SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

524

FROM: Department of Mental Health

SUBMITTAL DATE: May 7, 2014

SUBJECT: Accept the Mental Health Triage Grant Award Number 13MHSOAC-T007 from the Mental Health Services Oversight and Accountability Commission (MHSOAC). (District: All) $7,441,142 [ongoing]. State and Amend Ordinance No. 440 pursuant to Resolution No. 440-8964.

RECOMMENDED MOTION: That the Board of Supervisors:

1. Accept the Mental Health Triage Program Grant Award in the amount of $7,441,142 from MHSOAC;
2. Ratify the attached grant standard agreement with MHSOAC (13MHSOAC-T007) to employ personnel to provide intensive crisis intervention services for the period of March 24, 2014 - June 30, 2017;
3. Authorize the Riverside County Director of Mental Health to sign the MHSOAC grant standard agreement and subsequent annual renewals in accordance with Riverside County Board of Supervisors Policy A-30; and
4. Approve the addition of positions as listed in Attachment A in accordance with Riverside County Board of Supervisors Policy C-19 and Salary Ordinance No. 440, Section 4(a)(ii), and amend Salary Ordinance No. 440.pursuant to Resolution No. 440-8964.

(Continued on page 2)

JW:KAS

Jerry Wengerd, Director
Department of Mental Health

Approved by Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FORM APPROVED COUNTY COUNSEL
BY: ELENA M. BOEVA 4-25-14

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 488,257	$ 2,134,233	$ 7,441,142	$	Consent ☐ Policy ☑
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: State 100%

Budget Adjustment: NO

For Fiscal Year: 2013/14-2016/17

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature

BY: Jennifer L. Sargent

MINUTES OF THE BOARD OF SUPERVISORS

☐ Positions Added ☐ Change Order ☑ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.:	District: All	Agenda Number:

3-26

BACKGROUND:
Summary

As a result of Senate Bill (SB) 82, known as the Investment in Mental Health Wellness Act of 2013, California has an opportunity to use Mental Health Services Act (MHSA) dollars to expand crisis services statewide that are expected to lead to improved life outcomes for the persons served and improved system outcomes for the Department of Mental Health (DMH) and its community partners. Among the objectives cited in the Mental Health Wellness Act of 2013 is to "expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs." This objective is consistent with the vision and focus for services identified in the MHSA. Improving the client experience, with a focus on recovery and resiliency in a way that will reduce costs, is the very essence of the MHSA.

With MHSA funding, the Mental Health Wellness Act of 2013 is intended to increase California's capacity for client assistance and services in crisis intervention including the availability of crisis triage personnel, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams.

This grant as administered by the MHSOAC provides funding for counties, counties acting jointly and city mental health departments, to hire at least 600 triage personnel statewide to provide intensive case management, which may include Medi-Cal reimbursable targeted case management, and linkage to services for individuals with mental illness or emotional disorders who require crisis interventions. Increasing access to effective outpatient and crisis services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals experiencing a mental health crisis in the least restrictive manner possible.

On December 23, 2013, DMH submitted a grant application to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the Mental Health Triage Program grant.

As a result of this application, the DMH was awarded $7,441,142 in State Funds from MHSOAC. The official grant award agreement was received on March 27, 2014. Under this grant, the DMH will hire mental health personnel to respond to medical emergency departments throughout the county, seven (7) days a week to assist individuals who present with a mental health crisis. The program staff will include clinical therapists and peer support who will provide on-site crisis and support services. These services will focus on linking the individual and/or their family with community based voluntary crisis support as an alternative to inpatient treatment.

The period of performance for this grant is March 24, 2014 through June 30, 2017.

Therefore, the DMH is requesting that the Board of Supervisors accept the Mental Health Triage Program Grant Award in the amount of $7,441,142 from MHSOAC; Approve the addition of positions as listed in Attachment A in accordance with Riverside County Board of Supervisors Policy C-19 and Salary Ordinance No. 440, Section 4(a) (ii), amend Salary Ordinance No. 440; and Authorize the Riverside County Director of Mental Health to sign the MHSOAC grant agreement and future MHSOAC grant award renewals and amendments in accordance with Riverside County Board of Supervisors Policy A-30.

Impact on Citizens and Businesses
These services are a component of the Department's system of care aimed at improving the health and safety of consumers and the community. One of the grant outcomes is to ultimately decrease the use of medical emergency departments by individuals experiencing a mental health crisis. The program proposal received broad support from the Hospital Association of Southern California and their affiliate medical inpatient providers throughout the county for its potential to reduce demand and costs.

Additional Fiscal Information

Under this grant award, the DMH will receive $7,441,142 in State Funds. Funding will be utilized to hire mental health personnel as listed in Attachment A to provide a range of services to persons seeking emergency support for a mental health crisis. These positions are anticipated to be continuously funded in the future fiscal year budgets with MHSOAC grant. Due to grant funding restrictions, the Department will have to contribute approximately $365,000 of program cost annually towards the operation of the program. No additional County funds are required.

Contract History and Price Reasonableness

This is the first Mental Health Triage Program Award to DMH. As indicated in the Mental Health Wellness Act of 2013, program personnel will provide field based crisis intervention, peer-to-peer support and targeted case management services face to face and by telephone.

ATTACHMENT A

LIST OF POSITIONS

Job Code	Number of Positions	Class Title	Salary Plan/Grade
13866	1	Office Assistant III	UPE/190
79726	11	Mental Health Peer Specialist/Trainee	UPE/229-331
57745	11	Behavioral Health Specialist II	SEU/223
79742	9	Clinical Therapist II	SEU/502
79717	1	Mental Health Services Supervisor-A	SEU/616
TOTAL	**33**		

C. Ordinance No. 440 - 8964

RESOLUTION NO. 440-8964

BE IT RESOLVED by the Board of Supervisors of the County of Riverside, State of California, in regular session assembled on _____, 2014, that pursuant to Section 4(a)(ii) of Ordinance No. 440, the Mental Health Director is authorized to make the following listed change(s), operative on the date of approval, as follows:

Job Code	+/-	Department ID	Class Title
57745	+11	4100206587	Behavioral Health Specialist II
79742	+ 9	4100206587	Clinical Therapist II
79726	+11	4100206587	Mental Health Peer Specialist
79717	+ 1	4100206587	Mental Health Services Supervisor-A
13865	+ 1	4100206587	Office Assistant II

