii. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall deliver a comprehensive specialty mental health program. Behavioral health services include but are not limited to:

a. Assessment

b. Treatment or Care planning/Goal setting

c. Pediatric Symptom Checklist (PSC) 35 and the Child and Adolescent Needs and Strengths (CANS) assessment

d. Individual therapy

e. Group therapy

f. Family therapy

g. Case Management

h. Medication Support

i. Intensive Home-Based Services

j. Intensive Care Coordination

k. Consultation

l. Linkage to additional services and supports

m. Hospitalization/Post Hospitalization Support

iii. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will ensure that all services:

a. Be values-driven, Strengths-based, individual-driven, and co- occurring capable.

b. Be culturally and linguistically competent.

c. Be age, culture, gender, and language appropriate.

d. Include accommodations for individuals with physical disability(ies).

iv. Methods for service coordination and communication between program and other service providers shall be developed and implemented consistent with Tehama County Mental Health Plan (MHP) confidentiality rules.

v. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall maintain an up-to-date caseload record of all individuals enrolled in services, and provide individual, programmatic, and other demographic information to DBH as requested.

vi. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall ensure billable specialty mental health services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards and provide all pertinent and appropriate information in a timely manner to DBH to bill Medi-Cal services rendered.

vii. STRTP specific programming

The STRTP program is designed so that youth and non-minor dependents placed within the STRTP home have the ability to receive services – including specialty mental health services – in one place. Specialty mental health services are provided within the home by the STRTP's mental health staff, with youth and non-minor dependents Frequency and intensity of specialty mental health services are determined by the person served's treatment plan, or as identified in their day-to-day needs. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall have a plan to meet the youth's mental health needs outside of the regular working hours of mental health staff, including weekends.

Based on the acuity of this population, each youth shall receive a minimum of two direct treatment encounters per week. The STRTP shall ensure and document daily attempts to engage youth in a mental health service when a youth is refusing to participate in all other services offered by the program. All mental health services are trauma-informed, culturally,

and developmentally appropriate. Additionally, all specialty mental health services shall meet Medi-Cal standards and the STRTP shall collaborate with the Interagency Placement Committee

(IPC), Wrap Team, and Child and Family Team (CFT) for treatment planning and linkage to support systems.

Additional services provided by the STRTP program include, but are not limited to:

a. Crisis Intervention

b. EPSDT Supplemental Specialty Mental Health Services

c. Medication Support

Shall be provided via the STRTP's psychiatrist on staff or a subcontracted psychiatrist. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will monitor that the following is adhered to by the psychiatrist for these services:

a) The psychiatrist shall examine each youth prior to prescribing any psychotropic medication and include a screening to determine whether there are potential medical complications that may contribute to the youth's health condition. This examination shall be noted in the youth's record.

b) The psychiatrist shall sign a written medication review for each youth prescribed psychotropic medication as clinically appropriate, but at least every forty-five (45) days. This review shall be included in the youth's record.

c) The psychiatrist shall review the course of treatment for all youth who are not on psychotropic medication at least every ninety (90) days and include the results of this review in a progress note signed by the prescribing physician at the time the review is completed.

d) Psychotropic medications for a youth placed in an STRTP shall be administered in accordance with all applicable State and Federal laws, which include but are not limited to laws related to informed consent, documentation of informed consent, and California Welfare & Institutions (WIC) Code Sections 369.5 and 739.5.

e) A nurse practitioner, physician's assistant or registered, licensed or vocational nurse acting within their scope of practice; may perform the functions in subdivisions (b), (c), and (d) under the direction of a psychiatrist. However, each child shall be examined by a psychiatrist at least once during the child's stay at the STRTP."

viii. A licensed mental health professional (LMHP) or waivered/registered professional shall perform a clinical review every ninety (90) days of the youth's status and progress in

treatment to determine whether the youth should continue admission in the program or be transitioned to a different level of care. The LMHP or waivered/registered professional shall make this determination in consultation with the CFT. A report documenting the clinical review shall be maintained in the youth's record and provided to DBH upon request.

ix. The STRTP shall ensure continuity of care, services, and treatment as a youth moves from his or her STRTP placement to home-based family care or to a permanent living situation through reunification, adoption, or guardianship, in accordance with the youth's case plan or treatment plan. This includes notifying all outside treating mental health providers when the youth is no longer residing in the STRTP. The STRTP shall

make appropriate referrals for mental health services if a youth does not have an assigned mental health provider outside of the STRTP.

I. Location of Services

Services shall be provided at Z.N.D. RESIDENTIAL, INC. (Z.N.D.) licensed STRTP site, as shown below. These sites shall maintain STRTP licensure through CDSS, as well as mental health program application approval (MHPA) and Medi-Cal site certification through the Tehama County Department of Behavioral Health

(DBH). The County must be notified of any addition or change to the location of an STRTP and the new site must obtain its own, separate licensure, MHPA approval, and Medi-Cal site certification. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) must also be capable of offering services through Telehealth-phone and Telehealth-video should the need arise.

II. Hours of Z.N.D. RESIDENTIAL, INC. (Z.N.D.)

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall have services available between 9:00 am and 5:00 pm five (5) days per week.

III. Care Coordination/Transition Plan

i. Intake and Initial Assessment

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall complete the following, upon intake or as indicated below.

1. Mental Health Assessment

A mental health assessment shall be completed by a licensed mental health professional (LMHP) or waivered/registered associate within five (5) calendar days of a youth's arrival.

A mental health assessment that was completed by an LMHP within sixty (60) calendar days may also be used to meet this requirement.

2. Treatment Plan

Each youth admitted to the STRTP shall have a Treatment Plan reviewed and signed by a LMHP, waivered/registered professional, or the Head of Service (HOS) within ten (10) calendar days of the youth's arrival at the STRTP.

The Treatment Plan shall be reviewed by a member of the mental health program staff at least every thirty (30) calendar days.

3. Medication Support

Within the first thirty (30) days of youth's arrival, a psychiatrist shall examine each youth prior to prescribing any psychotropic medication and include a screening to determine whether there

are potential medical complications that may contribute to the youth's health condition. This examination shall be noted in the youth's record.

Medication support may be provided onsite or via telepsychiatry.

ii. Transition and Discharge

Discharge planning, including transition planning that supports a step- down process utilizing a CFT, permanency specialist (which may include family finding) and child specific strategies to build natural and formal support systems, shall begin at intake and is determined on a case-by- case basis, depending on the youth's progress toward individualized treatment goals. Additionally, linkages shall be made to ongoing support, such as specialty mental health resources, for all youth. All transitions and discharges shall be discussed in a CFT to ensure all members of the youths' support system are aware of the recommendation being made by the STRTP.

IV. Evidence Based Practices (EBPs)

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) must use evidence-based practices (EBPs) found effective in serving this target population. This includes the provision of training, ongoing sustainability, and fidelity to a core competency for Z.N.D. RESIDENTIAL, INC. (Z.N.D.) mental health clinicians. Evidence- Based Practices (EBP) utilized in the STRTP include butare not limited to: Cognitive Behavioral Therapy (CBT), Trauma Focused CBT (TF-CBT), Dialectical Behavioral Therapy (DBT), and Motivational Interviewing (MI). Any additional evidence-based practices Z.N.D. RESIDENTIAL, INC. (Z.N.D.) would like to utilize will require review and consultation with County.

V. County Shall

i. Assist the Z.N.D. RESIDENTIAL, INC. (Z.N.D.) efforts to evaluate the needs of each enrolled child on an ongoing basis to ensure each child is receiving clinically appropriate services.

ii. Provide oversight and collaborate with Z.N.D. RESIDENTIAL, INC. (Z.N.D.) and other County Departments and community agencies to help achieve State program goals and outcomes. Oversight includes, but is not limited to, contract monitoring and coordination with the State Department of Health Care Services and California Department of Social Services in regard to program administration and outcomes.

iii. Assist the Z.N.D. RESIDENTIAL, INC. (Z.N.D.) in making links with the total mental health system of care. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

iv. Participate in evaluating overall program progress and efficiency and be available to Z.N.D. RESIDENTIAL, INC. (Z.N.D.)) for ongoing consultation.

v. Gather outcome information from target person served groups and

throughout each term of this Agreement. County shall notify Z.N.D. RESIDENTIAL, INC. (Z.N.D.)) when their participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, a personon served and staff interviews, chart reviews, and other methods of obtaining required information.

vi. Assist Z.N.D. RESIDENTIAL, INC. (Z.N.D.) efforts toward cultural and linguistic competency by providing the following:

1. Technical assistance regarding cultural competency requirements.

2. Mandatory cultural competency training for Z.N.D. RESIDENTIAL, INC. (Z.N.D.) personnel, if training capacity allows.

VI. Staffing

vii. Z.N.D. RESIDENTIAL, INC. (Z.N.D.)) shall provide the following staffing components, at minimum:

i. Mental health program staff shall be consistent with the current STRTP regulations and should be appropriate for services needed by each youth, which would include any of the following classifications: physicians, psychologists/waivered psychologists, LCSW/ASW, LMFT/AMFT, LPCC/APCC,registered nurses, LVNs, psychiatric technicians, and mental health rehabilitation specialists..

viii. Of the direct service program staff required above, The STRTP shall have one (1) half-time equivalent LMHP or waivered/registered professional employed for each six (6) children admitted to the program. A LMHP or waivered/registered professional who is employed to meet this requirement may also be the head of service, if employed at least forty (40) hours per week.

ix. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall ensure staff are qualified in education, experience, and clinical competencies appropriate for their respective job classifications.

x. Z.N.D. RESIDENTIAL, INC. (Z.N.D.)) shall maintain adequate staffing levels in relation to the number of open person-served cases at any given point and align with the needs of the population. Clinician caseloads shall not exceed 6 individuals per clinician. Staffing levels shall not jeopardize the quality of services provided to the persons served.

xi. Peer support staff shall not be counted as part of the mental health program staff for the purpose of meeting regulatory staffing ratios and shall only be hired and utilized as approved in the selected bidder(s)' MHPA and site certification.

F. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will provide appropriate training for all staff to include but not limited to trauma-informed practice, EBPs utilized, working with specialized populations such as Human Trafficking, and co-occurring competence to serve individuals with mental health and substance use/abuse disorders.

G. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will comply with the training requirements and expectations referenced in Exhibit A, Department of Behavioral Health Selected Bidder Training Requirements Reference Guide.

H. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will provide sufficient number of licensed staffing and will manage assignment of persons served within the program to ensure that all services for persons with dual coverage are claimable (e.g. Medicare/Medi-Cal dually enrolled persons).

VII. General Requirements

A. Guiding Principles of Care Delivery: All services provided by Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall be in accordance with DBH's Guiding Principles of Care Delivery in accordance to Exhibit B.

B. Compliance Program

Z.N.D. RESIDENTIAL, INC. (Z.N.D.)) shall be responsible for conducting internal monitoring and auditing of its agency. Internal monitoring and auditing include, but are not limited to billing practices, licensure/ certification verification and adherence to County, State and Federal regulations. If a selected bidder identifies improper procedures, actions or

circumstances, including fraud/waste/abuse and/or systemic issue(s), prompt steps shall be taken to correct said problem(s) and must report to DBH any overpayments discovered as a result of such problems. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall either adopt DBH's Compliance Plan/ Program or establish its own Compliance Plan/Program and provide documentation to DBH to evaluate whether the program is consistent with the elements of a compliance program as recommended by the United States Department of Health and Human Services, Office of Inspector General. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall adhere to applicable DBH Policies and Procedures relating to the Compliance Program or develop its own compliance related policies and procedures.

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall comply with Tehama County

Department of Behavioral Health Compliance Program Code of Conduct and Acknowledgement and Agreement Form in accordance with Exhibit

C. Specific Compliance requirements will be outlined in the resulting agreement.

C. Cultural Responsivity: Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall be required to adhere to DBH's Cultural Responsivity requirements included as Exhibit D –National Standards for Culturally and Linguistically Appropriate Services (CLAS).

D. Federal/HIPAA Laws: Strictly adhere with all applicable Federal (including HIPAA laws), State of California and/or local laws and regulations relating to confidentiality and protected health information.

E. Interpreter/Translation Services: Provide/demonstrate ability to access competent and appropriate linguistic services in the identified individual's language of choice and have a working knowledge of accessing and utilizing qualified staff /third-party interpreters or language lines during provision of services. Interpretation/Translation services will be at the cost of Z.N.D. RESIDENTIAL, INC. (Z.N.D.).

F. Licensing, Certification, and Credentialing: MHP requires its licensed/registered/waivered and certified providers to comply with and maintain professional competencies in their fields of expertise. To ensure competency, the credentialing process is required for all new and current provider staff. Credentialing Committee must approve Z.N.D. RESIDENTIAL, INC. (Z.N.D.) mental health program staff before service delivery. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will be required to submit related documents to the County's DBH Plan Administration Division for review by DBH's Credentialing Committee. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will define their protocol for ensuring the Tehama County credentialing process is adhered to. If Z.N.D. RESIDENTIAL, INC. (Z.N.D.) is not certified at the time of award, Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will

work with DBH to execute the process for certification within 60 days of the start of the contract.

G. Service Data for Billing Purposes

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will provide accurate and timely input of services provided in the County's Electronic Health Record (EHR). The current EHR is a web-based application and requires a computer with a minimum of 16 GB RAM using either Edge or Chrome as the browser, and a stable high speed internet connection. Additional drivers may be needed to scan documents into the EHR.

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will be responsible for equipment to support the using of the EHR. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) may be required to utilize data entry forms, portals, or related systems for compliance with County data reporting requirements during the duration of the contract.

Data entry shall be the responsibility of Z.N.D. RESIDENTIAL, INC. (Z.N.D.). The County shall monitor the number and amount of services entered into the EHR. Any and all audit exceptions resulting from the provision and billing of Medi-Cal services by Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall be the sole responsibility of the selected bidder(s).

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will utilize the County's EHR for all Behavioral Health Plan billing and reporting functions and may elect to utilize the County's EHR for all clinical documentation, at no additional cost to the selected bidder. Preference will be given to bidders electing to utilize the County's EHR for clinical documentation.

elects to not use the County's EHR for all clinical documentation, Z.N.D. RESIDENTIAL, INC. (Z.N.D.) must submit a plan demonstrating how all necessary requirements involving electronic health information exchange between Z.N.D. RESIDENTIAL, INC. (Z.N.D.) and the county will be

H. mOuetc. omes

In an effort to satisfy required state, federal and other funding and reporting requirements and to successfully administer, assess and evaluate program outcomes effectiveness, Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall be asked to collect data and measures applicable to services requested in this RFSQ and submit them in a timely manner to the Departments. The Departments will collect data and develop the required annual reports. The data that shall be requested is necessary for the Departments to successfully complete its reporting and outcome requirements with appropriate funders, which may include local, State and Federal agencies.

The outcomes will be composed of two sections: a general data requirement for systemic services delivery oversight and reporting, and a specific data set dependent on the level of service, age range, modality, funding source requirements, and other specific measures.

Outcomes shall include improvement in functioning as demonstrated via IP-CANS assessment. IP-CANS assessments shall be conducted at intake and in response to changes in the child's case including, but not limited to, placement changes, visitation changes, and any "significant changes in child circumstances or functioning". IP-CANS assessments shall be completed at least every six (6) months even in the absence of significant changes. Outcome measures shall be expected after six (6) months of receiving services.

Specific outcomes requirements are outlined in Exhibit E. As noted previously in this RFSQ, regulations are expected to change and Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will be required to adhere to new requirements and changes in collaboration with the Department.

I. CLAS and Diversity, Equity and Inclusion (DEI) Outcomes

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) providing direct care and services shall adhere to the CLAS standards to adhere with regulatory requirements and ensure culturally and linguistically responsive care.

Z.N.D. RESIDENTIAL, INC. (Z.N.D.) shall provide annual documentation to demonstrate implementation and compliance with CLAS standards, which may include an organizational CLAS plan, training records, records of interpreter/translation services utilized, etc.

Additionally, Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will be required to collect the required demographic data related to their funding source to meet outcomes and evaluation requirements.

Participation on the annual diversity, equity and inclusion survey provides the Department vital data necessary to assess its effectiveness in meeting the Cultural Competency Plan Requirements (CCPR), and thus Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will be required to participate in the annual survey process.

Specific CLAS and DEI requirements will be outlined in the resulting agreement.

VIII. Reports

quarterly shall track data and provide reporting on the following items and send all applicable information and reports to the DBH Contract Analysts.

A. The STRTP shall be expected to comply with all contract monitoring and compliance protocols, procedures, data collection methods, and reporting requirements conducted by County.

B. The STRTP will be responsible for meeting with DBH on a quarterly

basis, or more often as agreed upon between County and the

for contract and performance monitoring.

C. All reports will be due to the County by the 10th of each month, unless otherwise specified, and will be reviewed for accuracy. (If the 10th lands on a weekend or Holiday, reports will be due the next business day). Reimbursement for monthly expenses may be delayed in the event inaccurate reports are submitted.

D. The STRTP shall submit a census report to the CWMH Team on the 1st and 15th of each month.

E. The STRTP shall provide DBH with Outcome Reports on an annual and semi-annual basis, respectively. Outcome Report formats will be established through County/STRTP collaboration. Outcome Report measures may change, based on information or measures needed.

F. Z.N.D. RESIDENTIAL, INC. (Z.N.D.) will report and document all major and/or sensitive incidents ("critical incidents") to the County. The County, at its sole discretion, may require Z.N.D. RESIDENTIAL, INC. (Z.N.D.) to conduct all necessary follow-up activities after reporting critical incidents. If there is any doubt about whether an incident should be reported, the default shall be for Z.N.D. RESIDENTIAL, INC. (Z.N.D.) to report the incident to the County.

G. Additional reports and outcome information may be requested by County at a later date, as needed.

Exhibit D

COMPLIANCE AND PROGRAM INTEGRITY

Evidence of Contractual Compliance

Contractor shall document evidence of compliance with all contractual provisions and provide to County upon request.

Exclusions Checks

Consistent with the requirements of 42 Code of Federal Regulations, (C.F.R.) part 455.436, Contractor shall confirm the identity and determine the exclusion status of all providers (employees and subcontractors), as well as any person with an ownership or control interest, or who is an agent or managing employee of Contractor through monthly checks of Federal and State databases. The databases to be included are:

A. The Social Security Administration's Death Master File
B. The National Plan and Provider Enumeration System (NPPES)
C. The Office of Inspector General's List of Excluded Individuals/Entities (LEIE)
D. The System for Award Management (SAM)
E. The California Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List (S & I List)

Contractor shall retain evidence of monthly checks and provide to County upon request. If the Contractor finds a party that is excluded, Contractor shall notify the County within one (1) business day. Contractor shall not permit an excluded provider to render services to a County client.

Ownership Disclosure

Pursuant to the requirements of 42 C.F.R. § 455.104, Contractor must make disclosures regarding any person (individual or corporation) who has an ownership or control interest in the Contractor, whether the person (individual or corporation) is related to another person with an ownership or control interest in the Contractor 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 Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

The term “person with an ownership or control interest” means, with respect to the Contractor, a person who:

A. Has directly or indirectly an ownership of five percent (5%) or more in the Contractor; or
B. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured in whole (or in part) by the Contractor or any property of or assets thereof, which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets or the entity; or

C. Is an officer or director of the Contractor if the Contractor is organized as a corporation; or
D. Is a partner in the Contractor, if the Contractor is organized as a partnership

Contractor will provide County the following disclosures prior to the execution of this contract (and annually thereafter), prior to its extension or renewal (and annually thereafter), and within thirty five (35) days after any change in Contractor ownership:

A. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. 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 Contractor or in any subcontractor in which the Contractor has a five percent (5%) or more interest];
D. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor 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 Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;
E. The name of any other disclosing entity in which the Contractor has an ownership or control interest. Other disclosing entity means any other Medicaid disclosing entity

and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

Business Transactions Disclosure

Contractor must submit disclosures and updated disclosures to County regarding certain business transactions within thirty five (35) days, upon request. The following must be disclosed:

A. The ownership of any subcontractor with whom Contractor had business transactions totaling more than $25,000 during the 12-month period ending on the date of request; and

B. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of request.

