- Obtain from each consumer admitted any insurance/financial data as requested by the COUNTY.

TREATMENT PLANNING

The interdisciplinary master treatment plan shall be individualized to the consumer and include long term goals, and short term goals that are clear, realistic, specific and measurable. The plan shall also include specific staff interventions and methods of achieving the goals including treatment modalities, medications, etc. Diagnosis, medical necessity criteria on admission, high risk behaviors and tentative discharge plan will be documented on the interdisciplinary treatment plan. Cultural competency considerations shall be documented in the treatment plan. The consumer will review and sign the interdisciplinary treatment plan and be given a copy. The interdisciplinary treatment plan will substantiate all persons involved in developing the interdisciplinary treatment plan including the consumer, family, case manager, conservator and PHF staff.

The interdisciplinary treatment plan will be formulated with PHF staff including a psychiatrist, registered nurse, social services staff and rehabilitation therapist.

The interdisciplinary treatment plan shall be reviewed daily in treatment team meetings and updated in writing as needed, but at least weekly. Consumer's participation in treatment modalities as outlined in the interdisciplinary treatment plan shall be clearly documented in the record. The interdisciplinary treatment plan will reflect the input of the consumer's family/support persons whenever feasible.

5150/5250 DESIGNATION

The CONTRACTOR will apply to the COUNTY for LPS designation of the PHF for involuntary treatment of individuals pursuant to W & I Code Sections 5150 and 5250. The County will notify the State of their recommended approval of the designation. The CONTRACTOR shall maintain the ability to receive, hold and treat involuntary admissions at all times pursuant to

State approved designation. Appropriate documentation shall be maintained pursuant to all legal statutes including Department of Justice Firearms notification, hearings, etc. and will be incorporated into the medical record.

PHF SERVICES

Medical

Completion of the medical history and physical exam of each consumer within 24 hours of admission by the attending physician. A physician shall be responsible for physical health treatment of physical health issues. The CONTRACTOR's physician will coordinate any medical care with current outpatient medical care the consumer has been receiving and may recommend medical follow up care as appropriate for individual consumers.

Psychiatry

The PHF psychiatrist shall be responsible for all care and treatment upon admission.
There will be a legible psychiatrist progress note each time the consumer is seen but at least daily (seven days/week) reflecting a face to face contact with the consumer. The psychiatrist note will describe medication employed to ameliorate the medical, psychiatric or behavioral symptoms including the side effects, response to the medication and medical necessity for continued treatment. The absence or discontinuation of medication will be documented in the psychiatrist's progress note, including rationale for not providing medication.
In the event medication is not included in the treatment milieu, ongoing monitoring for the need for psychopharmacology intervention shall be included in the interdisciplinary treatment plan.
The psychiatrist will request a Riese hearing to administer medication involuntarily on the third day of irrational refusal by a consumer to take medication as ordered; or be discharged as no longer meeting criteria for locked involuntary treatment.

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Social Service
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The PHF social services staff shall enter a daily note daily (seven days a week) reflecting a face-
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to-face consumer contact. Notes will also document all collateral contacts with family, agencies
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and others contacted on the consumer's behalf. Individual, group and family therapy or
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counseling will be provided as needed by a Qualified Mental Health Professional within their
scope of practice.
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Nursing
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Nursing shall enter a note summarizing consumer activity that occurred during the shift. Charting
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should be present at least once each shift and whenever significant events occur. The nursing
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note will reflect the consumer's current status, functioning, response to treatment, medical
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necessity criteria, and their intervention. Registered Nurses and Licensed Vocational Nurses or
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Licensed Psychiatric Technicians shall administer medication as prescribed and complete all
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documentation regarding medication.
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Treatment Program
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A structured schedule of activities and groups will be maintained daily, during both day and
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evening shifts including weekends. The consumer will be incorporated into the intensive
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treatment program immediately upon admission and assisted into attending groups. A variety of
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individual, group and therapeutic milieu activities will be provided within a highly structured
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schedule. The treatment program will be designed to address major presenting psychiatric
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problems, facilitate rapid stabilization of mental status and functioning and increase reality
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contact, leading to an ability to return to a lower level of care. This highly structured schedule
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will be individually planned in order to provide pertinent treatment based on each consumer's
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needs, strengths, functioning level and discharge plan. It is expected that all consumers will
complete Activities of Daily Living (ADL's), dress in street clothes and participate in all
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activities.
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STAFFING REQUIREMENTS ON THE PHF:

Psychiatrist:

A psychiatrist will be on-site at the PHF seven days a week, a minimum of 30 minutes per client (e.g., 8 hours/day if the PHF is fully occupied with 16 residents). Any failure to meet this staffing requirement will be documented as a "critical incident" and the COUNTY will be notified within 48 hours, using a reporting protocol approved by the COUNTY.

LCSW:

CONTRACTOR will staff the PHF Social Services to insure a minimum of 8 hours a day of LCSW staffing seven days a week. Additional social service staffing may include staff who are either licensed or have Associate status with the CA Board of Behavioral Sciences.

Nursing:

Nurse staffing will meet all regulatory requirements of Title 22, PHF regulations, and the 5150 requirements of the COUNTY.

Rehabilitation Services

Rehabilitation staffing on the PHF unit shall comply with Title 22 requirements and the RCDMH Policy No. 140, and CONTRACTOR shall use any combination of staffing that does so and is approved by the State, Licensing and Certification Section.

FAMILY INVOLVEMENT

The PHF staff shall obtain a signed consent to release of information from the consumer to contact family/significant others at the time of admission whenever possible. Social Service staff shall contact the family within 24 hours of admission. If the consumer refuses to consent to family contact, they will be asked daily throughout their stay and the outcome of these efforts will be documented in the record. Every attempt will be made to involve the family in

treatment/discharge planning. All contact with family/significant others will be documented in the chart.

DISCHARGE PLANNING

Discharge planning shall be an integral part of the consumer's treatment program. Beginning at the time of admission and throughout the course of treatment, discharge planning is addressed jointly by the COUNTY, CONTRACTOR and the treatment team. Readiness for discharge will be assessed on an ongoing basis with the goal of discharge to a lower level of care as soon as possible.

The CONTRACTOR will be responsible for preparing the consumer and family for discharge, and assisting the COUNTY with discharge planning.

The CONTRACTOR staff are responsible for making all post-discharge medical appointments and medical follow up for consumers being discharged to independent living (non-placement).

The CONTRACTOR shall arrange transfer, placement and follow up for out of county consumers. The cost for the out of county transfers will be assumed by the CONTRACTOR. Out of County residents will be referred back to their county or state of residence.

COUNTY staff will be responsible for placement and follow-up for Riverside County consumers.

COUNTY case management staff will provide CONTRACTOR staff with an initial discharge plan and daily updates regarding discharge plan development and family/significant other contacts which CONTRACTOR social service staff will document in the medical record.

In situations where the consumer is admitted and discharged without COUNTY contact and plan, The CONTRACTOR shall provide a copy of the Aftercare and discharge paperwork to the COUNTY case manager upon their return with a full explanation of situation.