/kc
05/07/2014
440 Resolutions\KC

STANDARD AGREEMENT
STD 213 (Rev 06/03)

AGREEMENT NUMBER	REGISTRATION NUMBER
13MHSOAC-TG007	

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME
Mental Health Services Oversight and Accountability Commission (MHSOAC)

CONTRACTOR'S NAME
County of Riverside on behalf of Department of Mental Health

2. The term of this Agreement is: March 24, 2014 through June 30, 2017

3. The maximum amount of this Agreement is: **$7,441,142.00**
Seven Million, Four Hundred Forty-One Thousand, One Hundred Forty-Two Dollars and No Cents

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A – Scope of Work	6 pages
Attachment A.1 – Triage Grant Application	10 pages
Attachment A.2 – Annual Fiscal Report Instructions	3 pages
Attachment A.3 – Annual Fiscal Report Form	1 page
Exhibit B – Budget Detail and Payment Provisions	2 pages
Attachment B.1 – Grant Award Claim Form	1 page

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
County of Riverside on behalf of Department of Mental Health

BY *(Authorized Signature)* — DATE SIGNED *(Do not type)*: 4-24-2014

PRINTED NAME AND TITLE OF PERSON SIGNING
Jerry Wengerd, LCSW, Director

ADDRESS
County of Riverside, Department of Mental Health, 3625 14th Street
Riverside, CA 92501

STATE OF CALIFORNIA

AGENCY NAME
Mental Health Services Oversight and Accountability Commission

BY *(Authorized Signature)* — DATE SIGNED *(Do not type)*:

PRINTED NAME AND TITLE OF PERSON SIGNING
Andrea Jackson, Executive Director

ADDRESS
1325 J Street, Suite 1700, Sacramento, CA 95814

California Department of General Services Use Only

☒ Exempt per: Welfare and Institution Code 5897 (e)

APPROVED COUNTY COUNSEL
BY: ELENA M. BOEVA — DATE: 5-8-14

Exhibit A

Scope of Work

1. Riverside County Department of Mental Health, hereafter referred to as Grantee, agrees to hire mental health triage personnel to provide a range of triage services to persons with mental illness requiring crisis intervention. As indicated in the Mental Health Wellness Act of 2013 triage personnel may provide targeted case management services face to face, by telephone, or by tele-health.
2. The project representatives during the term of this agreement will be:

Direct all Triage Grant inquiries to:

State Agency: Mental Health Services Oversight & Accountability Commission	**Contractor:** Riverside County Department of Mental Health
Name: Jose Oseguera, Chief of Plan Review and Committee Operations	**Name:** Maria Marquez, Deputy Director
Phone: (916) 445-8722	**Phone:** (951) 955-1523
Fax: (916) 445-4927	**Fax:** (951) 955-1620
Email: jose.oseguera@mhsoac.ca.gov	**Email:** mimarquez@rcmhd.org

Direct all administrative inquiries to:

State Agency: Mental Health Services Oversight & Accountability Commission	**Contractor:** Riverside County Department of Mental Health
Section/Unit: Administrative Services	**Section/Unit:** MHSOAC Triage Grant Program
Attention: Gina Van Nes	**Attention:** Maria Marquez, Deputy Director
Address: 1325 J Street, Suite 1700 Sacramento, CA 95814	**Address:** 3625 14th Street Riverside, CA 92501
Phone: (916) 445-8798	**Phone:** (951) 955-1523
Fax: (916) 445-4927	**Fax:** (951) 955-1620
Email: gina.vannes@mhsoac.ca.gov	**Email:** mimarquez@rcmhd.org

3. Detailed Scope of Work

A. Introduction

As a result of Senate Bill (SB) 82, known as the Investment in Mental Health Wellness Act of 2013, California has an opportunity to use Mental Health Services

Act (MHSA) dollars to expand crisis services statewide that are expected to lead to improved life outcomes for the persons served and improved system outcomes for mental health and its community partners. Among the objectives cited in the Mental Health Wellness Act of 2013 is to "expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs." This objective is consistent with the vision and focus for services identified in the MHSA. Improving the client experience, with a focus on recovery and resiliency, in a way that will reduce costs, is the very essence of the MHSA.

B. Background

With MHSA funding, the Mental Health Wellness Act of 2013 is intended to increase California's capacity for client assistance and services in crisis intervention including the availability of crisis triage personnel, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. Under the terms of the Mental Health Wellness Act of 2013 there will be two competitive grant opportunities. One grant process will be administered by the California Health Facilities Financing Authority (CHFFA) to fund mobile crisis support teams and crisis stabilization and crisis residential programs. The other grant process, administered by the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission), provides funding for counties, counties acting jointly and city mental health departments, to hire at least 600 triage personnel statewide to provide intensive case management, which may include Medi-Cal reimbursable targeted case management, and linkage to services for individuals with mental illness or emotional disorders who require crisis interventions. Increasing access to effective outpatient and crisis services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals experiencing a mental health crisis in the least restrictive manner possible.

C. SB 82 Triage Personnel Objectives

Among the specific objectives cited in the Mental Health Wellness Act of 2013 are:

i. **Improving the client experience, achieving recovery and wellness, and reducing costs**

The level of engagement between a person experiencing a mental health crisis and persons providing crisis intervention triage services are considered critical to the life outcomes for the individual being served and system outcomes for mental health and its community partners.

Triage personnel funded through these grants should be skilled at engaging persons in crisis in a stabilizing, therapeutic, recovery focused manner. Per SB 82, the Commission shall take into account the use of peer support when selecting grant recipients and determining the amount of grant awards. Having

lived experience with mental illness either as an individual or family member, may be seen as an added qualification for delivering effective service.

ii. **Adding triage personnel at various points of access, such as at designated community-based service points, homeless shelters, and clinics**

The availability of triage personnel at various points of access designated throughout the community throughout the day is essential to both improving the client experience and improving timely access to services.

iii. **Reducing unnecessary hospitalizations and inpatient days**

Reductions in unnecessary hospitalizations are dependent on the availability of programs that serve as alternatives to hospitalization, such as crisis stabilization and crisis residential programs. As mentioned, one resource to expand these services will be available through the grants administered by CHFFA. Because the triage personnel available through the MHSOAC grants are intended to provide immediate, recovery-focused crisis interventions that divert persons from unnecessary hospitalizations to less restrictive treatment settings, they are an essential component for mental health and community crisis response systems.

iv. **Reducing recidivism and mitigating unnecessary expenditures of law enforcement**

To meet both of these objectives requires collaboration with and participation from partner counties, law enforcement, hospitals, local social networks, mental health and substance use non-profits, foundations and providers of service to various racial, ethnic and cultural groups and low-to-moderate income persons, in developing and delivering services in a community-based, mental health crisis response system.