Persons Convicted of Crimes Disclosure

Contractor shall submit the following disclosures to County regarding Contractor's management prior to execution of this contract and at any time upon County request:

(A) The identity of any person who is a managing employee of Contractor who has been convicted of a crime related to federal health care programs. [42 C.F.R. § 455.106(a)(1), (2).]

(B) The identity of any person who is an agent of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)

For this purpose, the word "agent" has the meaning described in 42 C.F.R. § 455.101.

Criminal Background Checks

Contractor must require providers (employees and contracted) to consent to criminal background checks including livescans pursuant to 42 C.F.R. 455.434(a). Upon DHCS' determination that Contractor or a person with a five percent (5%) or more direct or indirect ownership interest in Contractor meets DHCS' criteria for criminal background checks as a high risk to the Medicaid program, Contractor's providers (employees and contracted) must submit livescans pursuant to 42 C.F.R. 455.434(b)(1).

Exhibit E

TEHAMA COUNTY Behavioral Health Member Handbook

Specialty Mental Health Services and Drug Medi-Cal

Tehama County Health Services Agency
Mental Health and Substance Use Recovery Division
P.O. Box 400
1860 Walnut Street
Red Bluff, CA 96080
Phone: (530) 527-5631
TCHSA Access Line 1-800-240-3208 is available 24 hours a day, 7 days a week.

Effective Date: January 1, 2025[1]

1 The handbook must be offered at the time the member first accesses services.

LANGUAGE TAGLINES

English Tagline
ATTENTION: If you need help in your language call 1-800-240-3208 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-240-3208 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-240-3208
(TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-240-3208
(TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-240-3208 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-240-3208 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-240-3208 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-240-3208 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 1-800-240-3208
(TTY:
711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-240-3208 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-240-3208 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-240-3208 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-240-3208
(TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-240-3208 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-240-3208 (TTY:

711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-240-3208 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-800-240-3208 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-240-3208 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-240-3208 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-240-3208 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-240-3208 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ
1-800-240-3208 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-240-3208
(TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-240-3208 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-240-3208 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-240-3208 (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-240-3208 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-240-3208 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-240-3208 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-240-3208 (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-240-3208 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-240-3208 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-240-3208 (TTY: 711) **นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข** 1-800-240-3208 (TTY: 711) **ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้**

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-240-3208 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-240-3208 (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-240-3208 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-240-3208 (TTY: 711). Các dịch vụ này đều miễn phí.

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Other languages

If you need help in your language call 1-800-240-3208 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-240-3208 (TTY: 711). These services are free of charge.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

Interpreter Services

The county provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter,

linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

COUNTY CONTACT INFORMATION

We are here to help. The following county contact information will help you get the services you need.

Telephone Number: (530) 527-5631

County 24/7 Access Line: (800) 240-3208

County behavioral health website hyperlink:

https://www.tehamacohealthservices.net/administration/about-us/behavioral-health/

County Provider Directory hyperlink:

https://www.tehamacohealthservices.net/behavioral-health-provider-directory/

Tehama County Patient Access Application Programming Interfaces (APIs) are still under development at this time. When they are completed and ready to be accessed, an update will be made to this handbook.

Who Do I Contact If I'm Having Suicidal Thoughts?

If you or someone you know is in crisis, please call the 988 Suicide and Crisis Lifeline at **988** or the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. Chat is available at https://988lifeline.org/.

To access your local programs, please call the 24/7 Access Line or county telephone number listed above.

PURPOSE OF THIS HANDBOOK

Why is it important to read this handbook?

Your county has a mental health plan that offers mental health services known as “specialty mental health services”. Additionally, your Drug Medi-Cal county provides services for alcohol or drug use, known as “substance use disorder services”. Together these services are known as ”behavioral health services”, and it is important that you have information about these services so that you can get the care you need. This handbook explains your benefits and how to get care. It will also answer many of your questions.

You will learn:

- How to receive behavioral health services through your county.
- What benefits you can access.
- What to do if you have a question or problem.
- Your rights and responsibilities as a member of your county.
- If there is additional information about your county, which may be indicated at the end of this handbook.

If you do not read this handbook now, you should hold on to it so you can read it later. This book is meant to be used along with the book you got when you signed up for your Medi-Cal benefits. If you have any questions about your Medi-Cal benefits, call the county using the phone number on the front of this book.

Where Can I Go for More Information About Medi-Cal?

Visit the Department of Health Care Services website at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Beneficiaries.aspx for more information about Medi-Cal.

BEHAVIORAL HEALTH SERVICES INFORMATION

How to Tell if You or Someone You Know Needs Help?

Many people go through hard times in life and may experience mental health or substance use conditions. The most important thing to remember is that help is available. If you or your family member are qualified for Medi-Cal and need behavioral health services, you should call the county's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. Your managed care plan can also help you contact your county if they believe you or a family member need behavioral health services that the managed care plan does not cover. Your county will help you find a provider for the services you may need.

The list below can help you decide if you or a family member needs help. If more than one sign is present or happens for a long time, it may be a sign of a more serious problem that requires professional help. Here are some common signs you might need help with a mental health condition or substance use condition:

Thoughts and Feelings

- Strong mood changes, possibly with no reason, such as:
    - Too much worry, anxiety, or fear
    - Too sad or low
    - Too good, on top of the world
    - Moody or angry for too long
- Thinking about suicide
- Focusing only on getting and using alcohol or drugs
- Problems with focus, memory or logical thought and speech that are hard to explain
- Problems with hearing, seeing, or sensing things that are hard to explain or that most people say don't exist

Physical

- Many physical problems, possibly without obvious causes, such as:
    - Headaches
    - Stomach aches
    - Sleeping too much or too little
    - Eating too much or too little
    - Unable to speak clearly
- Decline in looks or strong concern with looks, such as:
    - Sudden weight loss or gain
    - Red eyes and unusually large pupils
    - Odd smells on breath, body, or clothing

Behavioral

- Having consequences from your behavior because of changes to your mental health or using alcohol or drugs, such as:
    - Having issues at work or school
    - Problems in relationships with other people, family, or friends
    - Forgetting your commitments
    - Not able to carry out usual daily activities
- Avoiding friends, family, or social activities
- Having secretive behavior or secret need for money
- Becoming involved with the legal system because of changes to your mental health or using alcohol or drugs

Members Under the Age of 21

How Do I Know When a Child or Teenager Needs Help?

You may contact your county or managed care plan for a screening and assessment for your child or teenager if you think they are showing signs of a behavioral health condition. If your child or teenager qualifies for Medi-Cal and the screening or

assessment shows that behavioral health services are needed, then the county will arrange for your child or teenager to receive behavioral health services. Your managed care plan can also help you contact your county if they believe your child or teenager needs behavioral health services that the managed care plan does not cover. There are also services available for parents who feel stressed by being a parent.

Minors 12 years of age or older, may not need parental consent to receive outpatient mental health services or residential shelter services if the attending professional person believes the minor is mature enough to participate in the behavioral health services or residential shelter services. Minors 12 years of age or older, may not need parental consent to receive medical care and counseling to treat a substance use disorder related problem. Parental or guardian involvement is required unless the attending professional person determines that their involvement would be inappropriate after consulting with the minor.

The list below can help you decide if your child or teenager needs help. If more than one sign is present or persists for a long time, it may be that your child or teenager has a more serious problem that requires professional help. Here are some signs to look out for:

- A lot of trouble paying attention or staying still, putting them in physical danger or causing school problems
- Strong worries or fears that get in the way of daily activities
- Sudden huge fear without reason, sometimes with racing heart rate or fast breathing
- Feels very sad or stays away from others for two or more weeks, causing problems with daily activities
- Strong mood swings that cause problems in relationships
- Big changes in behavior
- Not eating, throwing up, or using medicine to cause weight loss
- Repeated use of alcohol or drugs

- Severe, out-of-control behavior that can hurt self or others
- Serious plans or tries to harm or kill self
- Repeated fights, use of a weapon, or serious plan to hurt others

ACCESSING BEHAVIORAL HEALTH SERVICES

How Do I Get Behavioral Health Services?

If you think you need behavioral health services such as mental health services and/or substance use disorder services, you can call your county's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. Once you contact the county, you will receive a screening and be scheduled for an appointment for an assessment.

You can also request behavioral health services from your managed care plan if you are a member. If the managed care plan determines that you meet the access criteria for behavioral health services, the managed care plan will help you to get an assessment to receive behavioral health services through your county. Ultimately, there is no wrong door for getting behavioral health services. You may even be able to receive behavioral health services through your managed care plan in addition to behavioral health services through your county. You can access these services through your behavioral health provider if your provider determines that the services are clinically appropriate for you and as long as those services are coordinated and not duplicative.

In addition, keep the following in mind:

- You may be referred to your county for behavioral health services by another person or organization, including your general practitioner/doctor, school, a family member, guardian, your managed care plan, or other county agencies. Usually, your doctor or the managed care plan will need your consent or the permission of the parent or caregiver of a child, to make the referral directly to

the county, unless there is an emergency.

- Your county may not deny a request to do an initial assessment to determine whether you meet the criteria for receiving behavioral health services.
- Behavioral health services can be provided by the county or other providers the county contracts with (such as clinics, treatment centers, community-based organizations, or individual providers).