1 Upon discharge a comprehensive legible discharge summary signed by the psychiatrist shall be
2 sent within 14 days, along with pertinent medical records, to the COUNTY office providing
3 follow up or case management services. The discharge summary shall include:

4 a. Physical assessment
5 b. Psychiatric assessment
6 c. Psychological assessment (if available)
7 d. Length of stay
8 e. Course of treatment and treatment provided
9 f. Response to treatment
10 g. Status of treatment plan objectives at discharge
11 h. Mental status at discharge
12 i. Final DSM IV diagnosis (5 axis)
13 j. Admission and discharge GAF
14 k. Medications
15 l. Discharge plan, inclusive of family participation and support

16 All discharges will be planned in advance and with full approval of the COUNTY. Every effort
17 will be made to avoid precipitous discharges. The CONTRACTOR shall maintain policies and
18 procedures approved by RCDMH Director or his designee, in regard to AMA (Against Medical
19 Advice) and AWOL (Absent Without Leave) discharges. For unplanned discharges, the
20 CONTRACTOR will be responsible for referring the consumer to appropriate mental health
21 services and providing information and aftercare plans to placement facilities, the family or other
22 providers.
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CONSUMER OUTCOME MEASURES

1. Fewer than 10% of all PHF discharges will be re-hospitalized at the acute level of care within 30 days of discharge from the PHF. The CONTRACTOR shall prepare a quarterly report utilizing ELMR data to show incidence of re-hospitalization at Riverside County 5150 designated inpatient facilities (PHF, ITF, or County-contracted inpatient facilities).
2. Maintain the number of unauthorized bed days (due to lack of medical necessity for inpatient care) to less than twenty (20) per month.
3. Maintain an average length of stay (ALOS) on the PHF that is equal to or less than the ALOS for the PHF during the previous fiscal year; and maintain at least an average daily census of 13.0 consumers.

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CRISIS STABILIZATION UNITS (CSU)

TARGET POPULATION

The CSU emergency service treats consumers who are in need of urgent psychiatric services making them at risk for hospitalization. Referrals are typically made from local emergency departments of acute medical hospitals; 5150 designated facilities; psychiatric hospitals; law enforcement agencies; outpatient mental health services; Indio County Jail (Sheriff's Department); and self referrals.

All consumers who present at the door will be assessed and triaged, and contact with the consumer and their disposition will be documented. No consumer reporting a psychiatric crisis will be referred away from CSU prior to assessment.

TREATMENT PHILOSOPHY AND PLANNING

The Crisis Stabilization Units (CSU) is committed to providing immediate, quality crisis stabilization services for consumers with a full range of behavioral and psychiatric emergencies who require high levels of supervision in a supportive, locked milieu. Professional staff will be trained to safely and legally contain consumers who may lack the capacity for informed consent or decision making. The main mission of the CSU is to facilitate the rapid resolution of crisis, and the appropriate disposition and referral to community services. Secondarily, CSU will arrange psychiatric hospitalization in situations where no community alternative exists. The hospitalization of consumers will always be considered the treatment of last resort.

STAFFING:

The CSU will be staffed a minimum of 3 licensed staff on all shifts, allowing for a maximum occupancy of 12 consumers at any one time. The CSU MD will be on-site a minimum of 12 hours/day, seven days a week. A licensed LCSW or LMFT, or unlicensed MSW/MFT registered associate of the Board of Behavioral Sciences, will be present a minimum of 8 hours a day, seven days a week. Any failure to meet these staffing requirements will be documented as a "critical incident" and the COUNTY will be notified within 48 hours, using a reporting protocol approved by the COUNTY.

ADMISSION HOURS AND PROCESS

CSU shall be available to accept admission of adults and youth 24 hours per day, 7 days per week. Consumers may be admitted voluntarily if they are capable of giving informed consent to treatment and present with a significant psychiatric crisis. Individuals are admitted involuntarily only if they manifest a danger to others, are seriously suicidal, or cannot provide for their basic life needs (including food, clothing or shelter), and these problems result from a mental disorder, as documented on the 5150 hold.

Regarding referrals from local emergency departments or other agencies, the charge nurse receives the referring party's communication, contacts the psychiatrist on duty for admission clearance and orders; or admits according to psychiatric and medical protocols pre-approved by CSU Medical Director and the COUNTY. The charge nurse or designee will make a decision to accept or deny a referral within one hour of the initial referral.

The nurse greets the consumer upon arrival, and advises them of their rights, and completes the

admission process, documenting all pertinent information, and obtaining patient's signature on all forms.

A basic medical evaluation will be conducted by nursing staff at time of initial assessment, including a brief medical history and taking vitals. Additional medical evaluation can be performed as needed by the treating psychiatrist, or by the facility's on-call internist. Consumers with medical problems requiring urgent diagnosis, assessment or treatment beyond routine outpatient care which will be provided following discharge from the CSU will be sent to a local emergency department of an acute medical hospital.

CONSUMER ASSESSMENT AND TREATMENT FOLLOWING ADMISSION:

Following admission, the CONTRACTOR shall provide the following services:

- Nursing staff shall complete an admission agreement ; complete all admission paperwork; complete the Patients Rights advisement; notify the consumer of their legal status and financial obligation; complete a personal property inventory and appropriately secure the consumer's belongings; orient the consumer to the rules, regulations, personnel and environment of the unit; notify the family/guardian/ conservator of the consumer's arrival on the unit, and obtain consumer's signed consent to speak with the family/significant others.
- If applicable, a copy of the 5150 paperwork and/or LPS conservatorship court appointment documents (either public or private) shall be obtained upon admission and conservator consent for treatment and release of information shall be obtained in lieu of consumer consent.

- The psychiatrist will complete their psychiatric assessment of the consumer in a timely manner to insure that the consumer can be discharged to the community, or admitted to an inpatient facility, within 24 hours of being admitted to the CSU.
- The Master's level clinician (MSW/MFT/LCSW/LMFT) will conduct individual, group, and/or therapy; assess the consumer's strengths and resources; contact the consumer's caretakers, family, probation officer, child welfare worker, outpatient treatment staff, etc., with the intent of doing whatever is needed to assist the consumer's return to the community and avoid unnecessary hospitalization.
- The treatment plan and all interdisciplinary assessments shall be completed and present in the chart.
- Obtain from each consumer admitted any insurance/financial data as required for billing for services.

The range of services provided by CSU interdisciplinary staff includes:

a. Psychiatric evaluation and diagnostic services;

b. Psychosocial assessment and crisis intervention to optimize the ability of the consumer to return to the community and avoid hospitalization whenever possible;

c. Evaluation of medical/physical healthcare problems, and identify outpatient treatment options for same;

d. Medication therapy;

e. Discharge planning, including assertive efforts to link the consumer back to their family, friends, other care providers, and outpatient treatment resources.

1 The interdisciplinary treatment team works with consumers to reduce the acute nature of the
2 disorder as quickly as possible in order to return or refer the consumer to a less intensive level of
3 care, and avoid hospitalization whenever possible.

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5 CHILD/ADOESCENT SERVICES

6 Minors are defined as persons aged 17 and under, who have not been legally emancipated either
7 through a legal marriage, or by court action. Minors will be treated in the CSU either
8 voluntarily, as admitted by their parent or legal guardian; or involuntarily, as documented by a
9 5150/4011.6 hold. The treatment standards of care, and patient's rights, are the same as adults,
10 unless as noted in policies of the CSU or as specified by law.