D. Grantee Work Plan

Grantee shall implement the triage program as described in Grantee's Triage Grant Application which is attached to this Exhibit A as "Attachment A.1" and incorporated herein by reference.

E. Grant Cycle

Grants are approved for a grant cycle that covers four fiscal years, with funds allocated annually for Year 1 (5 months), Year 2 (12 months), Year 3 (12 months), and Year 4 (12 months).

If the Grantee does not submit the reports listed below by the reporting deadline the MHSOAC may withhold payments of the funds described in Exhibit B:

i. Process Information Report as described in Section "F. Reports"

ii. Encounter Based Information Report as described in Section "F. Reports"

iii. Evaluation of Program Effectiveness as described in Section "F. Reports"

iv. Annual Fiscal Report as described in Section "F. Reports". Grantee showing unexpended Grant Funds may have equivalent funding withheld from the following year's grant allocation.

F. Reporting and Evaluation

i. Process Information Report

Grantees shall submit a Process Information Report to the MHSOAC as follows:

a) No later than six months (September 30, 2014) following the date of the Triage Grant Award letter to Grantee from the MHSOAC; and

b) No later than twelve months (March 31, 2015) following the date of the Triage Grant Award letter to Grantee from the MHSOAC. If at 12 months all proposed triage personnel are not hired, additional updates will be requested every 6 months until all triage personnel are hired.

The Process Information Report shall include the following information:

a) Number of triage personnel hired by county and/or hired by contractor.

b) Number for each type of triage personnel hired by county and/or hired by contractor (e.g., peers, social workers, nurses, clinicians, mental health workers, etc.) Please identify which personnel are county staff and which are contract staff.

c) Triage service locations/points of access (e.g., hospital emergency rooms, psychiatric hospitals, crisis stabilization programs, homeless shelters, jails, clinics, other community-based service points).

ii. Encounter Based Information Report

Grantee shall submit an Encounter Based Information Report to the MHSOAC as follows:

a) No later than twelve months (March 31, 2015) following the date of the Triage Grant Award letter to Grantee from the MHSOAC; and

b) Every six months thereafter as follows:

- 1st Report: Reporting period is from March 2014 through March 2015 Due on April 30, 2015

- 2nd Report: Reporting period is from April 2015-September 2015
  Due on October 30, 2015
- 3rd Report: Reporting period is from October 2015-March 2016
  Due on April 30, 2016
- 4th Report: Reporting period is from April 2016-September 2016
  Due on October 31, 2016
- 5th Report: Reporting period is from October 2016-March 2017
  Due on April 30, 2017

The Encounter Based Information Report shall include the following information for the reporting period:

a) Total unduplicated persons served.

b) Total number of service contacts.

c) Basic demographic information for each individual client shall include information on age, race, ethnicity, gender. If available, the county shall provide information on language spoken, cultural heritage, LGBTQ, and military status.

d) Description of specific services that each client was referred to by triage personnel.

e) At the time the triage service was provided, was the person served enrolled in any mental health service? If yes, what service?

iii. Evaluation of Program Effectiveness

Grantees shall submit an Evaluation of Program Effectiveness analyzing whether the goals, objectives and outcomes identified in the Grantee's Triage Grant Application have been attained to the MHSOAC as follows:

a) 1st Evaluation report of the program during the 24 months following the date of the Triage Grant Award letter to Grantee from the MHSOAC (March 2014 through March 2016)

- Due no later than June 30, 2016

b) 2nd Evaluation Report of the program during the 36 months following the date of the Triage Grant Award letter to Grantee from the MHSOAC (March 2014 through March 2017)

- Due no later than May 31, 2017

The Evaluation of Program Effectiveness report shall include the following information:

a) Grantee's goals and objectives for increased triage personnel and/or the improved crisis response system.

b) The system indicators, measures, and outcomes that Grantee used to track to document the effectiveness of services.

c) Evaluation analysis and findings about whether specific system and individual outcomes have been attained.

iv. Annual Fiscal Report

Grantee shall submit an Annual Fiscal Report to the MHSOAC by no later than April 30th of each fiscal year. The Annual Fiscal Report shall be certified by the mental health director and the county's auditor-controller as being true and correct. The Annual Fiscal Report form is "Attachment A.3" to this Exhibit A. The Annual Fiscal Report Instructions is "Attachment A.2" of this Exhibit A.

G. Allowable Costs

Grant funds must be used as proposed in the grant application approved by the MHSOAC as follows:

a) Allowable costs include triage personnel, evaluation, direct costs, indirect costs, and county administration. The sum of the direct costs, indirect costs and county administration per year shall not exceed 15 percent of the total budget.

b) Grant funds may be used to supplement existing programs but may not be used to supplant existing funds for mental health triage personnel available for crisis services.

c) Grant funds cannot be transferred to any other program account for specific purposes other than the stated purpose of this grant.

H. Amendments

This contract may be amended upon mutual consent of the parties. All amendments must be in writing and fully executed by authorized representatives of each party.

1. *Crisis Response System and Needs*

a. Describe your current array of crisis response services. Include programs that offer alternatives to hospitalization, including crisis stabilization and crisis residential programs.

Riverside County Department of Mental Health (RCDMH) does not currently have field based triage personnel in our system of care. There is one (1) full time clinical therapist position assigned to, and located at, City of Riverside Police Department (RPD). This position is dispatched by RPD to assist patrol officers response to 911 calls that appear to involve a mental health crisis. The role of this clinician is to provide crisis intervention, linkage and follow-up to calls in order to prevent repeated law enforcement response. Individuals in crisis typically present at, or are transported by law enforcement to medical emergency departments throughout the county or one of two LPS designated locked crisis stabilization units (CSUs). The CSUs are geographically distant from each other with one in Riverside (10 beds) and the other in the eastern portion of Coachella Valley Desert Region in Indio (12 beds). Individuals also present at traditional outpatient clinics. In addition to the two CSUs, RCDMH uses a contract provider to operate two crisis residential programs, one in Riverside (15 beds) and the other in Indio (15 beds). RCDMH provides two contract operated peer-to-peer 24/7 Drop-In Centers for homeless persons with mental illness, one is located in Palm Springs, the other in Riverside. These programs are engagement portals of entry to Full Service Partnership (FSP) programs. The local Adult FSP provides 24/7 response to crisis events at the drop-in center in Riverside.