Where Can I Get Behavioral Health Services?

You can get behavioral health services in the county where you live, and outside of your county if necessary. Each county has behavioral health services for children, youth, adults, and older adults. If you are under 21 years of age, you are eligible for additional coverage and benefits under Early and Periodic Screening, Diagnostic, and Treatment. See the “Early and Periodic Screening, Diagnostic, and Treatment” section of this handbook for more information.

Your county will help you find a provider who can get you the care you need. For mental health services, the county must refer you to the closest provider to your home, or within time or distance standards who will meet your needs.

When Can I Get Behavioral Health Services?

Your county has to meet appointment time standards when scheduling a service for you. For mental health services, the county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with themental health plan;
- Within 48 hours if you request services for an urgent condition;
- Within 15 business days of your non-urgent request for an appointment with a psychiatrist; and,
- Within 10 business days from the prior appointment for nonurgent follow up appointments for ongoing conditions.

For substance use disorder services, the Drug Medi-Cal county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with a

substance use disorder provider for outpatient and intensive outpatient services;
- Within 3 business days of your request for Narcotic Treatment Program services;
- A follow-up non-urgent appointment within 10 days if you're undergoing a course of treatment for an ongoing substance use disorder, except for certain cases identified by your treating provider.

However, these times may be longer if your provider has determined that a longer waiting time is medically appropriate and not harmful to your health. If you have been told you have been placed on a waitlist and feel the length of time is harmful to your health, contact your mental health plan's 24/7 Access Line or the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook. You have the right to file a grievance if you do not receive timely care. For more information about filing a grievance, see "The Grievance Process" section of this handbook.

What Are Emergency Services?

Emergency services are services for members experiencing an unexpected medical condition, including a psychiatric emergency medical condition. An emergency medical condition has symptoms so severe (possibly including severe pain) that an average person could reasonably expect the following might happen at any moment:

- The health of the individual (or the health of an unborn child) could be in serious trouble
- Causes serious harm to the way your body works
- Causes serious damage to any body organ or part

A psychiatric emergency medical condition occurs when an average person thinks that someone:

- Is a current danger to himself or herself or another person because of a mental health condition or suspected mental health condition.
- Is immediately unable to provide or eat food, or use clothing or shelter because of a mental health condition or suspected mental health condition.

Emergency services are covered 24 hours a day, seven days a week for Medi-Cal members. Prior authorization is not required for emergency services. The Medi-Cal program will cover emergency conditions, whether the condition is due to a physical health or mental health condition (thoughts, feelings, behaviors which are a source of distress and/or dysfunction in relation to oneself or others). If you are enrolled in Medi-Cal, you will not receive a bill to pay for going to the emergency room, even if it turns out to not be an emergency. If you think you are having an emergency, call **911** or go to any hospital or other setting for help.

Who Decides Which Services I Will Receive?

You, your provider, and the county are all involved in deciding what services you need to receive. A behavioral health professional will talk with you and will help determine what kind of services are needed.

You do not need to know if you have a behavioral health diagnosis or a specific behavioral health condition to ask for help. You will be able to receive some services while your provider completes an assessment.

If you are under the age of 21, you may also be able to access behavioral health services if you have a behavioral health condition due to trauma, involvement in the child welfare system, juvenile justice involvement, or homelessness. Additionally, if you are under age 21, the county must provide medically necessary services to help your behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary.

Some mental health services may require prior authorization from the county. Services that require prior authorization include Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. You may ask the county for more information about its prior authorization process. Call your county's 24/7 Access Line using the telephone number on the cover of this handbook to request additional information.

The county's authorization process for mental health services must follow specific timelines.

- For a standard prior mental health authorization, the county must decide based on your provider's request as quickly as your condition requires, but not to exceed five (5) business days from when the county receives the request.
    - For example, if following the standard timeframe could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, your mental health plan must rush an authorization decision and provide notice based on a timeframe related to your health condition that is no later than 72 hours after receipt of the service request. Your county may extend the time for up to 14 additional calendar days after the county receives the request if you or your provider request the extension or the county provides justification for why the extension is in your best interest.

If the county does not make a decision within the listed timelines or denies, delays, reduces, or terminates the services requested, the county must send you a Notice of Adverse Benefit Determination telling you that the services are denied, delayed, reduced or terminated, inform you that you may file an appeal, and give you information on how to file an appeal.

You may ask the county for more information about its authorization process.

If you don't agree with the county's decision on an authorization process, you may file an appeal. For more information, see the "Problem Resolution" section of this handbook.

What Is Medical Necessity?

Services you receive must be medically necessary and clinically appropriate to address your condition. For members 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect your life, prevent significant illness or disability, or improve severe pain.

For members under the age of 21, a service is considered medically necessary if it corrects, sustains, supports, improves, or makes more tolerable a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment services.

How Do I Get Other Mental Health Services That Are Not Covered by the County?

If you are enrolled in a managed care plan, you have access to the following outpatient mental health services through your managed care plan:

- Mental health evaluation and treatment, including individual, group and family therapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring prescription drugs.
- Psychiatric consultation.

To get one of the above services, call your managed care plan directly. If you are not in a managed care plan, you may be able to get these services from individual providers and clinics that accept Medi-Cal. The county may be able to help you find a provider or clinic.

Any pharmacy that accepts Medi-Cal can fill prescriptions to treat a mental health condition. Please note that most prescription medication dispensed by a pharmacy, called Medi-Cal Rx, is covered under the Fee-For-Service Medi-Cal program, not your managed care plan.

What Other Substance Use Disorder Services Are Available from Managed Care Plans or the Medi-Cal "Fee for Service" Program?

Managed care plans must provide covered substance use disorder services in primary care settings and tobacco, alcohol, and illegal drug screening. They must also cover substance use disorder services for pregnant members and alcohol and drug use screening, assessment, brief interventions, and referral to the appropriate treatment setting for members ages 11 and older. Managed care plans must provide or arrange

services for Medication Assisted Treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings. Managed care plans must also provide emergency services necessary to stabilize the member, including voluntary inpatient detoxification.

How Do I Get Other Medi-Cal Services (Primary Care/Medi-Cal)?

If you are in a managed care plan, the plan is responsible for finding a provider for you. If you are not enrolled in a managed care plan and have "regular" Medi-Cal, also called Fee-For-Service Medi-Cal, then you can go to any provider that accepts Medi-Cal. You must tell your provider that you have Medi-Cal before you begin getting services. Otherwise, you may be billed for those services. You may use a provider outside your managed care plan for family planning services.

Why Might I Need Psychiatric Inpatient Hospital Services?

You may be admitted to a hospital if you have a mental health condition or signs of a mental health condition that can't be safely treated at a lower level of care, and because of the mental health condition or symptoms of mental health condition, you:

- Represent a danger to yourself, others, or property.
- Are unable to care for yourself with food, clothing, or shelter.
- Present a severe risk to your physical health.
- Have a recent, significant deterioration in the ability to function as a result of a mental health condition.
- Need psychiatric evaluation, medication treatment, or other treatment that can only be provided in the hospital.

SELECTING A PROVIDER

How Do I Find a Provider For The Behavioral Health Services I Need?

Your county is required to post a current provider directory online. You can find the provider directory link in the County Contact section of this handbook. The directory contains information about where providers are located, the services they provide, and

other information to help you access care, including information about the cultural and language services that are available from the providers.

If you have questions about current providers or would like an updated provider directory, visit your county's website or use the telephone number located on the cover of this handbook. You can get a list of providers in writing or by mail if you ask for one.

Note: The county may put some limits on your choice of providers for mental health services. When you first start receiving mental health services you can request that your county provide you with an initial choice of at least two providers. Your county must also allow you to change providers. If you ask to change providers, the county must allow you to choose between at least two providers when possible and that there are enough providers close to you to make sure that you can get covered mental health services if you need them. Your county is responsible for ensuring that you have timely access to mental health services.

Sometimes the county's contracted providers choose to no longer provide mental health services because they may no longer contract with the county or no longer accept Medi-Cal. When this happens, the county must make a good faith effort to give written notice to each person who was receiving mental health services from the provider. You are required to get a notice 30 calendar days prior to the effective date of the termination or 15 calendar days after the county knows the provider will stop working. When this happens, your county must allow you to continue receiving services from the provider who left the county, if you and the provider agree. This is called "continuity of care" and is explained below.

Note: American Indian and Alaska Native individuals who are eligible for Medi-cal and reside in Drug Medi-Cal counties, can also receive Drug Medi-Cal services through Indian Health Care Providers that have the necessary Drug Medi-Cal certification.

Can I Continue To Receive Specialty Mental Health Services From My Current Provider?

If you are already receiving mental health services from a managed care plan, you may continue to receive care from that provider even if you receive mental health services from your county, as long as the services are coordinated between the providers and the services are not the same.

In addition, if you are already receiving mental health services from another county, managed care plan, or an individual Medi-Cal provider, you may request “continuity of care” so that you can stay with your current provider, for up to 12 months. You may wish to request continuity of care if you need to stay with your current provider to continue your ongoing treatment or because it would cause serious harm to your mental health condition to change to a new provider. Your continuity of care request may be granted if the following is true:

- You have an ongoing relationship with the provider you are requesting and have seen that provider in the last 12 months;
- You need to stay with your current provider to continue ongoing treatment to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
- The provider is qualified and meets Medi-Cal requirements;
- The provider agrees to the county’s requirements for contracting with the mental health plan and payment for services; and
- The provider shares relevant documentation with the county regarding your need for the services.

YOUR RIGHT TO ACCESS YOUR MENTAL HEALTH MEDICAL RECORDS AND PROVIDER DIRECTORY INFORMATION USING SMART DEVICES

You can access your mental health records and/or find a provider using an application downloaded on a computer, smart tablet, or mobile device. Information to think about before choosing an application to get information this way can be found on your mental health plan's website listed in the County Contact section of this handbook.