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13 FAMILY INVOLVEMENT

14 The CSU staff shall obtain a signed consent to release of information from the consumer to
15 contact family/significant others at the time of admission whenever possible. Every attempt will
16 be made to involve the family in treatment/discharge planning. All contact with
17 family/significant others will be documented in the chart; this is especially important in the
18 treatment of children and teens ages 17 and younger. CSU staff will also make every effort to
19 contact and involve a youth's child welfare worker, probation officer, or other legally involved
20 persons or caregivers (foster parents, etc.).

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1 CONSUMER CARE

2 The CONTRACTOR agrees to provide consumer accommodations necessary for the care of
3 consumers suffering from mental disorders, including meals, services of a dietician and general
4 nursing, social and psychological services and psychiatric services.

5 This shall include:

6 a) Assessment of the consumer by a licensed/waivered staff person to include presenting
7 problem, MSE (mental status exam), imminent risk (danger to self, danger to others,
8 and/or grave disability) psychiatric history, and basic medical clearance.

9 b) Efforts to contact consumer's support system and any current outpatient mental health
10 treatment providers. All treatment will be coordinated with the current psychiatric
11 care the consumer may be receiving on an outpatient basis whenever possible.
Collaboration between outpatient and CSU shall be documented in the CSU record.

12 c) Medication Services on the CSU: Medication will be prescribed in accordance with
13 "RCDMH Medication Guidelines". Medi-Cal beneficiaries will be prescribed
14 medication consistent with the Medi-Cal formulary. Uninsured consumers will be
15 prescribed medication that they can afford to acquire following discharge. All other
16 consumers will be prescribed medication included on their health insurance
17 formulary. All consumers who are prescribed medication will receive medication
18 education provided by an M.D. or licensed nursing personnel prior to discharge from
the facility to the community.

19 d) Arrangements for medical care when medically necessary, including the following:

20 - Clinical laboratory services- upon admission as ordered by the psychiatrist or other
21 physician.

22 - On-site drug screens will be conducted on all consumers upon admission, unless the
23 consumer has had a drug screen done at a referring acute facility, and the results are
24 available to the CSU staff prior to the consumer's discharge from CSU. The results of

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1 the drug screen will recorded in the CSU chart, and provided to either the inpatient or
2 outpatient treatment provider, at the time of discharge or transfer from CSU.
3 - Radiology services, as required by the treating physician.
4 - Other medical testing as required by the treating physician, to identify urgent medical
5 conditions, and determine urgent medical clearance, including EKG, EEG AND EMG
6 -The program will have a written procedure allowing for access to immediate medical
7 care, including proximity to a hospital and a contract or agreement with that facility.
8
9 DISCHARGE PLANNING
10 The CSU staff is responsible for discharge planning and referrals. County staff may be available
11 to assist during regular business hours. The objective is to provide evaluation, stabilization and
12 referral to meet the needs of the consumer and family as well as to take preventive measures to
13 avoid the necessity for repeated crisis intervention and to allow the consumer and family to
14 appropriately utilize community resources, and to live in the least restrictive setting.
15 Those consumers deemed capable of transitioning to a lower level of care will be provided with
16 discharge preparation and planning services. Prior to discharge the CSU staff will formulate a
17 comprehensive discharge plan which will be placed in the patient's medical record. This should
18 include housing, psychiatric and medical treatment, and support planning for successful
19 transition to a lower level of care. All discharges shall have a discharge summary prepared by
20 the licensed nurse. Consumers discharged from the CSU will be given a paper prescription for
21 two weeks of psychotropic medication(s) upon discharge, as prescribed by the attending
22 psychiatrist. Consumers referred to the Crisis Residential Treatment (CRT) facility will be given
23 three days of medication. Unplanned discharges may occur as a result of medical acuity (in
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which case consumers will be transferred to an acute medical facility); or because the consumer is absent without leave (AWOL) from facility; or because the consumer demands discharge against medical advice (AMA). An Incident Report will be completed for all AMA and AWOL discharges.

TELEMEDICINE

The CONTRACTOR'S operational plan, policies and procedures for the use of telemedicine services must be submitted and approved by the COUNTY prior to telemedicine services being provided. CONTRACTOR must comply with all COUNTY policies and procedures relative to telemedicine.

5150 DESIGNATION

The CONTRACTOR will apply to the COUNTY for LPS designation of the CSU for involuntary treatment of individuals pursuant to W & I Code Sections 5150. The County will notify the State of their recommended approval of the designation. The CONTRACTOR shall maintain the ability to receive, hold and treat involuntary admissions at all times pursuant to State approved designation.

CONSUMER OUTCOME MEASURES

The following measures will be reported monthly via the Monthly Report.

1. Consumer Length of Stay reported in hours
2. Number of Consumers retained over 24 hours
3. Consumer disposition at discharge
4. Number of shifts not operated at full capacity, and why.
5. Monthly summary of all drug testing results, in order to track how many consumers are positive for drug use; and which drugs are most likely to be abused.

EXHIBIT B - MENTAL HEALTH

LAWS, REGULATIONS AND POLICIES

Services shall be provided in accordance with policies and procedures as developed by COUNTY and those Federal and State laws, regulations and policies which are applicable to the terms of this AGREEMENT, including but not limited to the following:

General Regulations

Government Code Section 8350 et. seq. (Drug-Free Workplace Act of 1990)

Government Code 26227 (Contracting with County)

Government Code 7550 (Reports)

Welfare and Institutions Code 5814(b) (Information and Reporting)

California Code of Regulations Title 9 Section 640 (Records)

42 Code of Federal Regulation 1320d et seq (Data Handling)

Welfare and Institutions Code 5608 (Program Monitoring)

Welfare and Institutions Code 5751.2 (Staffing)

HIPAA 1996: Public Law 104-91

http://mentalhealth.co.riverside.ca.us

Adult System of Care

California Welfare and Institutions Code Sections 5689 et seq.

Case Management/Service Regulations

California Code of Regulations, Title 9, Division 1, Chapters 2, 3, 4, 4.5, 9, 11, 12 (Rehabilitative and Developmental Services)

Welfare and Institutions Code 5610 to 5613 (Client Service Information Reporting)

Welfare and Institutions Code 5678-79

Welfare and Institutions Code 5867 (Maintenance of Effort)

42 Code of Federal Regulations 438.608 (Program Integrity Requirements)

California Welfare & Institutions Code Sections 5600.4 and 5699.4.

Charges and Billing (Financial Regulations)

California Welfare and Institutions Code 5651(a)(4), 5664, 5705(b)(3), 5718(c) (Cost Reporting)

California Welfare and Institutions Code 5704.5 & 5704.6 (Expenditure Requirements)

Government Code 8546.7 (Audits)

Uniform Method of Determining Ability to Pay, State Dept. of Mental Health.

Centers for Medicare and Medicaid Services Manual

Child Abuse Reporting/Child Support

California Penal Code Sections 11164 – 11174.4 et seq.

Family Code, Section 5200 (Child Support)

Children System of Care

California Welfare and Institutions Code Section 5880 (Children System of Care)

Community Care Facilities

California Code of Regulations, Title 22, Division 6 (Social Security, Licensing of Community Care Facilities)

Community Residential Treatment Program

California Welfare & Institutions Code Sections 5150 to 5152, 5600.2 to 5600.9 and 5672 to 5699 (Community Treatment)

California Welfare & Institutions Code Section 5670 et seq.