RCDMH has also entered into an agreement with Riverside County Department of Public Social Services (DPSS) to provide crisis services to CalWORKS recipients involved in domestic violence as well as families in mental health crisis. These services are provided at 11 DPSS locations throughout the county.

b. Describe the need for mental health crisis triage personnel

There is a great need to introduce triage personnel at points of service access throughout the system of care. A recent Emergency Medical Services (EMS) study released in October 2013 and conducted by The Abaris Group[1] for the County of Riverside identified only 191 psychiatric beds (93 designated and 98 undesignated beds) in the county. As a result, many psychiatric emergencies are taken to local hospital medical emergency departments (EDs) who experience long delays in accessing psychiatric inpatient beds (as of 12/17/13 there are 130 designated beds and 58 undesignated beds). The Abaris report also found that in 2011 there were 11,930 psychiatric related discharges from emergency departments, 90% were residents of Riverside County. Ambulance transport data revealed that there were 11,263 5150 transports in 2012, with approximately 5081 in Western region, 3749 in the Desert region and 2429 in the Mid-County region, available data does not include 5150 transports by local law enforcement. Individuals may remain in EDs for periods longer than 24 hours while the facility attempts to link the individual to an available psychiatric inpatient facility bed. Due to the severe limitations of designated psychiatric beds within Riverside County (137 beds), individuals are routinely diverted to out-of-county designated facilities.

[1] *County of Riverside EMS Evaluation Report, Sept. 2013; The Abaris Group; pp 43-47*

RCDMH believes there is a critical need to provide non-hospital based crisis supports to both divert individuals from acute inpatient care and to avoid out of county services whenever possible. In response to this need RCDMH began expanding community-based crisis services by investing in the establishment of three contract operated peer-to-peer voluntary 23-hour crisis stabilization units. Each of the three County service regions will have a voluntary, recovery based crisis service as an accessible consumer-driven alternative to locked or involuntary crisis services. These voluntary CSUs are in the contract provider selection phase. In addition, RCDMH is applying for SB82 funds to both a new facility for the voluntary CSU program as well as a 15 bed peer-to-peer crisis residential treatment facility. The facilities will be co-located on a crisis support center campus in Riverside.

This proposal will further expand community based crisis services by introducing a diversion focused crisis response system of care. RCDMH proposes to add regionally based triage personnel that will respond to local medical emergency departments with the focus on linking individuals in mental health crisis to a crisis stabilization network of care. Emergency room response will be available seven (7) days a week, 10 hours a day. The triage personnel will provide crisis intervention and linkage to alternative crisis support services to reduce extended emergency department stays or admission to inpatient psychiatric facilities.

i. *Where triage staff are needed to fill gaps and link persons to services:*
   a. Triage personnel are needed in each of the three service regions. A RCDMH employed triage response team consisting of a Clinical Therapist (CT) and Mental Health Peer Support Specialist (MHPSS), consumer or family member, will be assigned to respond to local EDs in each service region.

Desert Region	Mid-County Region	Western Region
Eisenhower Med Ctr	Hemet Valley Med Ctr	Kaiser Riverside
Desert Regional	Menifee Valley Med Ctr	Kaiser-Moreno Valley
San Gorgornio Hosp.	Inland Valley Reg. Med.	Riverside Community
JFK Memorial	Rancho Springs	Parkview Hospital
	Loma Linda- Menifee	Corona Regional Med. Ctr.
	Temecula Valley	RCRMC – ETS

   b. A RCDMH employed triage response team will be assigned to Riverside County Regional Medical Center (RCRMC) Emergency Treatment Services (ETS), one of the two LPS designated CSUs and the primary recipient of current crisis requests. Due to the high volume and primary emergency access function of this program, the RCRMC-ETS triage response team will included a clinical therapist, behavioral health specialist, consumer peer specialist and family peer specialist. Focus will be on collaborating with RCRMC staff to assess for diversion to voluntary crisis supports, engaging and linking individuals and their families to crisis and non-crisis support resources, peer and family supports, and follow-up contacts to encourage and support successful engagement in non-hospital based services.
   c. RCDMH employed triage response teams will be assigned to respond to community based locations where individuals present in crisis (e.g. shelters,

community health centers) and to provide adjunctive support to regionally based teams (additional coverage for periods of high demand, coverage for absences [sick, vacation, training/support]). Their function will be the same as ED and RCRMC-ETS teams but will have more flexibility to respond to non-hospital based point of access programs.

d. A RCDMH employed Behavioral Health Specialist II will be assigned to each of the new Peer CSUs to provide short term intensive case management linkage and follow-up for persons served and linked to follow-up recovery services (e.g. FSPs, Recovery Learning Center, outpatient services, community resources, etc.)
e. A central Dispatch and Coordination Center will be established to house four (4) RCDMH employed Behavioral Health Specialist II (BHS II). The BHS IIs will be responsible for answering the 800 central response line, notifying and dispatching crisis response triage team members. Additionally, they will provide follow-up monitoring of post crisis linkage effectiveness and consumer progress. The Dispatch and Coordination Center will also house the program supervisor and office support.

ii. The numbers of triage personnel required by type of position:

Class	Desert	Mid-County	Western	Centralized	TOTAL
MH Serv. Sup				1.0	**1.0**
Clinical Therapist	2	2	5		**9.0**
BHS II	2	2	3	4.0	**11.0**
MH Peer Support Spec	3	3	5		**8.0**
Office Assist III				1.0	**1.0**

iii. Racial, ethnic and cultural groups targeted for service:

According to the State and County Population Projections by Race/Ethnicity, Detailed Age and Gender[2] Riverside County's population is 39.4% Caucasian, 6.2% Black, 6.1% Asian/Pacific Islander, 45.7% Hispanic, and .5% Native American. In FY12-13 of the consumers served by RCDMH 29.7% were Caucasian, 10.2% were Black, 1.4% were Asian/Pacific Islander, 32.9% were Hispanic in origin, and.3% were Native American. It is RCDMH's practice to recruit bilingual and bicultural staff for every program. This will be a priority for new field based Triage Response teams. In addition to hiring Spanish speaking staff, RCDMH will seek to ensure that Triage response personnel reflect the ethnic and cultural heritage of the communities served. RCDMH continues to outreach to underserved cultural and ethnic populations, including the LGBTQ and Deaf communities of Riverside. The Cultural Competency Program will be consulted to assist the Department to identify potential access barriers and to develop plans to overcome any access/utilization barriers for the communities served.