SCOPE OF SERVICES

If you meet the criteria for accessing behavioral health services, the following services are available to you based on your need. Your provider will work with you to decide which services will work best for you.

Specialty Mental Health Services

Mental Health Services

- Mental health services are individual, group, or family-based treatment services that help people with mental health conditions to develop coping skills for daily living. These services also include work that the provider does to help make the services better for the person receiving care. These kinds of things include assessments to see if you need the service and if the service is working; treatment planning to decide the goals of your mental health treatment and the specific services that will be provided; and "collateral", which means working with family members and important people in your life (if you give permission) to help you improve or maintain your daily living abilities.
- Mental health services can be provided in a clinic or provider's office, your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

Medication Support Services

- These services include prescribing, administering, dispensing, and monitoring of psychiatric medicines. Your provider can also provide education on the medication. These services can be provided in a clinic, the doctor's office, your home, a community setting, over the phone, or by telehealth (which includes both audio-only and video interactions).

Targeted Case Management

- This service helps members get medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with a mental health condition to get on their own. Targeted

case management includes, but is not limited to:

- Plan development;
- Communication, coordination, and referral;
- Monitoring service delivery to ensure the person's access to service and the service delivery system; and
- Monitoring the person's progress.

Crisis Intervention Services

- This service is available to address an urgent condition that needs immediate attention. The goal of crisis intervention is to help people in the community so that they won't need to go to the hospital. Crisis intervention can last up to eight hours and can be provided in a clinic or provider's office, or in your home or other community setting. These services can also be done over the phone or by telehealth.

Crisis Stabilization Services

- This service is available to address an urgent condition that needs immediate attention. Crisis stabilization lasts less than 24 hours and must be provided at a licensed 24-hour health care facility, at a hospital-based outpatient program, or at a provider site certified to provide these services.

Adult Residential Treatment Services

- These services provide mental health treatment to those with a mental health condition living in licensed residential facilities. They help build skills for people and provide residential treatment services for people with a mental health condition. These services are available 24 hours a day, seven days a week. Medi-Cal does not cover the room and board cost for staying at these facilities.

Crisis Residential Treatment Services

- These services provide mental health treatment and skill building for people who have a serious mental or emotional crisis. This is not for people who need psychiatric care in a hospital. Services are available at licensed facilities for 24

hours a day, seven days a week. Medi-Cal does not cover the room and board cost for these facilities.

Day Treatment Intensive Services

- This is a structured program of mental health treatment provided to a group of people who might otherwise need to be in the hospital or another 24-hour care facility. The program lasts three hours a day. It includes therapy, psychotherapy and skill-building activities.

Day Rehabilitation

- This program is meant to help people with a mental health condition learn and develop coping and life skills to better manage their symptoms. This program lasts at least three hours per day. It includes therapy and skill-building activities.

Psychiatric Inpatient Hospital Services

- These are services provided in a licensed psychiatric hospital. A licensed mental health professional decides if a person needs intensive around-the-clock treatment for their mental health condition. If the professional decides the member needs around-the-clock treatment, the member must stay in the hospital 24 hours a day.

Psychiatric Health Facility Services

- These services are offered at a licensed psychiatric health facility specializing in 24-hour rehabilitative treatment of serious mental health conditions. Psychiatric health facilities must have an agreement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

Therapeutic Behavioral Services

Therapeutic Behavioral Services are intensive short-term outpatient treatment interventions for members up to age 21. These services are designed specifically for

each member. Members receiving these services have serious emotional disturbances, are experiencing a stressful change or life crisis, and need additional short-term, specific support services.

These services are a type of specialty mental health service available through the county if you have serious emotional problems. To get Therapeutic Behavioral Services, you must receive a mental health service, be under the age of 21, and have full-scope Medi-Cal.

- If you are living at home, a Therapeutic Behavioral Services staff person can work one-to-one with you to decrease severe behavior problems to try to keep you from needing to go to a higher level of care, such as a group home for children and young people under the age of 21 with very serious emotional problems.
- If you are living in an out-of-home placement, a Therapeutic Behavioral Services staff person can work with you so you may be able to move back home or to a family-based setting, such as a foster home.

Therapeutic Behavioral Services will help you and your family, caregiver, or guardian learn new ways of addressing problem behavior and increasing the kinds of behavior that will allow you to be successful. You, the Therapeutic Behavioral Services staff person, and your family, caregiver, or guardian will work together as a team to address problematic behaviors for a short period until you no longer need the services. You will have a Therapeutic Behavioral Services plan that will say what you, your family, caregiver, or guardian, and the Therapeutic Behavioral Services staff person will do while receiving these services. The Therapeutic Behavioral Services plan will also include when and where services will occur. The Therapeutic Behavioral Services staff person can work with you in most places where you are likely to need help. This includes your home, foster home, school, day treatment program, and other areas in the community.

Intensive Care Coordination

This is a targeted case management service that facilitates the assessment, care planning for, and coordination of services to beneficiaries under age 21. This service is for those that are qualified for the full-scope of Medi-Cal services and who are referred to the service on basis of medical necessity. This service is provided through the principles of the Integrated Core Practice Model. It includes the establishment of the Child and Family Team to help make sure there is a healthy communicative relationship among a child, their family, and involved child-serving systems.

The Child and Family Team includes professional support (for example: care coordinator, providers, and case managers from child-serving agencies), natural support (for example: family members, neighbors, friends, and clergy), and other people who work together to make and carry out the client plan. This team supports and ensures children and families reach their goals.

This service also has a coordinator that:

- Makes sure that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven, culturally and language appropriate manner.
- Makes sure that services and support are based on needs of child.
- Makes a way to have everyone work together for the child, family, providers, etc.
- Supports parent/caregiver in helping meet child's needs.
- Helps establish the Child and Family Team and provides ongoing support.
- Makes sure the child is cared for by other child-serving systems when needed.

Intensive Home-Based Services

- These services are designed specifically for each member. It includes strength-based interventions to improve mental health conditions that may interfere with the child/youth's functioning. These services aim to help the child/youth build necessary skills to function better at home and in the community and improve their family's ability to help them do so.

- Intensive Home-Based Services are provided under the Integrated Core Practice Model by the Child and Family Team. It uses the family's overall service plan. These services are provided to members under the age of 21 who are eligible for full-scope Medi-Cal services. A referral based on medical necessity is needed to receive these services.

Therapeutic Foster Care

- The Therapeutic Foster Care service model provides short-term, intensive, and trauma-informed specialty mental health services for children up to the age of 21 who have complex emotional and behavioral needs. These services are designed specifically for each member. In Therapeutic Foster Care, children are placed with trained, supervised, and supported Therapeutic Foster Care parents.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services, post-release and discharge planning, laboratory and radiology services, medication information, and support services. To receive these services, individuals must be a Medi-Cal or CHIP member, and:
    - If under the age of 21 in custody at a Youth Correctional Facility.
    - If an adult, be in custody and meet one of the health care needs of the program.
- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be

received at the same time as you receive other mental health services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the county, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.

- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.
- Providing Medi-Cal Peer Support Services is optional for participating counties. At this time TCHSA does not cover Peer Support Services for the Specialty Mental Health Services System.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a mental health crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.
- Mobile Crisis Services include rapid response, individual assessment, and community-based stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

Substance Use Disorder Services

What are Drug Medi-Cal County Services?

Drug Medi-Cal County services are for people who have a substance use condition, meaning they may be misusing alcohol or other drugs, or people who may be at risk of developing a substance use condition that a pediatrician or general practitioner may not be able to treat. These services also include work that the provider does to

help make the services better for the person receiving care. These kinds of things include assessments to see if you need the service and if the service is working.

Drug Medi-Cal services can be provided in a clinic or provider's office, or your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

American Society of Addiction Medicine (ASAM)

Some of the Drug Medi-Cal services you may receive are based on the American Society of Addiction Medicine standards. The county or provider will use the American Society of Addiction Medicine tool to find the right type of services for you – if needed. These types of services are described as "levels of care," and are defined below.

Screening, Assessment, Brief Intervention, and Referral to Treatment (American Society of Addiction Medicine Level 0.5)

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) is not a Drug Medi-Cal benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for members that are aged 11 years and older. Managed care plans must provide covered substance use disorder services, including this service for members ages 11 years and older.

Early Intervention Services

Early intervention services are a covered Drug Medi-Cal service for members under age 21. Any member under age 21 who is screened and determined to be at risk of developing a substance use disorder may receive any service covered under the outpatient level of service as early intervention services. A substance use disorder diagnosis is not required for early intervention services for members under age 21.

Early Periodic Screening, Diagnosis, and Treatment

Members under age 21 can get the services described earlier in this handbook as well as additional Medi-Cal services through a benefit called Early and Periodic Screening, Diagnostic, and Treatment.

To be able to get Early and Periodic Screening, Diagnostic, and Treatment services, a member must be under age 21 and have full-scope Medi-Cal. This benefit covers services that are medically necessary to correct or help physical and behavioral health conditions. Services that sustain, support, improve, or make a condition more tolerable are considered to help the condition and are covered as Early and Periodic Screening, Diagnostic, and Treatment services. The access criteria for members under 21 are different and more flexible than the access criteria for adults accessing Drug Medi-Cal services, to meet the Early and Periodic Screening, Diagnostic, and Treatment requirement and the intent for prevention and early intervention of substance use disorder conditions.

If you have questions about these services, please call your Drug Medi-Cal county or visit the DHCS Early and Periodic Screening, Diagnostic, and Treatment webpage.

Outpatient Treatment Services (American Society of Addiction Medicine Level 1)

- Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for members under age 21 when medically necessary. You might get more hours based on your needs. Services can be provided by someone licensed, like a counselor, in person, by telephone, or by telehealth.
- Outpatient Services include assessment, individual counseling, group counseling, patient education, medication services, Medication Assisted Treatment for opioid use disorders, and substance use disorder crisis intervention services.