California Code of Regulations, Title 22, Division 6.

Confidentiality

California Welfare & Institutions Code Section 5328 - 5330

California Welfare & Institutions Code Section 5330 (Monetary Penalties)

42 CFR 431.300

45 CFR Parts 160, 162 and 164 (Standards for Privacy of Individually Identifiable Health Information)

45 CFR 205.50

Elderly and Dependent Adult Abuse Reporting

California Welfare & Institutions Code Sections 15600 et seq.

Health Care Facilities

California Code of Regulations, Title 22, Division 5 (Social Security, Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies)

Occupational Safety and Health Administration (OHSA) and Cal OHSA

Homeless Mentally Disabled

McKinney-Vento Homeless Assistance Act, 42 USC 11411 (Homeless Services)

California Welfare & Institutions Code Section 5680 et seq.

Life Support

California Welfare & Institutions Code Section 4075 to 4078

DMH Letter 03-04 (Health Care Facility Rates)

DMH Letter 86-01 (Life Support Supplemental Rate)

Medication Protocol

Riverside County Mental Health "Psychotropic Medication Protocols for Children and Adolescents" Publication

Riverside County Mental Health "Medication Guidelines" Publication

Minors in Health Care Facilities

California Welfare & Institutions Code Section 5751.7

Negotiated Net Amount and Negotiated Net Agreements

California Welfare and Institutions Code Sections 5705 to 5716

Non Discrimination

Americans with Disabilities Act of 1990 (42 U.S.C. Section 12111 et seq.)

California Fair Employment and Housing Act, Government Code Section 12900 et seq.

California Code of Regulations, Title 2, Section 7285 et seq.

Section 504 of the Rehabilitation Act of 1973, 29 USC 794 (Non-Discrimination)

Patients Rights

California Welfare & Institutions Code Sections 5325 et seq.

California Code of Regulations, Title 22, Section 70707

Policies

California Code of Regulations, Title 9, Section 1810.226 (State Department of Mental Health Plan)

Harassment in the Workplace, Board of Supervisors Policy C-25

Workplace Violence, Threats and Security, Board of Supervisors Policy C-27

County and Departmental policies, as applicable to this Agreement

Quality Assurance

California Welfare & Institutions Code Section 4070 et seq. (Quality Assurance)

Short-Doyle/Medi-Cal

California Code of Regulations, Title 22, Division 3

California Welfare and Institutions Code Sections 5718-5724 (Reimbursement for Mental Health Services)

Welfare and Institutions Code 5250 (Hearing Procedure)

Welfare and Institutions Code 5332-5337 (Incapacity Hearings)

Welfare and Institutions Code 14132.47 & Department of Health Services and 42 Code of Federal Regulations (Mental Health Medi-Cal Administrative Activities)

Social Rehabilitation Programs

California Code of Regulations, Title 9, Division 1, Chapter 3, Article 3.5

Special Education Pupils (AB 3632)

California Welfare & Institutions Code Section 18350 et seq.

California Code of Regulations, Title 2, Division 9, Chapter 1

Voter Registration

National Voter Registration Act of 1993

Rev. 01/30/07 kds

EXHIBIT C
REIMBURSEMENT & PAYMENT

CONTRACTOR NAME: Telecare Corporation
PROGRAM NAME: Psychiatric Hospital Facility (PHF) and Crisis Stabilization Unit (CSU)
DEPARTMENT ID: 4100202293-74700-83550-530280

A. <u>REIMBURSEMENT:</u>

1. In consideration of services provided by CONTRACTOR pursuant to this Agreement, CONTRACTOR shall receive monthly reimbursement based upon the reimbursement type as indicated by an "X" <u>below</u>:

   _____ The Negotiated Rate, as approved by the COUNTY, per unit as specified in the Schedule I, multiplied by the actual number of units of service provided, less revenue collected, not to exceed the maximum obligation of the COUNTY for that fiscal year as specified herein.

   __X___One-twelfth (1/12th), on a monthly basis of the overall maximum obligation of the COUNTY as specified herein.

2. CONTRACTOR'S Schedule I issued by COUNTY for budget purposes is attached hereto and incorporated herein by this reference.

3. The final year-end settlement shall be based upon the final year end settlement type or types as indicated by an "X" below (please mark all that apply), including allowable costs for this Agreement such as administrative cost, indirect cost and operating income and shall not exceed the percentage(s) or amounts(s) as specified in the original Agreement proposal or subsequent negotiations received, made and/or approved by the COUNTY:

__X___The final year-end settlement for non-Medi-Cal services (only) shall be based upon the actual allowable cost per unit, multiplied by the actual number of units of service, less revenue collected.

___X__The final year-end settlement for Medi-Cal services (only) shall be based on final State approved Medi-Cal units, multiplied by the actual allowable cost per unit of service provided; or the Riverside County Maximum Allowable Rate (RCMAR); or Drug Medi-Cal rate; or customary charges (published rate), whichever is the lowest rate, less revenue collected. In addition, all year-end settlement for Drug Medi-Cal services shall be less a COUNTY administrative fee.

______The final year-end settlement for Narcotics Treatment Program (NTP) Medi-Cal services (only) shall be based on final State approved Medi-Cal units, multiplied by the Riverside County Drug Medi-Cal rate, or customary charges (published rate), whichever is lower, less revenue collected.

______The final year-end settlement for Negotiated Rate services (only) shall be based upon the Negotiated Rate, as approved by the COUNTY, multiplied by the actual number of units of service provided and approved by the COUNTY, less revenue collected.

__X____The final year-end settlement for ancillary, start-up or flexible spending categories shall be based on actual allowable cost, less revenue collected.

4. The combined final year-end settlement for all services shall not exceed the maximum obligation of the COUNTY as specified herein, and the applicable maximum reimbursement rates promulgated each year by the COUNTY.

B. <u>MAXIMUM OBLIGATION:</u>

COUNTY'S maximum obligation for FY 2014/2015 shall be $7,117,772 subject to availability of applicable Federal, State, local and/or COUNTY funds.

C. START-UP REIMBURSEMENT

1. If and when applicable, items to be purchased through Start-Up funds are to be pre-approved by the COUNTY prior to purchase. CONTRACTOR will submit a formal, written request for purchases to the Program Manager or designee. This request shall include estimated costs, justification for purchase, and proof of price reasonableness.

2. CONTRACTOR will be paid in arrears based upon the actual cost of pre-approved items up to the maximum Start-Up cost obligation. CONTRACTOR will submit a claim on their stationery to include proof of cost(s) for said Start-Up items. Claims shall be submitted to the appropriate Program or Regional Manager/Adiministrator of the County's Department of Mental Health, no later than the tenth (10th) working day of each month. Start-Up cost claims shall be submitted separately from the claim for Agreement Client Services.

~~D. START-UP COST FURNISHINGS AND EQUIPMENT:~~

1. APPROVAL FOR PURCHASE: Any equipment or furnishings are required to be approved by COUNTY in writing prior to making purchase. Any equipment or furnishings not approved by COUNTY prior to purchase shall not be reimbursed to CONTRACTOR by COUNTY either as a start up or operating cost at any time.

2. OWNERSHIP: Equipment and furnishings purchased through this Agreement are the property of COUNTY. Procedures provided by COUNTY for the acquisition, inventory, control and disposition of the equipment and the acquisition and payment for administrative services to such equipment (e.g. office machine repair) are to be followed.