iv. Estimate of persons in crisis served in each year of the grant -

[2] *State of California Department of Finance Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age and Gender, 2010-2060; Sacramento California January 2013. Retrieved from www.dof.ca.gov/research/demographic/reports/projections/P-3*

The Abaris Group report indicated there were 11,930 psychiatric emergency department discharges in 2012. During FY 12-13 RCRMC ETS had 14,677 admissions. Combined, 26,607 individuals were served via local hospital emergency departments and/or RCRMC ETS. The need to respond to several regional hospitals during a single work shift will impact the number of persons that are able to be served by each regional team. Therefore, based on 10 hour a day x 7 days a week coverage, RCDMH is projecting that a triage response team will be able to encounter approximately 25% to 33% of those persons presenting at emergency departments and RCRMC ETS. RCDMH is projecting that 6,650 to 8,780 individuals will be served by triage response personnel each year. It is anticipated that the team stationed at RCRMC ETS full time will be able to serve more persons each day than regionally based teams. It is anticipated that during the first year less individuals will be served (est. 5,000) due to start-up, recruitment, training and orientation. The second year goal has been set to serve a minimum of 6,650 and the third year to serve 8,780.

2. ***Collaboration***

RCDMH has historically collaborated with the Hospital Association of Southern California (HASC) Inland Empire and participated in the HASC Behavioral Health Committee. RCDMH has also actively collaborated with local law enforcement, providing comprehensive Crisis Intervention Training (CIT) to 100% of the City of Riverside's Police Department (RPD) and provided a full time clinical therapist to provide supportive response to RPD officers in the field. RCDMH collaborates with Riverside County Sheriff's Department to provide comprehensive CIT at the Sheriff's Academy twice a year. Law enforcement personnel from multiple jurisdictions attend this training. In developing the proposed programs, RCDMH is actively consulting with HASC, area hospitals and various law enforcement jurisdictions during program development and has committed to facilitating a regular ongoing work group with HASC and affiliate hospitals during program start-up and implementation. Working with Inland Empire HASC, RCDMH met with Western Region area hospitals on 11/12/13, with Mid-County area hospitals on 11/15/13, and Desert Region hospitals on 11/18/13. Hospitals that participated in the meetings included CEO/COOs, Behavioral Health and Emergency Room Directors from Kaiser Permanente, Riverside Community, Parkview Medical Center, Loma Linda Medical Center - Murrieta, Corona Regional, Moreno Valley Medical Center, Hemet Valley Medical Center, Rancho Springs Medical Center, Inland Valley Medical Center, Desert Regional Medical Center, JFK Medical Center, Eisenhower Medical Center, San Gorgonio Memorial, the Vice President of HASC and RCDMH. At each meeting RCDMH presented the assessment of need, goals of the programs, and proposed strategies to address the need. Information shared included the expansion of crisis support through voluntary peer crisis stabilization programs as well as the intent to apply for funds to build both crisis stabilization and crisis residential treatment facilities as well as funding for mobile response teams to assist law enforcement in the field. Letters of support are provided in Attachment D.

The hospitals all provided strong support for the proposed triage response plan. They provided feedback regarding ideal staff skills and abilities as well as preferred hours of coverage. They stated that the development of crisis stabilization and crisis residential expansion were critical to any effort to divert persons from emergency

rooms. They welcomed the strategy to work with law enforcement, stating that many of the individuals brought in by law enforcement were placed on unnecessary involuntary holds. Each facility expressed an interest in working with RCDMH during start-up and implementation to develop protocols and to refine protocols once the program becomes operational. HASC committed to promoting ongoing collaboration using the HASC Behavioral Health Committee as an information/problem solving clearing house forum once the program is fully operational.

RCDMH also works very closely with RCRMC – ETS in the provision of crisis stabilization services. Prior to the release of this grant, RCDMH and RCRMC had identified a need to triage persons presenting for care at RCRMC – ETS and the Inpatient Treatment Facility (ITF). The goal of would be to identify persons served that could better served by non-hospital based services. This would include diverting individuals from ETS prior to admission to the ITF as well as identifying individuals in the ITF that could be discharged earlier if they had access to appropriate community support (e.g. crisis residential treatment, peer support, etc.). In an effort to begin to address this need, RCDMH has already funded one full time Clinical Therapist to RCRMC ETS/ITF. Through the use of funds available from this grant RCDMH is proposing to expand the number of staff and enhance the team to insure that peer support and case management are included in the diversion effort.

3. ***Program Operations***
   a. *Activities to be performed by triage personnel, including targeted case management.*
      i. *Communication, coordination and referrals*

Triage workers will receive broad orientation and training in the RCDMH system of care so that they are knowledgeable in the full array of services available, eligibility requirements and referral processes. They will be provided with key contact persons that can assist to resolve any access barriers. With the advent of RCDMH's electronic health record (Electronic Management Record or ELMR), triage workers will be equipped with laptop computers so that they can research a client's history, enter the encounter in the ELMR Contact Log and/or begin to register and enroll the individual in the ELMR system. They will also be able to e-mail and communicate/transmit relevant information to receiving programs. Triage workers will have authority to initiate direct referrals to appropriate RCDMH system of care programs. Additionally, they will facilitate "warm" transfers or linkages to other community based referrals as needed and appropriate. All referrals and linkages will be recorded to facilitate post intervention follow-up and monitoring by the Triage case management team of BHS IIs and/or MHPSS. Targeted case management will focus on successful linkage to non-crisis community based supports especially those that offer ongoing peer supports, housing assistance and benefit application assistance.

      ii. *Monitoring service delivery to ensure the individual accesses and receives services.*

Once an individual has been referred and linked for follow-up services, the centralized triage BHS II case managers will follow-up with the individual and the receiving program to monitor the effectiveness of the linkage. BHS IIs may call

upon MHPSS for additional engagement activity as needed. In addition, the triage office support staff will run data reports for persons served by triage staff so that the program coordinator can review if individuals served are receiving ongoing services. If individuals were referred to other community services, the triage case workers will contact the individual to monitor their status and if needs are being met.