Intensive Outpatient Services (American Society of Addiction Medicine Level 2.1)

- Intensive Outpatient Services are given to members a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for members under age 21 when medically necessary. Services may exceed the maximum based on individual medical

necessity. Services are mostly counseling and education about addiction-related issues. Services can be provided by a licensed professional or a certified counselor in a structured setting. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.

- Intensive Outpatient Services include the same things as Outpatient Services. More hours of service is the main difference.

Perinatal Residential Substance Use Disorder Treatment Services

- Providing non-medical rehabilitative substance use disorder treatment services for pregnant and postpartum women. The types of services offered include assessments, counseling, education, and medication assistance.
- For information about these services call the Drug Medi-Cal county telephone number within the hours of operation listed on the cover of this handbook.

Narcotic Treatment Program

- Narcotic Treatment Programs are programs outside of a hospital that provide medications to treat substance use disorders, when ordered by a doctor as medically necessary. Narcotic Treatment Programs are required to give medications to members, including methadone, buprenorphine, naloxone, and disulfiram.
- A member must be offered, at a minimum, 50 minutes of counseling sessions per calendar month. These counseling services can be provided in person, by telehealth, or by telephone. Narcotic Treatment Services include assessment, individual counseling, group counseling, patient education, medical psychotherapy, medication services, care management Medication Assisted Treatment for opioid use disorders, and substance use disorder crisis intervention services.

Medication Assisted Treatment

- Medication Assisted Treatment is available in clinical and non-clinical settings. Medication Assisted Treatment includes all FDA-approved medications and biological products to treat opioid use disorders. Members have a right to be

offered Medication Assisted Treatment on-site or through a referral outside of the facility. A list of approved medications include:

  - Acamprosate Calcium
  - Buprenorphine Hydrochloride
  - Buprenorphine Extended-Release Injectable (Sublocade)
  - Buprenorphine/Naloxone Hydrochloride
  - Naloxone Hydrochloride
  - Naltrexone (oral)
  - Naltrexone Microsphere Injectable Suspension (Vivitrol)
  - Lofexidine Hydrochloride (Lucemyra)
  - Disulfiram (Antabuse)
  - Methadone (delivered by Narcotic Treatment Programs)

- Medication Assisted Treatment may be provided with the following services: assessment, individual counseling, group counseling, patient education, medical psychotherapy, medication services, substance use disorder crisis intervention services, and prescribing and monitoring of Medication Assisted Treatment. Medication Assisted Treatment may be provided as part of all Drug Medi-Cal services, including Outpatient Treatment Services, Intensive Outpatient Services, and Residential Treatment, for example.
- Members may access Medication Assisted Treatment outside of the Drug Medi-Cal county as well. For instance, Medication Assisted Treatment, such as buprenorphine, can be prescribed by some prescribers in primary care settings that work with your managed care plan and can be dispensed or administered at a pharmacy.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services, post-release and discharge planning, laboratory and radiology services, medication information, and support services. To receive these services, individuals must be a Medi-Cal or CHIP member, and:

    - If under the age of 21 in custody at a Youth Correctional Facility.
    - If an adult, be in custody and meet one of the health care needs of the program.
- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be received at the same time as you receive other Drug Medi-Cal county services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the counties, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.
- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.
- Providing Medi-Cal Peer Support Services is optional for participating counties. At this time TCHSA does not cover Peer Support Services for the Specialty Mental Health Services System.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a substance use crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other

community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.

- Mobile Crisis Services include rapid response, individual assessment, and community-based stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

AVAILABLE SERVICES BY TELEPHONE OR TELEHEALTH

In-person, face-to-face contact between you and your provider is not always required for you to be able to receive behavioral health services. Depending on your services, you might be able to receive your services through telephone or telehealth. Your provider should explain to you about using telephone or telehealth and make sure you agree before beginning services via telephone or telehealth. Even if you agree to receive your services through telehealth or telephone, you can choose later to receive your services in-person or face-to-face. Some types of behavioral health services cannot be provided only through telehealth or telephone because they require you to be at a specific place for the service, such as residential treatment services or hospital services.

THE PROBLEM RESOLUTION PROCESS: TO FILE A GRIEVANCE, APPEAL, OR REQUEST A STATE FAIR HEARING

What If I Don't Get the Services I Want From My County?

Your county must have a way for you to work out any problems related to the services you want or are receiving. This is called the problem-resolution process and it could involve the following:

- The Grievance Process: A verbal or written expression of unhappiness about anything regarding your specialty mental health services, substance use disorder services, a provider, or the county. Refer to the Grievance Process section in this handbook for more information.
- The Appeal Process: An appeal is when you don't agree with the county's decision to change your services (e.g., denial, termination, or reduction to services) or to not cover them. Refer to the Appeal Process section in this handbook for more information.
- The State Fair Hearing Process: A State Fair Hearing is a meeting with a judge from the California Department of Social Services (CDSS) if the county denies your appeal. Refer to the State Fair Hearing section in this handbook for more information.

Filing a grievance, appeal, or requesting a State Fair Hearing will not count against you and will not impact the services you are receiving. Filing a grievance or appeal helps to get you the services you need and to solve any problems you have with your behavioral health services. Grievances and appeals also help the county by giving them the information they can use to improve services. Your county will notify you, providers, and parents/guardians of the outcome once your grievance or appeal is complete. The State Fair Hearing Office will notify you and the provider of the outcome once the State Fair Hearing is complete.

Note: Learn more about each problem resolution process below.

Can I Get Help With Filing an Appeal, Grievance, or State Fair Hearing?

Your county will help explain these processes to you and must help you file a grievance, an appeal, or to request a State Fair Hearing. The county can also help you decide if you qualify for what's called an "expedited appeal" process, which means it will be reviewed more quickly because your health, mental health, and/or stability are at risk. You may also authorize another person to act on your behalf, including your provider or advocate.

If you would like help, contact your county using the telephone number listed on the cover of this handbook. Your county must give you reasonable assistance in completing forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

If You Need Further Assistance

Contact the Department of Health Care Services, Office of the Ombudsman:

- Phone: # **1-888-452-8609**, Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays).

OR

- E-mail: MMCDOmbudsmanOffice@dhcs.ca.gov. **Please note**: E-mail messages are not considered confidential (please do not include personal information in the e-mail message).

You may also get free legal help at your local legal aid office or other groups. To ask about your State Fair Hearing rights, you can contact the California Department of Social Services Public Inquiry and Response Unit at this phone number: **1-800-952-5253** (for TTY, call **1-800-952-8349**).

Grievances

What Is a Grievance?

A grievance is a complaint regarding your unhappiness with any aspect of your behavioral health services or the county that is not covered by the appeal or State Fair Hearing processes.

What Is the Grievance Process?

The grievance process will:

- Involve simple steps to file your grievance orally or in writing.
- Not cause you to lose your rights or services or be held against your provider.
- Allow you to approve another person to act on your behalf. This could be a provider or an advocate. If you agree to have another person act on your behalf, you may be asked to sign an authorization form, which gives your county permission to release information to that person.
- Make sure the approved person deciding on the grievance is qualified to make decisions and has not been a part of any previous level of review or decision-making.
- Determine the duties of your county, provider, and yourself.
- Make sure the results of the grievance are provided within the required timeline.

When Can I File a Grievance?

You can file a grievance at any time if you are unhappy with the care you have received or have another concern regarding your county.

How Can I File a Grievance?

You may call your county's 24/7 toll-free Access Line at any time or call the Drug Medi-Cal county phone number within the hours of operation to receive assistance with a grievance. Oral or written grievances can be filed. Oral grievances do not have to be followed up in writing. If you file your grievance in writing, please note the following: Your county supplies self-addressed envelopes at all provider sites. If you do not have a

self-addressed envelope, mail your written grievances to the address provided on the front of this handbook.

How Do I Know If the County Received My Grievance?

Your county is required to provide you with a written letter to let you know your grievance has been received within five calendar days of receipt. A grievance received over the phone or in person, that you agree is resolved by the end of the next business day, is exempt and you may not get a letter.

When Will My Grievance Be Decided?

A decision about your grievance must be made by your county within 30 calendar days from the date your grievance was filed.

How Do I Know If the County Has Made a Decision About My Grievance?

When a decision has been made about your grievance, the county will:

- Send you or your approved person a written notice of the decision;
- Send you or your approved person a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing if the county does not notify you of the grievance decision on time;
- Advise you of your right to request a State Fair Hearing.

You may not get a written notice of the decision if your grievance was filed by phone or in person and you agree your issue has been resolved by the end of the next business day from the date of filing.

Note: Your county is required to provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires. You may call the county for more information if you do not receive a Notice of Adverse Benefit Determination.

Is There a Deadline to File a Grievance?

No, you may file a grievance at any time.

Appeals

You may file an appeal when you do not agree with the county's decision for the behavioral health services you are currently receiving or would like to receive. You may request a review of the county's decision by using:

- The Standard Appeal Process.

OR

- The Expedited Appeal Process.

Note: The two types of appeals are similar; however, there are specific requirements to qualify for an expedited appeal (see below for the requirements).

The county shall assist you in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying you of the location of the form on their website or providing you with the form upon your request. The county shall also advise and assist you in requesting continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations.

What Does the Standard Appeal Process Do?

The Standard Appeal Process will:

- Allow you to file an appeal orally or in writing.
- Make sure filing an appeal will not cause you to lose your rights or services or be held against your provider in any way.
- Allow you to authorize another person (including a provider or advocate) to act on your behalf. Please note: If you authorize another person to act on your behalf, the county might ask you to sign a form authorizing the county to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe. Please note: This is 10 days from the date your Notice of Adverse Benefit Determination was mailed or personally given to you.
- Make sure you do not pay for continued services while the appeal is pending and if the final decision of the appeal is in favor of the county's adverse benefit determination.
- Make sure the decision-makers for your appeal are qualified and not involved in any previous level of review or decision-making.