3. INVENTORY: CONTRACTOR shall maintain an internal inventory control system that will provide accountability for equipment and furnishings purchased through this Agreement, regardless of cost. The

inventory control system shall record at a minimum the following information when property is acquired: date acquired; property description (to include model number); property identification number (serial number); cost or other basis of valuation; funding source; and rate of depreciation or depreciation schedule, if applicable. An updated inventory list shall be provided to COUNTY on a semi-annual basis, and filed with the Annual Cost Report. Once COUNTY is in receipt of this list, COUNTY inventory tags will be issued to CONTRACTOR, and are to be attached to the item as directed.

4. DISPOSAL: Approval must be obtained from COUNTY prior to the disposal of any property purchased with funds from this Agreement, regardless of the acquisition value. Disposal (which includes sale, trade-in, discard, or transfer to another agency or program) shall not occur until approval is received in writing from COUNTY.

5. CAPITAL ASSETS:

   a. Capital assets are tangible or intangible assets exceeding $5,000 that benefit an agency more than a single fiscal year. For capital assets approved for purchase by COUNTY, allowable and non-allowable cost information and depreciation requirements can be found in the Center for Medicare and Medicaid Services (CMS) Publication 15, Provider Reimbursement Manual (PRM) Parts I & II. It is CONTRACTOR'S responsibility to ensure compliance with these requirements.

   b. Any capital asset that was acquired or improved in whole or in part with funds disbursed under this Agreement, or under any previous Agreement between COUNTY and CONTRACTOR, shall either be, at the election of COUNTY as determined by the Director or designee: (1) transferred to COUNTY including all title and legal ownership rights; or (2) disposed of and proceeds paid to COUNTY in a manner that results in COUNTY being reimbursed in the amount of the current fair market value of the real or personal property less

any portion of the current value attributable to CONTRACTOR's out of pocket expenditures using non-county funds for acquisition of, or improvement to, such real or personal property and less any direct and reasonable costs of disposition.

E. BUDGET:

Schedule I presents (for budgetary and planning purposes only) the budget details pursuant to this Agreement. Where applicable, Schedule I contains department identification number (Dept. ID), Program Code, billable and non-billable mode(s) and service function(s), units, expected revenues, maximum obligation and source of funding pursuant to this Agreement.

F. MEDI-CAL (M/C):

1. With respect to services provided to Medi-Cal beneficiaries, CONTRACTOR shall comply with applicable Medi-Cal cost containment principles where reimbursement is based on actual allowable cost, approved Medi-Cal rate, RCMAR, Drug Medi-Cal rate, or customary charges (published rate), whichever rate is lower, as specified in Title 19 of the Social Security Act, Title 22 of the California Code of Regulations and applicable policy letters issued by the State. All cost containment reimbursement rates for Drug Medi-Cal shall include a COUNTY administrative fee.
2. RCMAR is composed of Local Matching Funds and Federal Financial Participation (FFP).

G. REVENUES:

As applicable:

1. Pursuant to the provisions of Sections 4025, 5717 and 5718 of the Welfare & Institutions Code, and as further contained in the State Department of Health Care Services Revenue Manual, Section 1, CONTRACTOR shall collect revenues for the provision of the services described pursuant to Exhibit A. Such revenues may include but are not limited to, fees for services, private contributions, grants or other

funds. All revenues received by CONTRACTOR shall be reported in their annual Cost Report, and shall be used to offset gross cost.

2. CONTRACTOR shall be responsible for checking and confirming Medi-Cal eligibility for its patient(s)/client(s) prior to the patient(s)/client(s) receiving services(s) and prior to services being billed in order to ensure proper billing of Medi-Cal eligible services for all applicable patient(s)/clients(s).

3. Patient/client eligibility for reimbursement from Medi-Cal, Private Insurance, Medicare, or other third party benefits shall be determined by the CONTRACTOR at all times for billing or service purposes. CONTRACTOR shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort.

4. CONTRACTOR is to attempt to collect first from Medicare (if site is Medicare certified and if CONTRACTOR staff is enrolled in Medicare program), then insurance and then first party. In addition, CONTRACTOR is responsible for adhering to and complying with all applicable Federal, State and local Medi-Cal and Medicare laws and regulations as it relates to providing services to Medi-Cal and Medicare beneficiaries.

5. If a client has both Medicare or Insurance and Medi-Cal coverage, a copy of the Medicare or Insurance Explanation of Benefits (EOB) must be provided to the COUNTY within thirty (30) days of receipt of the EOB date.

6. CONTRACTOR is obligated to collect from the client any Medicare co-insurance and/or deductible if the site is Medicare certified or if provider site is in the process of becoming Medicare certified or if the provider is enrolled in Medicare. CONTRACTOR is required to clear any Medi-Cal Share of Cost amount(s) with the State. CONTRACTOR is obligated to attempt to collect the cleared Share of Cost amount(s) from the client. CONTRACTOR must notify the COUNTY in writing of cleared Medi-Cal Share of Cost(s) within seventy two (72) hours (excluding holidays) of

the CONTRACTOR'S received notification from the State. CONTRACTOR shall be responsible for faxing the cleared Medi-Cal Share of Cost documentation to fax number (951) 955-7361 **OR** to your organization's appropriate COUNTY Region or Program contact. Patients/clients with share of cost Medi-Cal shall be charged their monthly Medi-Cal share of cost in lieu of their annual liability. Medicare clients will be responsible for any co-insurance and/or deductible for services rendered at Medicare certified sites.

7. If and when applicable, all other clients will be subject to an annual sliding fee schedule by CONTRACTOR for services rendered, based on the patient's/client's ability to pay, not to exceed the CONTRACTOR'S actual charges for the services provided. In accordance with the State Department of Health Care Services Revenue Manual, CONTRACTOR shall not be penalized for non-collection of patient/client revenues provided that reasonable and diligent attempts are made by the CONTRACTOR to collect these revenues. Past due patient/client accounts may not be referred to private collection agencies. No patient/client shall be denied services due to inability to pay.

8. If and where applicable, CONTRACTOR shall submit to COUNTY, with signed Agreement, a copy of CONTRACTOR'S customary charges (published rates).

9. If CONTRACTOR charges the client any additional fees (i.e. Co-Pays) above and beyond the contracted Schedule I rate, the CONTRACTOR must notify the COUNTY within each fiscal year Agreement period of performance.

10. CONTRACTOR must notify the COUNTY if CONTRACTOR raises client fees. Notification must be made within ten (10) days following any fee increase.

H. <u>REALLOCATION OF FUNDS:</u>

1. No funds allocated for any mode and service function as designated in Schedule I may be reallocated to another mode and service function

unless prior written consent and approval is received from COUNTY Program Administrator/Manager and confirmed by the Fiscal Supervisor prior to either the end of the Agreement Period of Performance or the end of the fiscal year (June 30th). Approval shall not exceed the maximum obligation.

2. In addition, CONTRACTOR may not, under any circumstances and without prior written consent and approval being received from COUNTY Program Administrator/Manager and confirmed by the Fiscal Supervisor, reallocate funds between mode and service functions as designated in the Schedule I that are defined as non-billable by the COUNTY, State or Federal governments from or to mode and service functions that are defined as billable by the COUNTY, State or Federal governments.