iii. Monitoring an individual's progress

The triage personnel will monitor the individual's progress for a period of 90 days post crisis service with the focus on whether case management supports and linkages were effective. If the linkage was unsuccessful, the worker will attempt to re-engage the consumer, calling on program peer staff from either the triage team or the receiving program to assist in engaging the individual in non-crisis based care.

iv. Placement services and service plan development

The triage personnel with be authorized to make direct referrals to crisis stabilization unit (CSU) and/or crisis residential treatment (CRT) programs. If the individual is placed in crisis residential treatment, the treatment program will be responsible for assisting the individual with additional placements as needed. Additionally, the triage Behavioral Health Specialist assigned to the new Peer CSUs can assist in housing linkage from the CSUs and monitor individuals served by the CRT programs to insure that placement services are timely and effective. RCDMH currently has staff assigned to county operated and private psychiatric inpatient facilities to assist in discharge placement. Field based service planning will focus on ameliorating the current crisis and successful linkage to non-hospital based supports. Crisis stabilization and crisis residential services will address a fuller complement of needs such as medication support, peer support, peer recovery based interventions such as W.R.A.P, family support, individual and group therapies, pre-vocational services etcetera.

v. Describe other activities that triage personnel will perform

Triage personnel will become community resource specialists and be skilled in providing system navigation support. As field based workers they will not only be able to provide information to consumers and family members but will also serve as community provider liaisons and consultants. They will be key in assisting the community service providers understanding and accessing RCDMH's system of care for the people they serve.

b. Describe triage personnel deployment. Hours of availability, field based or mobile:

Field based triage personnel will be regionally based and mobile. Regional teams will be assigned to respond to EDs in the Desert, Mid-County and Western Regions. Area hospitals have volunteered to host teams at their locations where they can await requests for assistance. RCDMH will "stage" teams at area hospitals that are found to have the highest number of psychiatric crisis or that are central* to the region in order to decrease response times. The Desert Region team's service area will include facilities that primarily serve the "pass"

communities of Banning and Beaumont as well as the Coachella Valley area (Palm Springs to Indio). The Mid-County Region team will focus on facilities located in the Hemet, Menifee and Murrieta communities. The Western Region team will respond to facilities located in Corona, Moreno Valley and Riverside.

Desert Region	Mid-County Region	Western Region
Eisenhower Med Ctr	Hemet Valley Med Ctr	Kaiser Riverside
Desert Regional*	Menifee Valley Med Ctr	Kaiser-Moreno Valley
San Gorgornio Hosp.	Inland Valley Reg. Med.	Riverside Community
JFK Memorial	Rancho Springs	Parkview Hospital*
	Loma Linda- Menifee*	Corona Regional Med. Ctr.
	Temecula Valley	

Each team will include a Clinical Therapist and Peer Support Specialist (either a consumer or family member). Depending on need/service demand the team members may respond together or independently.

Field based response teams will respond seven (7) days a week, 10 hours a day. RCDMH currently plans to provide triage personnel between the hours of 2PM – 12AM. This will provide additional community based crisis supports outside of "normal" business hours but has also been identified by hospitals as the period of greatest need.

A triage response team will also be assigned full time to RCRMC ETS campus. RCRMC ETS served more than 14,677 adults during FY12-13. Currently RCDMH has a full time clinical therapist assigned to the facility to focus on identifying persons that may be better served in a non-hospital setting and assisting with linkage to community supports. Additional triage personnel (another clinical therapist, a Behavioral Health Specialist II and a MH Peer Support Specialist) will be assigned to expand hours of coverage (from 40 to 80 hours a week) and to augment services to include peer support and targeted case management.

Triage personnel assigned to the new Peer CSUs will be Behavioral Health Specialists II (BHS II). Again, there will be one assigned to each service region where the CSUs will be located. Since the BHS IIs will be providing intensive case management to link individuals to community services, they will work while community services operate (5 days a week) so that they can effectively communicate and coordinate with on-going service providers.

Triage personnel assigned to the centralized coordination unit will work seven (7) days a week to answer requests for assistance and deploy field based teams. They will work during regular business hours as well as evening hours. The program coordinator/supervisor will be centrally based and work Monday-Friday but will also provide on-call support to field based teams 7 days a week. Office support will operate during normal business hours.

c. *Describe ability and expectations for obtaining federal Medi-Cal reimbursement:*

For field based triage services, the triage personnel will attempt to obtain Medi-Cal coverage information from the individual served and obtain the consent to claim. Hospitals have agreed to share information they may have regarding third party payors. Payor information will be transmitted to the Triage Office Assistant to establish Patient Financial Information in the consumer record that

will enable the department to request reimbursement. Individuals who are linked to services will receive assistance from the Triage BHS IIs and/or ongoing service program to apply for Medi-Cal benefits as needed and appropriate.

d. *Describe by type of position, how triage personnel, including persons with lived experience will be used.*
   i. Peer Providers – RCDMH currently offers a Mental Health Peer Support Specialist (MHPSS) classification for both peer consumers and family members. Both peer and family members have demonstrated a high level of effectiveness in providing crisis support, engaging consumers into care, and/or supporting and educating family members. Both are equally as effective serving as system navigators and service advocates. As Triage Personnel, the MHPSS will respond with the Clinical Therapist or, depending on the nature of request and activity demand, may respond to provide initial contact with individuals in EDs. For example, for the MHPSS assigned to RCRMC-ETS full time, they will be able to initiate contact with all persons entering the facility to initiate peer support. They will provide on-site support and information regarding non-hospital based crisis supports available with an emphasis on community based peer support services. They may make direct referrals to peer crisis stabilization units and/or crisis residential treatment programs. They may also seek to link individuals to other services such as Full Service Partnership programs, Peer Support and Resource Centers, the Recovery Learning Center, homeless drop-in centers, RCDMH's "Family Room", NAMI and family support groups, etc. They will receive clinical supervision and consultation from their partnered clinical therapist. MHPSS receive ongoing support and training (at least once a month) that is coordinated by the Director of Consumer Affairs and Senior MHPSS. The Triage Program supervisor will work closely with Sr. MHSS and the Director of Consumer Affairs to provide scope of practice oversight and support.

   ii. Behavioral Health Specialist IIs (BHS IIs) –
      1. BHS IIs located at crisis stabilization programs will provide intensive case management to persons served with a focus on successful linkage to follow-up community based care. Examples of duties include but are not limited to coordination between crisis stabilization and crisis residential programs, monitoring crisis residential programs for effective discharge placement and planning, assisting consumers to apply for benefits (Medi-Cal), direct referral and coordination with non-crisis system of care services (Peer Support & Resource Centers, Recovery Learning Centers, Family Room, FSPs, outpatient and managed care services including integrated health programs.
      2. BHS IIs located in central triage services will answer calls for assistance from emergency departments (ED) 7 days a week. They will notify appropriate triage personnel to respond to request and facilitate communication with ED until triage personnel arrive on-site. They will also provide follow-up on persons served by field based triage personnel. Follow-up services will monitor for successful linkage including

coordination with receiving program, identifying those that could benefit from continued peer-to-peer engagement, coordinating engagement efforts with peer staff and monitoring consumer progress post engagement.

3. BHS II located at RCRMC ETS and Inpatient Treatment Facility (ITF) will assist in providing case management to individuals served at both ETS and ITF to either divert from inpatient care or to assist the RCDMH Clinical Therapist (non-grant funded) assigned to identify consumers that may be better served in a lower level of crisis care (e.g. crisis residential) so as to shorten the length of their hospital stay.

iii. Clinical Therapist I/II – Clinical therapists will provide direct care crisis intervention in EDs or other field based locations (e.g. shelters, community health centers), seeking to resolve the immediate crisis and link the individual to non-hospital based crisis supports as needed and appropriate. They will work closely with peer and family MHPSS to provide adjunctive support to individuals and their families. They will be authorized to initiate W&I holds; however, the primary goal of the intervention will be to avoid inpatient care if at all possible. A clinical therapist will also be assigned to RCRMC – ETS to collaborate with RCRMC ETS personnel to assess for possible diversion from ETS to voluntary, non-hospital based crisis supports (e.g. peer crisis stabilization and/or crisis residential, urgent care outpatient services, etc.).

iv. Mental Health Services Supervisor (MHSS) – The MHSS will be responsible for overall program staff training, support, supervision and service coordination. The MHSS will monitor service outcomes and work with other programs to resolve access or service barriers for consumers served and referred by the triage response program. The MHSS will serve as the program coordinator contact for all EDs served by triage response personnel. The MHSS will also have lead responsibility for working with QI Research to review and report program outcomes.

v. Office Assistant III – The OA III will assist in data collection and reporting. They will also complete Patient Financial Information (PFI) entry to enable reimbursement for services from Medi-Cal or other known guarantors. The office assistant will also provide generalized office support.

e. *Describe specific supports for all triage staff, including peer providers, for mentoring, training continuing education and strategies to prevent burn out.* Triage personnel that work seven (7) days a week will overlap on Wednesdays. This will allow time for the supervisor to meet with staff on a regular basis and provide supervision and support. It will also enable staff to participate in training or other supports as the need is identified. Currently, RCDMH provides regular support to all MHPSS staff. This includes monthly MHPSS training and support days (held on Wednesday) and semi-annual retreats. The focus of these meetings/trainings is ongoing skill development and peer-to-peer support to avoid burn-out and to provide MHPPSs an environment to "voice" their

perspective, needs and ideas. The department also employs Senior MHPSSs. Senior peers have advanced experience and serve as mentors and support to MHPSSs. Additionally, RCDMH has promoted the use of Recovery Coaching and Leadership by all supervisory staff. This approach empowers employees to set their development goals that include self care. The supervisor role is to review the employee's progress toward their goals, use empowerment principles to coach the employee and provide support so that he or she can succeed in achieving the goal(s) they have established for themselves. Workload and stress management are areas that can receive ongoing attention and support at the individual level for each member of the triage response team.

f. *Intent to use contract providers or county staff to provide services:*
Currently, RCDMH plans to directly employee triage personnel. As RCDMH works to create a diversion focused crisis system of care, having department employees that will have full access and support from management and department resources will be critical to identification of collaboration and communication barriers, resolution of issues and protocol development.

g. *Planned expansion of crisis stabilization programs:*
RCDMH has released an RFP to seek (a) provider(s) to operate three (3) voluntary peer crisis stabilization programs. The goal is to establish one program in each of the three RCDMH service area regions (Desert, Mid-County and Western). The intent is that these program services will be peer-to-peer in design and will provide a robust Wellness and Recovery service environment. The following is an excerpt from the RFP:

> "To provide crisis stabilization service lasting less than 24 hours, provided to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24 hour health facility, hospital based outpatient program, or at other provider sites, which have been certified by the appropriate Governmental Agency to provide crisis stabilization services. The Crisis Walk-In Center may be provided as a stand-alone facility. It is intended that the facility will serve as a voluntary alternative to locked crisis stabilization services and that it will provide a voluntary crisis service alternative to local law enforcement jurisdictions 24/7....(Services shall) ensure the provision of culturally competent services including a rich consumer, peer-to-peer recovery environment."

In addition to establishing the peer crisis stabilization program in Western Region, RCDMH is applying for capital development funds to build a co-located crisis stabilization and crisis residential treatment facility in Riverside. The Western Region crisis stabilization program will eventually be moved into the new peer crisis recovery center facility.

Annual Fiscal Report Instructions

Information provided in the Annual Fiscal Report shall reflect the grantee's triage personnel staff hired, date hired, total hours worked, and expenditures for personnel, evaluation and administration.

The information listed below shall be included in the grantee's Annual Fiscal Report.

A. EXPENDITURES

1. Personnel Expenditures

- **Identify each type of staff position hired.** (Example: Such as clinical social worker, peer service provider, mental health worker, supervisor, etc.) [Line "A," Number 1: "Personnel Expenditures"]
- **Identify the date hired for each type of staff position.** [Column titled: "Date Hired"]
- **Identify the total number of hours worked by April of each fiscal year for each staff position.** [Column titled: "Total Hours Worked
- **Identify the number of county staff and contract staff hired for each type of position in full time equivalents (FTEs).** For instance, if you hired one full-time mental health worker and one half-time mental health worker, the FTEs would reflect 1.5. for mental health workers. [Columns titled: "County Staff FTEs" and "Contract Staff FTEs"]
- **Identify grant expenditures for staff salaries in total, for each type of staff position hired.** [Columns titled: "County Staff" and "Contract Staff"]
- **Total the FTEs and Salaries for all county staff and all contract staff.** [Line titled: "Total FTEs and Salaries"]
- **Total for employee benefits for all county staff and all contract staff.** [Line titled: "Total Employee Benefits"]

2. Total Personnel Expenditures

- **Add total personnel expenditures for county staff and contract staff from above.** [Line titled: "Total Personnel Expenditures"]

3. Evaluation Expenditures

- **Identify grant expenditures associated with collecting and reporting "process," "encounter based" and "local" evaluation information required by this grant.** [Line titled: "Evaluation Expenditures"]

4. **Direct**

- **Identify direct costs associated with this grant.** (The total of Direct Costs, Indirect Costs and County Administration shall not exceed 15%.) [Line titled: "Direct Costs"]

5. **Indirect**

- **Identify indirect costs associated with this grant.** (The total of Direct Costs, Indirect Costs and County Administration shall not exceed 15%.) [Line titled: "Indirect Costs"]

6. **County Administration Expenditures**

- **Identify grant costs for county administration.** (The total of Direct Costs, Indirect Costs and County Administration shall not exceed 15%.) [Line titled: "County Administration Costs"]

7. **Subtotal**

- **Add Personnel (line 2), Evaluation (line 3), Direct (line 4), Indirect (line 5) and County Administration (line 6) Expenditures.** [Line titled: "Subtotal"]

B. ACTUAL REVENUES

1. **Medi-Cal**

- **Identify revenue received from Medi-Cal (FFP only).** [Line titled: "Medi-Cal FFP only"]

2. **Other Revenue**

- **Identify any other revenue received.** [Line titled: "Other Revenue"]

3. **Total Revenue**

- **Identify Total revenue received.** [Line titled: "Total Revenue"]

C. GRANT FUNDING

1. **Total Grant/ Awarded**

- **Identify total grant funding awarded.** [Line titled: "Total Awarded"]

2. Total Spent

- **Identify total grant funding spent.** Subtract line 7, Section A from line 1, Section C, to get Total Grant Funding Spent. [Line titled: "Total Spent"]

3. Total Unspent

- **Identify total unspent grant funds.** Subtract line 2, Section C from line 1 Section C, to get Total Grant Funding Unspent. [Line titled: Total Unspent"]

Attachment A.3

Mental Health Triage Personnel Grant
Annual Fiscal Report

Fiscal Year: _____

County: _____ **Date:** _____

	Date Hired	Total Hours Worked	County Staff FTEs	County Staff	Contract Staff FTEs	Contract Staff
A. Expenditures						
1. Personnel Expenditures (Staff Title)						
a. _____				$		$
b. _____				$		$
c. _____				$		$
d. _____				$		$
e. _____				$		$
f. _____				$		$
g. _____				$		$
h. _____				$		$
i. _____				$		$
Total FTEs and Salaries				$		$
Total Employee Benefits				$		$
2. Total Personnel Expenditures						$
3. Evaluation						$
4. Direct						$
5. Indirect						$
6. County Administration Expenditures						$
7. Subtotal (Personnel, Evaluation, Admin)						$
B. Received Revenues						
1. Medi-Cal (FFP Only)						$
2. Other Revenue						$
3. Total Revenue						$
C. Grant Funding						
1. Total Awarded						$
2. Total Spent						$
3. Total Unspent						$

X _____ _____

Signature of Mental Health/Behavioral Health Director or Designee — Date

EXHIBIT B

BUDGET DETAIL AND PAYMENT PROVISIONS

1. INVOICING AND PAYMENT

A. The amount payable by the MHSOAC to the Grantee is specified in Section 5, Payment Schedule.

B. Grant Award Claim Forms (Attachment B.1) shall be submitted no later than July 1st each fiscal year.

2. INSTRUCTION TO THE GRANTEE

A. To expedite the processing of Grant Award Claim Forms submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for fund distribution, Grantee shall submit one original and two copies of all Grant Award Claim Forms to the MHSOAC Grant Manager at the following address:

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA, 95814

3. BUDGET CONTINGENCY CLAUSE

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall no longer be in full force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Grantee or to furnish any other considerations under this Agreement and Grantee shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Grantee to reflect the reduced amount.

C. If this contract overlaps federal and State fiscal years, should funds not be appropriated by Congress or approved by the Legislature for the fiscal year(s) following that during which this grant was executed, the State may exercise its option to cancel this grant.

D. In addition, this grant is subject to any additional restrictions, limitations, or conditions enacted by Congress or the Legislature which may affect the provisions or terms of funding of this grant in any manner.

4. BUDGET DETAIL

The total amount of this Agreement shall not exceed $7,441,142.00 Payment shall be made in accordance with the payment schedule below

5. PAYMENT SCHEDULE

Grantee was approved for a grant cycle that covers four fiscal years, with funds allocated annually at the beginning of each fiscal year.

Fiscal Year (FY)	Grant Funding
FY 2013-14	$488,257.00
FY 2014-15	$2,134,233.00
FY 2015-16	$2,307,808.00
FY 2016-17	$2,510,844.00

Mental Health Wellness Act of 2013 **Attachment B.1**
Grant Award Claim Form

To: Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814
Attn: Accounting Office

Fiscal Year 2013-14 ☐
Fiscal Year 2014-15 ☐
Fiscal Year 2015-16 ☐
Fiscal Year 2016-17 ☐

From: _____ **Grant No.** _____

Mailing Address: _____
_____
_____

Costs	A	B	C	D	
	Budget Amount	Beginning Balance	Adjustments	Current Expense	Ending Balance
Personnel					
Evaluation					
Direct					
Indirect					
Administration					

Total Allowable Costs $_____

MHSOAC USE ONLY	FOR GRANTEE'S USE – Please use blue ink
I hereby certify that all services and required reports have been received pursuant to the contract/grant.	I CERTIFY that I am a duly appointed and acting officer of the herein named county: that the costs being claimed are in all respects true, correct, and in accordance with the grant provisions, and that the funds were expended or obligated during the project year.
X_____ Signature Program Coordinator DATE	X_____ Signature of Mental Health/Behavioral Health Director or designee DATE
_____ Name of Signatory _____ Phone	_____ Name of Signatory _____ Title
FOR MHSOAC ACCOUNTING USE ONLY	**GRANTEE'S CONTACT INFORMATION**
SFY:_____ **Grant Title:** MHSOAC Triage Grant **MHSA Grant Award:**_____ **PCA:** 30118 **INDEX:** 1300 **OBJECT CODE:** 701	_____ Contact Person (Print) _____ Phone