- Allow you or your approved person to review your case file, including medical records and other relevant documents.
- Allow you to have a reasonable opportunity to present evidence, testimony, and arguments in person or in writing.
- Allow you, your approved person, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Give you written confirmation from your county that your appeal is under review.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File an Appeal?

You can file an appeal with your county when:

- The county or the contracted provider determines that you do not meet the access criteria for behavioral health services.
- Your healthcare provider recommends a behavioral health service for you and requests approval from your county, but the county denies the request or alters the type or frequency of service.
- Your provider requests approval from the county, but the county requires more information and does not complete the approval process on time.
- Your county does not provide services based on its predetermined timelines.
- You feel that the county is not meeting your needs on time.
- Your grievance, appeal, or expedited appeal was not resolved in time.
- You and your provider disagree on the necessary behavioral health services.

How Can I File an Appeal?

- You may file an appeal via one of the following three methods:
    - Call your county's toll-free phone number or Drug Medi-Cal county's phone number within the hours of operation listed on the cover of this handbook. After calling, you will have to file a subsequent written appeal as well; or
    - Mail your appeal (The county will provide self-addressed envelopes at all provider sites for you to mail in your appeal). Note: If you do not have a

self-addressed envelope, you may mail your appeal directly to the address in the front of this handbook; or

- Submit your appeal by e-mail or fax. Refer to the “Additional Information About Your County” section located at the end of this handbook for more information.

How Do I Know If My Appeal Has Been Decided?

You or your approved person will receive written notification from your county of the decision on your appeal. The notification will include the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved in your favor, the notice will provide information regarding your right to a State Fair Hearing and how to request a State Fair Hearing.

Is There a Deadline to File an Appeal?

You must file an appeal within 60 calendar days of the date on the Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination, so you may file this type of appeal at any time.

When Will a Decision Be Made About My Appeal?

The county must decide on your appeal within 30 calendar days of receiving your request.

What If I Can’t Wait 30 Days for My Appeal Decision?

If the appeal meets the criteria for the expedited appeal process, it may be completed more quickly.

What Is an Expedited Appeal?

An expedited appeal follows a similar process to the standard appeal but is quicker. Here is additional information regarding expedited appeals:

- You must show that waiting for a standard appeal could make your behavioral health condition worse.

- The expedited appeal process follows different deadlines than the standard appeal.
- The county has 72 hours to review expedited appeals.
- You can make a verbal request for an expedited appeal.
- You do not have to put your expedited appeal request in writing.

When Can I File an Expedited Appeal?

If waiting up to 30 days for a standard appeal decision will jeopardize your life, health, or ability to attain, maintain or regain maximum function, you may request an expedited resolution of an appeal.

Additional Information Regarding Expedited Appeals:

- If your appeal meets the requirements for an expedited appeal, the county will resolve it within 72 hours of receiving it.
- If the county determines that your appeal does not meet the criteria for an expedited appeal, they are required to provide you with timely verbal notification and will provide you with written notice within two calendar days, explaining the reason for their decision. Your appeal will then follow the standard appeal timeframes outlined earlier in this section.
- If you disagree with the county's decision that your appeal does not meet the criteria for expedited appeal, you may file a grievance.
- After your county resolves your request for an expedited appeal, you and all affected parties will be notified both orally and in writing.

State Fair Hearings

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by an administrative law judge from the California Department of Social Services (CDSS) to ensure you receive the behavioral health services that you are entitled to under the Medi-Cal program.
Please visit the California Department of Social Services website https://www.cdss.ca.gov/hearing-requests for additional resources.

What Are My State Fair Hearing Rights?

You have the right to:

- Request a hearing before an administrative law judge, also known as a State Fair Hearing, to address your case.
- Learn how to request a State Fair Hearing.
- Learn about the regulations that dictate how representation works during the State Fair Hearing.
- Request to have your benefits continue during the State Fair Hearing process if you request for a State Fair Hearing within the required timeframes.
- Not pay for continued services while the State Fair Hearing is pending and if the final decision is in favor of the county's adverse benefit determination.

When Can I File for a State Fair Hearing?

You can file for a State Fair Hearing if:

- You filed an appeal and received an appeal resolution letter telling you that your county denied your appeal request.
- Your grievance, appeal, or expedited appeal wasn't resolved in time.

How Do I Request a State Fair Hearing?

You can request a State Fair Hearing:

- Online: at the Department of Social Services Appeals Case Management website: https://acms.dss.ca.gov/acms/login.request.do
- In Writing: Submit your request to the county welfare department at the address shown on the Notice of Adverse Benefit Determination, or mail it to:
  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430
- By Fax: 916-651-5210 or 916-651-2789

You can also request a State Fair Hearing or an expedited State Fair Hearing:

- By Phone:
    - *State Hearings Division*, toll-free, at **1-800-743-8525** or **1- 855-795-0634**.
    - *Public Inquiry and Response*, toll-free, at **1- 800-952-5253** or TDD at **1-800-952-8349**.

Is There a Deadline to Ask for a State Fair Hearing?

You have 120 days from the date of the county's written appeal decision notice to request a State Fair Hearing. If you didn't receive a Notice of Adverse Benefit Determination, you may file for a State Fair Hearing at any time.

Can I Continue Services While I'm Waiting for a State Fair Hearing Decision?

Yes, if you are currently receiving authorized services and wish to continue receiving the services while you wait for the State Fair Hearing decision, you must request a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you. Alternatively, you can request the hearing before the date your county says that services will be stopped or reduced.

Note:

- When requesting a State Fair Hearing, you must indicate that you wish to continue receiving services during the State Fair Hearing process.
- If you request to continue receiving services and the final decision of the State Fair Hearing confirms the reduction or discontinuation of the service you are receiving, you are not responsible for paying the cost of services provided while the State Fair Hearing was pending.

When Will a Decision Be Made About My State Fair Hearing Decision?

After requesting a State Fair Hearing, it may take up to 90 days to receive a decision.

Can I Get a State Fair Hearing More Quickly?

If you think waiting that long will be harmful to your health, you might be able to get an answer within three working days. You can request for an Expedited State Fair Hearing

by either writing a letter yourself or asking your general practitioner or mental health professional to write a letter for you. The letter must include the following information:

1. Explain in detail how waiting up to 90 days for your case to be decided can seriously harm your life, health, or ability to attain, maintain, or regain maximum function.
2. Ask for an “expedited hearing” and provide the letter with your request for a hearing.

The State Hearings Division of the Department of Social Services will review your request for an expedited State Fair Hearing and determine if it meets the criteria. If your request is approved, a hearing will be scheduled, and a decision will be made within three working days from the date the State Hearings Division receives your request.

ADVANCE DIRECTIVE

What is an Advance Directive?

You have the right to an advance directive. An advance directive is a written document about your health care that is recognized under California law. You may sometimes hear an advance directive described as a living will or durable power of attorney. It includes information about how you would like health care provided or says what decisions you would like to be made, if or when you are unable to speak for yourself. This may include such things as the right to accept or refuse medical treatment, surgery, or make other health care choices. In California, an advance directive consists of two parts:

- Your appointment of an agent (a person) making decisions about your health care; and
- Your individual health care instructions.

Your county is required to have an advance directive program in place. Your county is required to provide written information on the advance directive policies and explain the state law if asked for the information. If you would like to request the information, you should call the telephone number on the cover of this handbook for more information.

You may get a form for an advance directive from your county or online. In California, you have the right to provide advance directive instructions to all of your healthcare providers. You also have the right to change or cancel your advance directive at any time.

If you have a question about California law regarding advance directive requirements, you may send a letter to:

California Department of Justice
Attn: Public Inquiry Unit
P. O. Box 944255
Sacramento, CA 94244-2550

RIGHTS AND RESPONSIBILITIES

County Responsibilities

What is my County Responsible for?

Your county is responsible for the following:

- Figuring out if you meet the criteria to access behavioral health services from the county or its provider network.
- Providing a screening or an assessment to determine whether you need behavioral health services.
- Providing a toll-free phone number that is answered 24 hours a day, seven days a week, that can tell you how to get mental health services. The telephone number is listed on the cover of this handbook.
- Making sure there are sufficient mental health providers nearby so that you can access the services covered by your county when necessary.
- Informing and educating you about services available from your county.

- Providing services in your language at no cost to you, and if needed, providing an interpreter for you free of charge.
- Providing you with written information about what is available to you in other languages or alternative forms like Braille or large-size print. Refer to the "Additional Information About Your County" section located at the end of this handbook for more information.
- Informing you about any significant changes in the information mentioned in this handbook at least 30 days before the changes take effect. A change is considered significant when there is an increase or decrease in the quantity or types of services offered, if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits you receive from the county.
- Making sure to connect your healthcare with any other plans or systems that may be necessary to help transition your care smoothly. This includes ensuring that any referrals for specialists or other providers are properly followed up on and that the new provider is willing to take care of you. (This responsibility is specific to mental health services only)
- Making sure you can keep seeing your current healthcare provider, even if they are not in your network, for a certain amount of time. This is important if switching providers would harm your health or raise the chance of needing to go to the hospital. (This responsibility is specific to mental health services only)

Is Transportation Available?

If you struggle to attend your medical or behavioral health appointments, the Medi-Cal program helps in arranging transportation for you. Transportation must be provided for Medi-Cal members who are unable to provide transportation on their own and who have a medical necessity to receive Medi-Cal covered services. There are two types of transportation for appointments:

- Non-Medical: transportation by private or public vehicle for people who do not have another way to get to their appointment.
- Non-Emergency Medical: transportation by ambulance, wheelchair van, or litter

van for those who cannot use public or private transportation.

Transportation is available for trips to the pharmacy or to pick up needed medical supplies, prosthetics, orthotics, and other equipment.

If you have Medi-Cal but are not enrolled in a managed care plan, and you need non-medical transportation to a health-related service, you can contact the non-medical transportation provider directly or your provider for assistance. When you contact the transportation company, they will ask for information about your appointment date and time.