3. If this Agreement includes more than one Exhibit C and/or more than one Schedule I, shifting of funds from one Exhibit C to another and/or from one Schedule I to another is also prohibited without prior written consent and approval being received from COUNTY Program Administrator/Manager and confirmed by the Fiscal Supervisor prior to the end of either the Agreement Period of Performance or fiscal year.

I. RECOGNITION OF FINANCIAL SUPPORT:

If, when and/or where applicable, CONTRACTOR'S stationery/letterhead shall indicate that funding for the program is provided in whole or in part by the COUNTY of Riverside Department of Mental Health.

J. PAYMENT:

1. Monthly reimbursements may be withheld and recouped at the discretion of the Director or its designee due to material Agreement non-compliance, including audit disallowances, invoice(s), or Agreement overpayment, and/or adjustments or disallowances resulting from the COUNTY Contract Monitoring Review (CMT), COUNTY Program Monitoring, Federal or State Audit, and/or the Cost Report Reconciliation/Settlement process.

1 2. In addition, if the COUNTY determines that there is any portion (or all) of the CONTRACTOR invoice(s) that cannot be substantiated, verified or proven to be valid in any way for any fiscal year, then the COUNTY reserves the right to disallow and/or withhold current and/or future payments from CONTRACTOR until valid, substantial proof of any and/or all items billed for is received, verified and approved by the COUNTY.

3. In addition to the annual CMT, Program Monitoring, and Cost Report Reconciliation/Settlement processes, the COUNTY reserves the right to perform impromptu CMTs without any prior written or verbal notice, or periodic system service reviews and subsequent deletes and denial monitoring for this Agreement throughout the fiscal year in order to minimize and prevent COUNTY and CONTRACTOR loss and/or inaccurate billing and/or reports. The COUNTY, at its discretion, may withhold and/or offset invoices and/or monthly reimbursements to CONTRACTOR, at any time without prior notification to CONTRACTOR, for service deletes and denials that may occur in association with this Agreement. COUNTY shall notify CONTRACTOR of any such instances of services deletes and denials and subsequent withholds and/or reductions to CONTRACTOR invoices or monthly reimbursements.

4. Notwithstanding the provisions of Paragraph J-1 and J-2 above, CONTRACTOR shall be paid in arrears based upon either the actual units of service provided and entered into the COUNTY'S specified Electronic Management Information System (MIS), or on a one-twelfth (1/12th) monthly basis as specified in Paragraph A-1 above.

   a. CONTRACTOR will be responsible for entering all service related data into the COUNTY's MIS (i.e. Provider Connect or CalOMS) on a monthly basis and approving their services in the MIS for electronic batching (invoicing) and subsequent payment.

   b. CONTRACTOR must also submit to the COUNTY a signed Program Integrity Form (PIF) **<u>(attached as Exhibit C,</u>**

Attachment A) signed by the Director or authorized designee of the CONTRACTOR organization. This form must be faxed and/or emailed (PDF format only) to the COUNTY at (951) 358-4792 and/or emailed to ELMR_PIF@rcmhd.org. The CONTRACTOR PIF form must be received by the COUNTY via fax and/or email for the prior month no later than 5:00 p.m. on the fifth (5th) working day of the current month.

c. Failure by the CONTRACTOR to enter and approve all applicable services into the MIS for the applicable month, and faxing and/or emailing the signed PIF, will delay payment to the CONTRACTOR until the required documents as outlined herein are provided.

d. CONTRACTOR is required to enter all units of service into the COUNTY'S MIS for the prior month no later than 5:00 p.m. on the fifth (5th) working day of the current month for electronic batching. Late entry of services into the COUNTY'S MIS may result in financial and/or service denials and/or disallowances to the CONTRACTOR.

5. CONTRACTOR shall work with their respective COUNTY Regions or Programs to generate a monthly invoice for payment through the MIS batching process. In addition, the COUNTY will work with the CONTRACTOR to access data in the MIS in order for the CONTRACTOR to provide a quarterly report to their designated COUNTY Region/Program describing outcomes, and progress updates and services delivered based upon the Agreement's Exhibit A "Scope of Work."

6. CONTRACTOR shall provide the COUNTY with all information necessary for the preparation and submission to the State, if applicable, for all billings, and the audit of all billings.

7. In order to ensure that CONTRACTOR will receive reimbursement for services rendered under this Agreement, CONTRACTOR shall be

responsible for notifying Medi-Cal if at any time CONTRACTOR discovers or is made aware that client Medicare and/or Insurance coverage has been terminated or otherwise is not in effect. CONTRACTOR shall provide COUNTY with a print screen from the Medi-Cal eligibility website indicating the Medicare and/or Insurance coverage has been removed within ten (10) days of termination request. CONTRACTOR shall include their name and the comment "Medicare/OHC Termed" on the documentation provided to the COUNTY.

8. Unless otherwise notified by the COUNTY, CONTRACTOR invoicing will be paid by the COUNTY thirty (30) calendar days after the date a correct PIF is received by the COUNTY and invoice is generated by the applicable COUNTY Region/Program.

K. <u>COST REPORT</u>:

1. For each fiscal year, or portion thereof, that this Agreement is in effect, CONTRACTOR shall provide to COUNTY two (2) copies, per each Program Code, an annual Cost Report with an accompanying financial statement and applicable supporting documentation to reconcile to the Cost Report within one of the length of times as follows and as indicated below by an "X":

______ Thirty (30) calendar days following the end of each fiscal year (June 30th), or the expiration or termination of the Agreement, whichever occurs first.

___X___ Forty-five (45) calendar days following the end of each fiscal year (June 30th), or the expiration or termination of the Agreement, whichever occurs first.

______ Seventy-Five (75) calendar days following the end of each fiscal year (June 30th), or the expiration or termination of the Agreement, whichever occurs first.

2. The Cost Report shall detail the actual cost of services provided. The Cost Report shall be provided in the format and on forms provided by the COUNTY.

3. CONTRACTOR shall follow all applicable Federal, State and local regulations and guidelines to formulate proper cost reports, including but not limited to OMB-circular A-122, OMB-circular A-87, etc.

4. It is mandatory that the CONTRACTOR send one representative to the cost report training annually that is held by COUNTY that covers the preparation of the year-end Cost Report. The COUNTY will notify CONTRACTOR of the date(s) and time(s) of the training. Attendance at the training is mandatory annually in order to ensure that the Cost Reports are completed appropriately. Failure to attend this training will result in delay of any reimbursements to the CONTRACTOR.

5. CONTRACTOR will be notified in writing by COUNTY, if the Cost Report has not been received within the specified length of time as indicated in Section K, paragraph 1 above. Future monthly reimbursements will be withheld if the Cost Report contains errors that are not corrected within ten (10) calendar days of written or verbal notification from the COUNTY. Failure to meet any pre-approved deadlines and/or extension will immediately result in the withholding of future monthly reimbursements.

6. The Cost Report shall serve as the basis for year-end settlement to CONTRACTOR including a reconciliation and adjustment of all payments made to CONTRACTOR and all revenue received by CONTRACTOR. Any payments made in excess of Cost Report settlement shall be repaid upon demand, or will be deducted from the next payment to CONTRACTOR.

7. All current and/or future payments to CONTRACTOR will be withheld by the COUNTY until all final, current and prior year Cost Report(s) have been reconciled, settled and signed by CONTRACTOR, and received and approved by the COUNTY.

8. CONTRACTOR shall report Actual Costs separately, if deemed applicable and as per CONTRACTOR Schedule I, to provide Agreement Client Ancillary Services, Prescriptions, Health Maintenance Costs, and Flexible funding costs under this Agreement on the annual cost report. Where deemed applicable, Actual Costs for Indirect Administrative Expenses shall not exceed the percentage of cost as submitted in the CONTRACT Request for Proposal or Cost Proposal(s).

L. BANKRUPTCY:

Within five (5) calendar days of filing for bankruptcy, CONTRACTOR shall notify COUNTY'S Department of Mental Health's Fiscal Services Unit, in writing by certified letter with a courtesy copy to the Department of Mental Health's Program Support Unit. The CONTRACTOR shall submit a properly prepared Cost Report in accordance with requirements and deadlines set forth in Section I before final payment is made.

M. AUDITS:

1. CONTRACTOR agrees that any duly authorized representative of the Federal Government, the State or COUNTY shall have the right to audit, inspect, excerpt, copy or transcribe any pertinent records and documentation relating to this Agreement or previous Agreements in previous years.

2. If this Agreement is terminated in accordance with Section XXVII, TERMINATION PROVISIONS, the COUNTY, Federal and/or State governments may conduct a final audit of the CONTRACTOR. Final reimbursement to CONTRACTOR by COUNTY shall not be made until all audit results are known and all accounts are reconciled. If applicable, revenue collected by CONTRACTOR during this period for services provided under the terms of this Agreement will be regarded as revenue received and deducted as such from the final reimbursement claim.

3. Any audit exception resulting from an audit conducted by any duly authorized representative of the Federal Government, the State or

COUNTY shall be the sole responsibility of the CONTRACTOR. Any audit disallowance adjustments shall be paid in full upon demand or withheld at the discretion of the Director of Mental Health against amounts due under this Agreement or Agreement(s) in subsequent years.

4. The COUNTY will conduct Program Monitoring Review and/or Contract Monitoring Team Review (CMT). Upon completion of monitoring, CONTRACTOR will be mailed a report summarizing the results of the site visit. If and when necessary, a corrective Action Plan will be submitted by CONTRACTOR within thirty (30) calendar days of receipt of the report. CONTRACTOR'S failure to respond within thirty (30) calendar days will result in withholding of payment until the corrective plan of action is received. CONTRACTOR'S response shall identify time frames for implementing the corrective action. Failure to provide adequate response or documentation for this or subsequent year's Agreements may result in Agreement payment withholding and/or a disallowance to be paid in full upon demand.

N. <u>TRAINING:</u>

1. CONTRACTOR understands that as the COUNTY implements its current MIS to comply with Federal, State and/or local funding and service delivery requirements, CONTRACTOR will, therefore, be responsible for sending at least one representative to receive all applicable COUNTY training associated with, but not limited to, applicable service data entry, client registration, billing and invoicing (batching), and learning how to appropriately and successfully utilize and/or operate the current and/or upgraded MIS as specified for use by the COUNTY under this Agreement. The COUNTY will notify the CONTRACTOR when such training is required and available.

Rev. 14/15

CERTIFICATION OF CLAIMS AND PROGRAM INTEGRITY FORM

Billing/Service Period:		Amount Certified:	
DeptID:	4100202293-74700-83550-530280		
Provider Name:	Telecare Corporation		
Contract Name/Region:	Desert Region- PHF and CSU		
Service Location (Address):	47915 Oasis Street, Indio, CA 92201		
RU's Certified:	33XXX and 33XXX		
Bill Enumerator:			

Medi-Cal and/or Medicare Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of ______________________________, **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by ______________________________ in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for Medi-Cal and Medicare beneficiaries. The beneficiaries were eligible to receive Medi-Cal and/or Medicare services at the time the services were provided to the beneficiaries. The services included in the claim were actually provided to the beneficiaries in association with and as stipulated by the claim. Medical necessity was established by my organization for the beneficiaries as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client plan was developed and maintained for the beneficiaries that met all client plan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

______________________________ ______________________________
Signature of Authorized Provider Printed Name of Authorized Provider

Date: ____________________

Non-Medi-Cal and/or Medicare Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of ______________________________, **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by ______________________________ in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for consumers who are referred by the County to the Provider for mental health specialty services. The beneficiaries were referred to receive services at the time the services were provided to the beneficiaries in association with and as stipulated by the claim. The services included in the claim were actually provided to the beneficiaries and for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client care plan was developed and maintained for the beneficiaries that met all client careplan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

______________________________ ______________________________
Signature of Authorized Provider Printed Name of Authorized Provider

Date: ____________________

RCDMH Admin. Use Only

BATCH #'s: ____________________

SCHEDULE I
MENTAL HEALTH

DESERT REGION

CONTRACT PROVIDER NAME: Telecare Corporation FISCAL YEAR 2014-2015

NEGOTIATED RATE ( ) ACTUAL COST (X) NET NEGOTIATED AMOUNT ()

DEPT ID/PROGRAM **4100202293-83550-74700**

	PHF	PHF	CSU	CSU		
MODE OF SERVICE:		5*		10*		
SERVICE FUNCTION:		20		25		
NUMBER OF UNITS:		4,395		27,500		
PROCEDURE CODE		151,153,154		208 & 209NB		
COST PER UNIT based on Total Cost		$879.61		$107.27		
START UP COSTS	$167,273		$134,619		$301,892	
MAXIMUM OBLIGATION:	$167,273	$3,865,868	$134,619	$2,950,012	$7,117,772	
REVENUES COLLECTED BY CONTRACTORS:						
A. PATIENT FEES						
B. PATIENT INSURANCE		193,293		161,230	354,523	
C. OTHER: Miscellaneous						
TOTAL CONTRACTOR REVENUES		193,293		$161,230	$354,523	
COUNTY ESTIMATED FUNDING OBLIGATION	$167,273	$3,672,575	$134,619	$2,788,782	$6,763,249	
SOURCES OF FUNDING FOR MAXIMUM OBLIGATION						%
A. MEDI-CAL/FFP		463,904		354,001	$817,906	12.09%
B. FEDERAL FUNDS					$0	0.00%
C. REALIGNMENT FUNDS	$167,273	3,208,671			$3,375,944	49.92%
D. STATE GENERAL FUNDS					$0	0.00%
E. COUNTY FUNDS					$0	0.00%
F. MHSA-CSS			134,619	2,434,781	$2,569,400	37.99%
TOTAL (SOURCES OF FUNDING)	167,273	3,672,575	134,619	2,788,782	$6,763,249	100.00%

*Program costs include Medi-Cal non-reimbursable costs such as Board & Care, Client Support, Operating Income, and Medication and Laboratory costs for Non Medi-Cal clients. These costs are assumed to be reimbursed with MHSA and/or other county general funds.

FUNDING SOURCES DOCUMENT: ____________________

ADMINISTRATIVE ANALYST SIGNATURE: Susan Marshall 5-6-14

Riverside County Board of Supervisors (emm)
Request to Speak

Submit request to Clerk of Board (right of podium), Speakers are entitled to three (3) minutes, subject to Board Rules listed on the reverse side of this form.

SPEAKER'S NAME: David Warpness

Address: ______________________
(only if follow-up mail response requested)

City: ______________ **Zip:** ______________

Phone #: ______________

Date: 6/2/2014 **Agenda #** 3-59

PLEASE STATE YOUR POSITION BELOW:

Position on "Regular" (non-appealed) Agenda Item:

_____ **Support** _____ **Oppose** _____ **Neutral**

Note: If you are here for an agenda item that is filed for "Appeal", please state separately your position on the appeal below:

_____ **Support** _____ **Oppose** _____ **Neutral**

I give my 3 minutes to: ______________________

3-59

BOARD RULES

Requests to Address Board on "Agenda" Items:

You may request to be heard on a published agenda item. Requests to be heard must be submitted to the Clerk of the Board before the scheduled meeting time.

Requests to Address Board on Items that are "NOT" on the Agenda:

Notwithstanding any other provisions of these rules, member of the public shall have the right to address the Board during the mid-morning "Oral Communications" segment of the published agenda. Said purpose for address must pertain to issues which are under the direct jurisdiction of the Board of Supervisors. YOUR TIME WILL BE LIMITED TO THREE (3) MINUTES.

Power Point Presentations/Printed Material:

Speakers who intend to conduct a formalized Power Point presentation or provide printed material must notify the Clerk of the Board's Office by 12 noon on the Monday preceding the Tuesday Board meeting, insuring that the Clerk's Office has sufficient copies of all printed materials and at least one (1) copy of the Power Point CD. Copies of printed material given to the Clerk (by Monday noon deadline) will be provided to each Supervisor. If you have the need to use the overhead "Elmo" projector at the Board meeting, please insure your material is clear and with proper contrast, notifying the Clerk well ahead of the meeting, of your intent to use the Elmo.

Individual Speaker Limits:

Individual speakers are limited to a maximum of three (3) minutes. Please step up to the podium when the Chairman calls your name and begin speaking immediately. Pull the microphone to your mouth so that the Board, audience, and audio recording system hear you clearly. Once you start speaking, the "green" podium light will light. The "yellow" light will come on when you have one (1) minute remaining. When you have 30 seconds remaining, the "yellow" light will begin flash, indicating you must quickly wrap up your comments. Your time is up when the "red" light flashes. The Chairman adheres to a strict three (3) minutes per speaker. ***Note: If you intend to give your time to a "Group/Organized Presentation", please state so clearly at the very bottom of the reverse side of this form.***

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Riverside County Board of Supervisors
Request to Speak

Submit request to Clerk of Board (right of podium), Speakers are entitled to three (3) minutes, subject to Board Rules listed on the reverse side of this form.

SPEAKER'S NAME: David Blanchard

Address: ____________________
(only if follow-up mail response requested)

City: __________ **Zip:** __________

Phone #: __________

Date: 6/2/2014 **Agenda #** 3-59

PLEASE STATE YOUR POSITION BELOW:

Position on "Regular" (non-appealed) Agenda Item:

_____**Support** _____**Oppose** _____**Neutral**

Note: If you are here for an agenda item that is filed for "Appeal", please state separately your position on the appeal below:

_____**Support** _____**Oppose** _____**Neutral**

I give my 3 minutes to: David Warpness

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Riverside County Board of Supervisors
Request to Speak

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SPEAKER'S NAME: Paul Jacobs

Address: ______
(only if follow-up mail response requested)

City: Temecula **Zip:** ______

Phone #: ______

Date: 6/3/14 **Agenda #** 3-59

PLEASE STATE YOUR POSITION BELOW:

Position on "Regular" (non-appealed) Agenda Item:

______**Support** ______**Oppose** ______**Neutral**

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I give my 3 minutes to: ______

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Riverside County Board of Supervisors
Request to Speak

Submit request to Clerk of Board (right of podium), Speakers are entitled to three (3) minutes, subject to Board Rules listed on the reverse side of this form.

SPEAKER'S NAME: Roman Martinez

Address: ______________________
(only if follow-up mail response requested)

City: __________ **Zip:** __________

Phone #: __________

Date: 6/2/2014 **Agenda #** 3-59

PLEASE STATE YOUR POSITION BELOW:

Position on "Regular" (non-appealed) Agenda Item:

_____**Support** _____**Oppose** _____**Neutral**

Note: If you are here for an agenda item that is filed for "Appeal", please state separately your position on the appeal below:

_____**Support** _____**Oppose** _____**Neutral**

I give my 3 minutes to: ______________________

3-59

BOARD RULES

Requests to Address Board on "Agenda" Items:

You may request to be heard on a published agenda item. Requests to be heard must be submitted to the Clerk of the Board before the scheduled meeting time.

Requests to Address Board on items that are "NOT" on the Agenda:

Notwithstanding any other provisions of these rules, member of the public shall have the right to address the Board during the mid-morning "Oral Communications" segment of the published agenda. Said purpose for address must pertain to issues which are under the direct jurisdiction of the Board of Supervisors. YOUR TIME WILL BE LIMITED TO THREE (3) MINUTES.

Power Point Presentations/Printed Material:

Speakers who intend to conduct a formalized Power Point presentation or provide printed material must notify the Clerk of the Board's Office by 12 noon on the Monday preceding the Tuesday Board meeting, insuring that the Clerk's Office has sufficient copies of all printed materials and at least one (1) copy of the Power Point CD. Copies of printed material given to the Clerk (by Monday noon deadline) will be provided to each Supervisor. If you have the need to use the overhead "Elmo" projector at the Board meeting, please insure your material is clear and with proper contrast, notifying the Clerk well ahead of the meeting, of your intent to use the Elmo.

Individual Speaker Limits:

Individual speakers are limited to a maximum of three (3) minutes. Please step up to the podium when the Chairman calls your name and begin speaking immediately. Pull the microphone to your mouth so that the Board, audience, and audio recording system hear you clearly. Once you start speaking, the "green" podium light will light. The "yellow" light will come on when you have one (1) minute remaining. When you have 30 seconds remaining, the "yellow" light will begin flash, indicating you must quickly wrap up your comments. Your time is up when the "red" light flashes. The Chairman adheres to a strict three (3) minutes per speaker. ***Note: If you intend to give your time to a "Group/Organized Presentation", please state so clearly at the very bottom of the reverse side of this form.***

Group/Organized Presentations:

Group/organized presentations with more than one (1) speaker will be limited to nine (9) minutes at the Chairman's discretion. The organizer of the presentation will automatically receive the first three (3) minutes, with the remaining six (6) minutes relinquished by other speakers, as requested by them on a completed "Request to Speak" form, and clearly indicated at the front bottom of the form.

Addressing the Board & Acknowledgement by Chairman:

The Chairman will determine what order the speakers will address the Board, and will call on all speakers in pairs. The first speaker should immediately step to the podium and begin addressing the Board. The second speaker should take up a position in one of the chamber aisles in order to quickly step up to the podium after the preceding speaker. This is to afford an efficient and timely Board meeting, giving all attendees the opportunity to make their case. Speakers are prohibited from making personal attacks, and/or using coarse, crude, profane or vulgar language while speaking to the Board members, staff, the general public and/or meeting participants. Such behavior, at the discretion of the Board Chairman may result in removal from the Board Chambers by Sheriff Deputies.