If you need non-emergency medical transportation, your provider can prescribe non-emergency medical transportation and put you in touch with a transportation provider to coordinate your ride to and from your appointment(s).

For more information and assistance regarding transportation, contact your managed care plan.

Member Rights

What Are My Rights as a Recipient of Medi-Cal Behavioral Health Services?

As a Medi-Cal member, you have the right to receive medically necessary behavioral health services from your county. When accessing behavioral health services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Get clear and understandable explanations of available treatment options.
- Participate in decisions related to your behavioral health care. This includes the right to refuse any treatment that you do not wish to receive.
- Get this handbook to learn about county services, county obligations, and your rights.
- Ask for a copy of your medical records and request changes, if necessary.
- Be free from any form of restraint or seclusion that is imposed as a means of coercion, discipline, convenience, or retaliation.

- Receive timely access to care 24/7 for emergency, urgent, or crisis conditions when medically necessary.
- Upon request, receive written materials in alternative formats such as Braille, large-size print, and audio format in a timely manner.
- Receive behavioral health services from the county that follows its state contract for availability, capacity, coordination, coverage, and authorization of care. The county is required to:
    - Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible members who qualify for behavioral health services can receive them in a timely manner.
    - Cover medically necessary services for you in a timely manner. In addition, the mental health plan must cover medically necessary services out-of-network for you in a timely manner, if the mental health plan does not have an employee or contract provider who can deliver the services. **Note:** The county must make sure you do not pay anything extra for seeing an out-of-network provider. See below for more information:
        - *Medically necessary behavioral health services* for individuals 21 years of age or older are services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Medically necessary behavioral health services for individuals under 21 years of age are services that sustain, support, improve, or make more tolerable a behavioral health condition.
        - *Out-of-network provider* is a provider who is not on the county's list of providers.
    - Upon your request, provide a second opinion from a qualified health care professional within or outside of the network at no extra cost.
    - Make sure providers are trained to deliver the behavioral health services that the providers agree to cover.
    - Make sure that the county's covered behavioral health services are enough in amount, length of time, and scope to meet the needs of Medi-Cal-eligible members. This includes making sure that the county's method for approving payment for services is based on medical necessity and that

the access criteria is fairly used.
    - Make sure that its providers conduct thorough assessments and collaborate with you to establish treatment goals.
    - Coordinate the services it provides with services being provided to you through a managed care plan or with your primary care provider, if necessary. (This requirement is specific to mental health services only)
    - Participate in the state's efforts to provide culturally competent services to all, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- Express your rights without harmful changes to your treatment.
- Receive treatment and services in accordance with your rights described in this handbook and with all applicable federal and state laws such as:
    - Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
    - The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
    - The Rehabilitation Act of 1973.
    - Title IX of the Education Amendments of 1972 (regarding education programs and activities).
    - Titles II and III of the Americans with Disabilities Act.
    - Section 1557 of the Patient Protection and Affordable Care Act.
- You may have additional rights under state laws regarding behavioral health treatment. To contact your county's Patients' Rights Advocate, please contact your county by using the telephone number listed on the cover of the handbook.

Adverse Benefit Determinations

What Rights Do I Have if the County Denies the Services I Want or Think I Need?

If your county denies, limits, reduces, delays, or ends a service you think you need, you have the right to a written notice from the county. This notice is called a "Notice of Adverse Benefit Determination". You also have a right to disagree with the decision by asking for an appeal. The sections below inform you of the Notice of Adverse Benefit Determination and what to do if you disagree with the county’s decision.

What Is an Adverse Benefit Determination?

An Adverse Benefit Determination is defined by any of the following actions taken by the county:

- The denial or limited authorization of a requested service. This includes determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the required timeframes for standard resolution of grievances and appeals. Required timeframes are as follows:
    - If you file a grievance with the county and the county does not get back to you with a written decision on your grievance within 30 days.
    - If you file an appeal with the county and the county does not get back to you with a written decision on your appeal within 30 days.
    - If you filed an expedited appeal and did not receive a response within 72 hours.
- The denial of a member's request to dispute financial liability.

What Is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination is a written letter that your county will send you if it decides to deny, limit, reduce, delay, or end services you and your provider believe you should get. This includes denial of:

- A payment for a service.
- Claims for services that are not covered.
- Claims for services that are not medically necessary.
- Claims for services from the wrong delivery system.
- A request to dispute financial liability.

Note: A Notice of Adverse Benefit Determination is also used to tell you if your grievance, appeal, or expedited appeal was not resolved in time, or if you did not get services within the county's timeline standards for providing services.

Timing of the Notice

The county must mail the notice:

- To the member at least 10 days before the date of action for termination, suspension, or reduction of a previously authorized behavioral health service.
- To the member within two business days of the decision for denial of payment or decisions resulting in denial, delay, or modification of all or part of the requested behavioral health services.

Will I Always Get A Notice Of Adverse Benefit Determination When I Don't Get The Services I Want?

Yes, you should receive a Notice of Adverse Benefit Determination. If you do not receive a notice, you may file an appeal with the county or if you have completed the appeal process, you can request a State Fair Hearing. When you contact your county, indicate you experienced an adverse benefit determination but did not receive a notice. Information on how to file an appeal or request a State Fair Hearing is included in this handbook and should also be available in your provider's office.

What Will the Notice of Adverse Benefit Determination Tell Me?

The Notice of Adverse Benefit Determination will tell you:

- What your county did that affects you and your ability to get services.
- The date the decision will take effect and the reason for the decision.
- The state or federal rules the decision was based on.
- Your rights to file an appeal if you do not agree with the county's decision.
- How to receive copies of the documents, records, and other information related to the county's decision.
- How to file an appeal with the county.
- How to request a State Fair Hearing if you are not satisfied with the county's decision on your appeal.
- How to request an expedited appeal or an expedited State Fair Hearing.
- How to get help filing an appeal or requesting a State Fair Hearing.
- How long you have to file an appeal or request a State Fair Hearing.
- Your right to continue to receive services while you wait for an appeal or State

Fair Hearing decision, how to request continuation of these services, and whether the costs of these services will be covered by Medi-Cal.
- When you have to file your appeal or State Fair Hearing request by if you want the services to continue.

What Should I Do When I Get a Notice of Adverse Benefit Determination?

When you get a Notice of Adverse Benefit Determination, you should read all the information in the notice carefully. If you don't understand the notice, your county can help you. You may also ask another person to help you.

You can request a continuation of the service that has been discontinued when you submit an appeal or request for a State Fair Hearing. You must request the continuation of services no later than 10 calendar days after the date the Notice of Adverse Benefit Determination was post-marked or delivered to you, or before the effective date of the change.

Member Responsibilities

What are my responsibilities as a Medi-Cal member?

It is important that you understand how the county services work so you can get the care you need. It is also important to:

- Attend your treatment as scheduled. You will have the best result if you work with your provider to develop goals for your treatment and follow those goals. If you do need to miss an appointment, call your provider at least 24 hours in advance, and reschedule for another day and time.
- Always carry your Medi-Cal Benefits Identification Card (BIC) and a photo ID when you attend treatment.
- Let your provider know if you need an oral interpreter before your appointment.
- Tell your provider all your medical concerns. The more complete information that you share about your needs, the more successful your treatment will be.
- Make sure to ask your provider any questions that you have. It is very important you completely understand the information that you receive during treatment.

- Follow through on the planned action steps you and your provider have agreed upon.
- Contact the county if you have any questions about your services or if you have any problems with your provider that you are unable to resolve.
- Tell your provider and the county if you have any changes to your personal information. This includes your address, phone number, and any other medical information that may affect your ability to participate in treatment.
- Treat the staff who provide your treatment with respect and courtesy.
- If you suspect fraud or wrongdoing, report it:
    - The Department of Health Care Services asks that anyone suspecting Medi-Cal fraud, waste, or abuse to call the DHCS Medi-Cal Fraud Hotline at **1-800-822-6222**. If you feel this is an emergency, please call **911** for immediate assistance. The call is free, and the caller may remain anonymous.
    - You may also report suspected fraud or abuse by e-mail to fraud@dhcs.ca.gov or use the online form at http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

Do I Have To Pay For Medi-Cal?

Most people in Medi-Cal do not have to pay anything for medical or behavioral health services. In some cases, you may have to pay for medical and/or behavioral health services based on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for medical or behavioral health services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or behavioral health services. The amount that you pay is called your ‘share of cost’. Once you have paid your ‘share of cost,’ Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don’t have medical expenses, you don’t have to pay anything.
- You may have to pay a ‘co-payment’ for any treatment under Medi-Cal. This means you pay an out-of-pocket amount each time you get a medical service or go to a hospital emergency room for your regular services.
- Your provider will tell you if you need to make a co-payment.

NONDISCRIMINATION NOTICE

Discrimination is against the law. TCHSA follows State and Federal civil rights laws. *[Partner Entity]* does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

[Partner Entity] provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio or accessible electronic formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact TCHSA-BH by calling 1-800-240-3208. Or, if you cannot hear or speak well, please call TTY: 711. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that TCHSA has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Quality Assurance Mananger. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact TCHSA Quality Assurance Manager between 8:00 AM and 5:00 PM by calling *(530) 527-8491.* Or, if you cannot hear or speak well, please call *TTY: 711*.

- In writing: Fill out a complaint form or write a letter and send it to:

Quality Assurance Manager, PO Box 400, Red Bluff, CA 96080.

- In person: Visit your doctor's office or TCHSA *Facility* and say you want to file a grievance.

- Electronically: Visit TCHSA website at:

  https://www.tehamacohealthservices.net/administration/quality-assurance/

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.

- In writing: Fill out a complaint form or send a letter to:

  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at:
  https://www.dhcs.ca.gov/discrimination-grievance-procedures

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call

TTY/TDD 1-800-537-7697.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

- Complaint forms are available at

  http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf