AMENDMENT NO. 1 TO SERVICE AGREEMENT

This Amendment No. 1 to Agreement No. A-24-592 is dated January 6, 2026 and is between each Contractor listed in Exhibit A "List of Contractor(s)" ("Contractor(s)"), and the County of Fresno, a political subdivision of the State of California ("County").

Recitals

A. On November 5, 2024, the County and the Contractors entered into Master Agreement for Wraparound and Super Wraparound services which is County agreement number A-24-592 ("Agreement"), to provide Senate Bill (SB) 163 wraparound services to eligible children and their families involved in the Child Welfare Services (CWS) and Probation systems as well as Super Wraparound services to high acuity foster youth who require intensive support through their involvement in the County's Children's Well-Being Continuum; and

B. On July 8, 2025, the California Department of Social Services (CDSS) has issued All County Letter (ACL) 25-47, which implements Part IV of the federal Family First Prevention Services Act (FFPSA). ACL 25-47 requires counties to utilize California's High Fidelity Wraparound (HFW) model when providing aftercare services for youth and families transitioning from congregate care or other intensive service settings; and

C. In order to comply with this new mandate, the County must align the scope of services in Agreement A-24-592 with the State's HFW model requirements for wraparound services. This alignment ensures fidelity to the model's family-centered, team-based, and strengths-driven approach, and supports improved outcomes for youth with complex needs; and

D. The County and the Contractors now desire to amend the Agreement to revise Exhibit B, Scope of Services, so that the Agreement is consistent with ACL 25-47 and the FFPSA Part IV requirements, and to ensure all services provided under this Agreement reflect the HFW model.

The parties therefore agree as follows:

1. Exhibit B-1, Scope of Services, is deleted in its entirety and replaced with a Revised Exhibit B-1. All references to Exhibit B-1 shall be renamed to Revised Exhibit B-1.

2. Exhibit B-2, Scope of Services, is deleted in its entirety and replaced with a revised Exhibit B-2. All references to Exhibit B-2 shall be renamed to Revised Exhibit B-2.

3. Section 4, “Compensation, Invoices, and Payments”, of the Agreement located at line nineteen (19) on page eight (8) is amended to add the following after the end of the section:

“4.18 **Fresno County Wraparound Flex Fund Policy.** All expenditures of flexible funds under this Agreement shall comply with the Flex Fund Policy attached hereto and incorporated herein as Exhibit T, “Fresno County Wraparound Flex Fund Policy.”

4. Section 12, “Assurances”, of the Agreement located at line eleven (11) on page twenty-seven (27) is amended to add the following after the end of the section:

“12.2 **Certification of Compliance with Wraparound Standards**

(A) In entering into this Agreement, Contractor(s) certifies that it has obtained, and shall maintain throughout the term of this Agreement, certification by the State of California as an authorized Wraparound provider. Contractor(s) further certifies that it will comply with all applicable High Fidelity Wraparound (HFW) standards, fidelity requirements, practice guidelines, and quality assurance protocols established by the State.

(B) Contractor(s) shall complete all re-certification processes required by the State to maintain its Wraparound certification.

(C) Failure to obtain or maintain such certification, or failure to comply with Wraparound standards, shall render the provisions of this Agreement null and void and may result in the immediate suspension or termination of this Agreement at the sole discretion of the County.”

5. When both parties have signed this Amendment No. 1, the Agreement, and this Amendment No. 1 together constitute the Agreement.

6. The Contractor represents and warrants to the County that:

a. The Contractor is duly authorized and empowered to sign and perform its obligations under this Amendment.

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b. The individual signing this Amendment on behalf of the Contractor is duly authorized to do so and his or her signature on this Amendment legally binds the Contractor to the terms of this Amendment.

7. The parties agree that this Amendment may be executed by electronic signature as provided in this section.

a. An “electronic signature” means any symbol or process intended by an individual signing this Amendment to represent their signature, including but not limited to (1) a digital signature; (2) a faxed version of an original handwritten signature; or (3) an electronically scanned and transmitted (for example by PDF document) version of an original handwritten signature.

b. Each electronic signature affixed or attached to this Amendment (1) is deemed equivalent to a valid original handwritten signature of the person signing this Amendment for all purposes, including but not limited to evidentiary proof in any administrative or judicial proceeding, and (2) has the same force and effect as the valid original handwritten signature of that person.

c. The provisions of this section satisfy the requirements of Civil Code section 1633.5, subdivision (b), in the Uniform Electronic Transaction Act (Civil Code, Division 3, Part 2, Title 2.5, beginning with section 1633.1).

d. Each party using a digital signature represents that it has undertaken and satisfied the requirements of Government Code section 16.5, subdivision (a), paragraphs (1) through (5), and agrees that each other party may rely upon that representation.

e. This Amendment is not conditioned upon the parties conducting the transactions under it by electronic means and either party may sign this Amendment with an original handwritten signature.

8. This Amendment may be signed in counterparts, each of which is an original, and all of which together constitute this Amendment.

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9. The Agreement as amended by this Amendment No. 1 is ratified and continued. All provisions of the Agreement and not amended by this Amendment No. 1 remain in full force and effect.

[*SIGNATURE PAGES FOLLOW*]

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The parties are signing this Amendment No. 1 on the date stated in the introductory clause.

COUNTY OF FRESNO

Garry Bredefeld, Chairman of the Board of Supervisors of the County of Fresno

Attest:
Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By: _____
Deputy

For accounting use only:

Org No.: 56107480
Account No.: 7870
Fund No.: 0001
Subclass No.: 10000

Please see additional signature page attached.

Aspiranet, Inc.

DocuSigned by:
Vernon Brown
66ACD384F072492...

Vernon Brown, CEO

90 W. Ashlan Ave, Suite 100

Clovis, CA 93612

Signed by:
Ann Domingo
40BF559E54CB4A4...

Ann Domingo, CFO

90 W. Ashlan Ave, Suite 100

Clovis, CA 93612

For accounting use only:

Org No.: 56107666
Account No.: 7870
Fund No.: 0001
Subclass No.: 10000

Please see additional signature page attached.

Central Star Behavioral Health

Kent Dunlap 12/01/2025
Kent Dunlap (Dec 1, 2025 11:39:21 PST)

Kent Dunlap, CEO

1501 Hughes Way, Suite 150

Long Beach, CA 90810

12.1.25

Olivia Aranda, Vice President/CFO

1501 Hughes Way, Suite 150

Long Beach, CA 90810

For accounting use only:

Org No.: 56107665
Account No.: 7870
Fund No.: 0001
Subclass No.: 10000

Revised Exhibit B-1

SCOPE OF SERVICES

ORGANIZATION:	Aspiranet, Inc.
ADDRESS:	90 W. Ashlan Ave, Suite 100 Clovis, CA 93612
SERVICES:	**Senate Bill 163 Wraparound and Super Wraparound Services**
TELEPHONE:	209-669-2577, ext. 2323
CONTACT:	Sharon Lawicki, Division Director
EMAIL:	slawicki@aspiranet.org
CONTRACT PERIOD:	Upon execution - June 30, 2027 with two (2) optional one-year extensions Year 1: Upon execution – June 30, 2025 Year 2: July 1, 2025 – June 30, 2026 Year 3: July 1, 2026 – June 30, 2027 Year 4: July 1, 2027 – June 30, 2028 Year 5: July 1, 2028 – June 30, 2029

I. BACKGROUND

The California Department of Social Services (CDSS) describes Wraparound as a strengths-based planning process that occurs in a team setting to engage with children, youth, and their families. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve well-being. Wraparound is also a team-driven process. From the start, a child and family team (CFT) is formed and works directly with the family as they identify their own needs and strengths. The team develops a service plan that describes specific strategies for meeting the needs identified by the family. The service plan is individualized, with strategies that reflect the youth and family's culture and preferences. California Wraparound is intended to allow youth to live and grow up in a safe, stable, permanent family environment with access to formal and natural supports, tribes when applicable, and services consistent with the High Fidelity Wraparound (HFW) model.

The Fresno County Children's Wellbeing Continuum (CWBC) is designed to offer a seamless service delivery model across multiple service levels and settings for Fresno youth with complex behavioral and emotional needs. The Wraparound program will have a key role in ensuring consistency as the youth moves through the continuum.

II. PROGRAM GOALS AND OUTCOMES

Wraparound services in Fresno County are designed to provide individualized and comprehensive supports that reflect true partnership with families and full adherence to the HFW values, principles, and fidelity indicators. Services aim to achieve permanent placement in safe and stable family-based settings, decrease behaviors that may lead to out-of-home placement, and support families in meeting their needs and vision for a better future.

The program also seeks to promote equitable access, cultural responsiveness, cost-effective, successful outcomes across multiple life domains while increasing family social supports and resources.

This Scope of Services is based on the current understanding of the needs of Fresno County (County) youth and the initial conceptualization of program design to best meet the needs of youth. The County and Aspiranet, Inc. (Contractor) acknowledge that circumstances may arise that necessitate adjustments to the program design. In such cases, both parties agree to work together in good faith to review and, if necessary, revise this Scope of Services provided that any modifications remain consistent with HFW Standards, including fidelity indicators and State and County requirements.

Any changes to this Scope of Services shall be documented in writing and agreed upon by both parties. These changes may include additions, deletions, or modifications to the services originally agreed upon, so long as they maintain alignment with HFW principles, phases, and required fidelity monitoring processes. Any adjustments to this Scope of Services may have an impact on the project timeline and deliverables, which will be discussed and agreed upon by both parties before implementation.

III. TARGET POPULATION

Youth considered eligible for **Wraparound** will meet the following criteria:

1. Must be California Welfare and Institutions Code (WIC) 300, 601, 602; and
2. Currently placed in, at risk of being placed in, or recently discharged from a Qualified Residential Treatment Program (QRTP), a licensed Short-Term Residential Therapeutic Program (STRTP) or otherwise determined at risk of congregate care placement through a CFT;
3. Must be approved for Wraparound through the Interagency Placement Committee (IPC) and/or Enhanced Interagency Placement Committee (E-IPC) process.
4. Must be receiving services through Fresno County or be eligible to receive services in Fresno County through presumptive transfer in accordance with Assembly Bill No. 1299 and Assembly Bill 1051. Presumptive transfer only transfers Medi-Cal benefits; selected provider(s) will be expected to contract directly with the youth's county of origin.
5. Youth considered eligible for **Super Wraparound** will meet the following criteria:

1. Must be California Welfare and Institutions Code (WIC) 300, 601, 602; and

2. Currently placed, or at risk of being placed, in a licensed STRTP; and
3. Must be receiving services through Fresno County and/or be eligible for Fresno County Medi-Cal; and
4. Must be identified as eligible to receive Super Wrap services through the Children's Well-Being Continuum enrollment process, including approval by IPC and/or E-IPC, to meet the following criteria, but not limited to:
    a) Requires enhanced level of service, care coordination and support beyond traditional Wrap due to more acute and urgent needs.
    b) The child or family demonstrates a need for more robust support across multiple areas, such as crisis stabilization or intensive mental health services.

IV. LOCATION OF SERVICES

Services will be provided at Contractor's clinic site, in the community, at home and education locations, whichever is most comfortable for the youth and family. Services must be family-driven, community-based, and culturally responsive.

Contractor must also be capable of offering services through telehealth-phone and telehealth-video, when clinically appropriate or when access barriers (e.g., transportation, safety, geography) prevent in-person participation. Telehealth services must meet all State and County requirements for confidentiality, accessibility, and informed consent.

V. HOURS OF OPERATION

Contractors' office(s) shall be open Monday through Friday, 8:00 a.m. to 5:00 p.m., with services available on evenings and weekends, if required to meet the unique needs of the youth and family. Scheduling shall prioritize family convenience and accessibility, including accommodations for cultural, linguistic, and disability-related needs. At least fifty percent (50%) of services will be provided in the community and shall be scheduled on days and times that are convenient for the families, including evenings and weekends, consistent with the HFW requirement that services occur in the most natural and supportive environments.

Youth/families also have access to on-call crisis support twenty-four hours a day, seven days a week (24/7). The Contractor's on-call worker, in consultation with a supervisor and Fresno County CWS Supervisor if needed, will determine the level of support needed to address the crisis. Support ranges from telephone support and coaching to an immediate in-person response by staff.

For crisis services, the telephonic response time is 10 minutes or less and the in-person response time for an emergency is 30 minutes or less; staff are required to respond in-person when the Persons Served identify an urgent need. Crisis services must be trauma-informed, culturally responsive, and coordinated with other County and State crisis systems (e.g., Family Urgent Response Service (FURS), mobile crisis, 911, inpatient psychiatric services) as clinically indicated.

VI. DESCRIPTION OF SERVICES - CONTRACTOR RESPONSIBILITIES

All services in this section shall be delivered in alignment with UC Davis HFW Standards, including fidelity indicators and the four HFW phases (Engagement, Plan Development, Implementation, Transition). Services must be family-driven, youth-guided, needs-driven, culturally and linguistically responsive, and accessible to youth with disabilities. Contractor shall provide a level of service and support that will reflect each youth's unique and individual needs.

A. Specialty Mental Health Services

1. Specialty Mental Health Services (SMHS) shall meet all MHP documentation, medical necessity, and claiming standards. Contractor shall provide the following services to all youth in the program. Services will include but are not limited to the following:

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

    ii. Make appropriate referrals and linkages to services that are beyond that of Contractor's services under this Agreement, or as appropriate when discharging/transitioning a youth from the program;

    iii. Coordinate services with any other community mental health and non-mental health providers as well as other medical professionals including behavioral health programs for Indian children.

    iv. Assist youth/family with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, SSI, Section 8 vouchers, etc.);

    v. Develop and Identify family support. Involvement whenever possible to engage with natural support early

    vi. Refer youth/family to supported education and employment opportunities, as appropriate;

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

    viii. Provide peer support activities, as appropriate; and

    ix. Ensure language access (interpreter/translation) and disability accommodations for all contacts (in-person and telehealth), and obtain informed consent consistent with State/County policy.

2. Contractor shall deliver a comprehensive Specialty Mental Health program. Behavioral Health services include, but are not limited to:

    i. Assessment;

    ii. Treatment or care planning/goal setting;

    iii. Pediatric Symptom Checklist (PSC) 35 and the clinically appropriate version of the Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) assessment;

    iv. Individual therapy;

v. Group therapy;

vi. Family therapy;

vii. Case management;

viii. Consultation;

ix. Medication support services;

x. Hospitalization/Post Hospitalization Support;

xi. Certified Peer Support Services; and

xii. Intensive Home-Based Services (IHBS), as appropriate.

3. Contractor will ensure that all services:

   i. Are determined in collaboration with youth and family and reflect the voice, choice, and cultural practices;

   ii. Be values-driven, strengths-based, individual-driven, trauma-informed and co-occurring capable;

   iii. Be culturally and linguistically competent;

   iv. Be age, culture, gender, and language appropriate; and

   v. Include accommodations for youth with physical disability(ies).

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

5. Contractor shall maintain up-to-date caseload records of all youth enrolled in services, and provide individual, programmatic, and other demographic information to County as requested.

6. Contractor shall ensure billable Specialty Mental Health Services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards and provide all pertinent and appropriate information in a timely manner to Fresno County Department of Behavioral Health (DBH) for the purpose of billing Medi-Cal for services rendered.

7. Staffing should be appropriate for services needed by the youth and family, and shall include a Wraparound trained clinician, Wraparound coach, Family Specialist, Facilitator, Parent Partner, and Youth Peer Partner. Wraparound Role Descriptions (ca.gov)

B. SB 163 Wraparound (Wrap)

1. Contractor shall provide Wraparound services for up to fifty (50) youth at any given time, with Wrap team caseload size of eight (8) to twelve (12) youth per team. Services shall be family driven, youth-guided, highly coordinated, individualized, trauma-informed, unconditional, and assist youth and families in addressing identified needs consistent with the HFW Standards.

2. Contractor shall ensure that at least one staff person is available by phone and in person, if needed, 24 hours per day, 7 days per week during the service period to provide support and services to youth and their Caregivers on request.

3. Contractor shall provide services based on the ten (10) foundational principles of Wraparound:

    i. Family voice and choice
    ii. Team-based
    iii. Natural supports
    iv. Collaborative
    v. Community-based
    vi. Culturally competent
    vii. Individualized
    viii. Strengths-based
    ix. Persistence
    x. Outcome-based

4. Ensure that each Wrap team provides four (4) phases of effective Wrap care coordination and supportive services, including:

    i. Engagement:
        1. Within 24 hours of receiving the referral, Facilitator or Parent Partner shall make voice-to-voice contact with the referral source and Caregiver to clarify the reason for the referral, ascertain any permanency plans for foster/probation youth, determine the referral source's anticipated outcomes, and to explain the Wrap process.
        2. At the start of Wrap and Super Wrap services, the HFW team shall provide a comprehensive orientation to the youth and family, which shall be documented in the case record and revisited as needed to ensure continued clarity for the youth, family, and team members. Orientation ensures that all participants understand the HFW process and their role within it. At minimum, the orientation shall include:
            a. Overview of the HFW principles and phases so that youth and families understand the foundation of services and what to expect over time.
            b. Legal and ethical considerations, including confidentiality limits and mandated reporter obligations.
            c. Roles of all team members, including the youth and family themselves, formal team members, natural supports, and Tribes in the case of an Indian child.
            d. Expectations for participation, including how the family's voice and choice will guide service planning and implementation.
        3. Within 72 hours of receiving the referral, Facilitator, Support Counselor, and Family Partner, as needed, engage in a face-to-face meeting with the Person Served and Caregiver to clarify expectations, explain the role and principles of Wrap, discuss the overall timeline, review family culture, values, and traditions, and begin to explore

strengths, needs, and vision for the future using UC Davis HFW engagement tools and fidelity indicators.

4. Within 48 hours of the initial meeting, Facilitator, Support Counselor, and Family Partner, as needed, meet with Person Served and caregiver to briefly identify or re-state referral areas of concern, explain the obligations of Wrap Team members as mandated reporters, identify any safety concerns, and develop an Initial Safety Plan as necessary. Engagement efforts shall also ensure that natural supports, cultural representatives, and Tribes (when applicable) are invited early into the process, in alignment with HFW practice standards.
5. Youth referred to this program may have a current mental health assessment with their primary treatment provider. If that assessment was completed within the last six months and there have been no significant changes in the youth's symptoms, the Contractor shall obtain a copy of that assessment and use it to inform treatment planning. If there is no current mental health assessment, the youth's symptoms have changed significantly, and/or the previous assessment was completed longer than six months ago, the Contractor shall complete a mental health assessment within 14 calendar days or as soon as clinically appropriate.
6. Each youth in Wrap and Super Wrap shall have access to an individual and/or family therapist utilizing evidence-based practices (e.g., Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Internal Family Systems (IFS)) to address relational and attachment trauma. Youth may continue with an existing mental health provider, in which case the Wrap/Super Wrap therapist will collaborate and provide consultation to the team to ensure coordinated services. Service frequency shall be at least one (1) contact per week for Wrap and two (2) contacts per week for Super Wrap, as clinically appropriate. In addition, a psychiatrist shall provide evaluation, assessment, and ongoing support for psychotropic medication management, clinical consultation, and linkage to psychiatric services, prioritizing continuity of care.
7. Contractor will ensure staff are trained to timely engagement strategies that include encouraging alternate strategies when contact with the family is difficult.

ii. Initial plan development. (All timelines are determined by date of first contact, which is to occur within 24 hours of receiving the referral.) The objective of the Plan Development phase is to create a comprehensive, individualized plan of care that addresses the prioritized needs and goals of the youth and family.

1. The Wrap team will review the current IP-CANS to identify the youth and caregiver's needs and strengths, determine medical necessity for Specialty Mental Health Services (SMHS), and drive the development of the individualized plan of care. The completion of the IP-CANS, and any subsequent updates, is generally the responsibility of the County

Social Worker (CSW) or Probation Social Worker (PSW) unless otherwise directed by the County. The person identified as responsible for completing the IP-CANS will also be responsible for ensuring compliance with the timelines and parameters specified in the All County Letter (ACL) 25-10. This includes reviewing and updating, as needed, the IP-CANS at least every 90 days for youth receiving certain Specialty Mental Health Services (SMHS) such as ICC and IHBS, as well as updating the document within 30 days following any triggering conditions such as a significant change in the youth's behavior, placement, or service needs. Specific examples of triggering conditions are provided in All County Letter (ACL) 25-10. The Wrap team should be knowledgeable about what types of triggering conditions prompt an IP-CANS update, and should notify the CFT, including the person responsible for completing the IP-CANS, within 24 hours of any event or condition that warrants an update to the document.

2. Facilitator, in collaboration with the referring CSW or Deputy Probation Officer (DPO), shall convene a CFT meeting within 30 calendar days of commencing Wrap services to engage all existing and potential sources of support and connection for the Person Served and Caregiver. By including them in the Wrap process from the outset, the goal is to build and strengthen a team that can sustain the Person Served and Caregiver after termination of Wrap services.
3. Facilitator, in collaboration with Person Served and Caregiver, referring CWS or DPO, and representative(s) of the MHP, develops individualized Plans that are in the language of the Person Served and Caregiver, and that include goals that are specific, measurable, achievable, relevant, and time-bound (i.e., SMART goals). The plan of care shall be completed within 30 calendar days from the start of services. The Wrap team will update the plan of care, distribute to all team members, and document the updated plan in the child or youth's file at least every 90 days and more often as needed.
4. Additionally, the Facilitator, in collaboration with the CFT, shall develop a Wraparound Action Plan (WAP) within 30 calendar days of commencing Wrap services that will be reviewed at each CFT meeting, delineating SMART goals and the specific action steps that each member of the CFT will take to put the plan into effect in order to achieve the goals, including: what is going to be done, who is going to do it, when it should be completed, and how the CFT will know the action step is completed and whether it was effective.
5. Clinician shall collaborate with the Person Served and Caregiver to complete an ecomap, genogram, PSC-35, and any other documentation required by the County within 60 calendar days of commencing Wrap services.
    a. Ecomaps and genograms will be used to identify and document known relatives, kin, and other lifelong supports as part of family finding engagement and efforts.

6. The Wrap team shall collaborate with the assigned CSW, DSS Family Finding Unit and/or DPO to support family finding, engagement, and reunification efforts in alignment with HFW principles of family voice, choice, and permanency. The Contractor shall actively participate in coordinated planning and information-sharing to identify, engage, and strengthen connections with birth family members and other natural supports who can contribute to the youth's long-term stability. The Wrap team shall document its engagement and support efforts and incorporate the County's findings and direction into the individualized plan of care and Wrap Action Plan, ensuring alignment with case plan goals and permanency objectives. Progress toward family finding and reunification shall be reviewed and updated during CFT meetings.

iii. Plan implementation: During the next three to four (3-4) months of Wrap services:

1. Facilitator and Support Counselor, in collaboration with the Person Served and Caregiver, shall conduct a more thorough functional analysis of particular target behavior.
2. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that a CFT meets no less frequently than every four (4) weeks in order to monitor progress since the prior CFT meeting; support the inclusion on the CFT of "natural supports," that is individuals in the ecologies of Persons Served and Caregivers who provide care and support; identify emerging skills and competencies, supports and resources that can be utilized to achieve objectives and foundational goals; develop hypotheses about how to achieve desired outcomes in short windows of time; and develop action steps designed to address larger foundational goals that can be accomplished weekly or monthly, in order to maintain momentum by quickly demonstrating to Person Served, Caregiver, and other CFT members that progress is being made and there is hope for change.
3. Facilitator, and Family Partner as needed, shall meet at least once a week with Person Served and Caregiver to ensure that the action steps are taken, to troubleshoot difficulties they may have encountered, and provide assistance navigating systems as needed.
4. Support Counselor shall meet at least once a week with Person Served and Caregiver to review, coach, and support behavioral interventions that may help shift behaviors, support insight building around connection between emotions, thoughts, behaviors, and support identity building and strengthening.
5. Contractor shall ensure that Wrap and Super Wrap services are delivered with persistence and unconditional commitment throughout the implementation phase. The Wrap Team shall continue engagement and service delivery even in the face of barriers, limited progress, or setbacks. Plans shall be revised, alternative strategies developed, and natural supports engaged rather than discontinuing services. When teams encounter barriers to implementation, they shall seek assistance from County partners, including the assigned CSW or DPO, the Wraparound County Coordinator, Court Connected

Care Justice Services (CCCJS) team, and/or other designated County resources.

6. Facilitator, Support Counselor, and Peer Partner as appropriate, shall monitor progress to identify when the Person Served and Caregiver are ready to begin the transition out of formal Wrap services and support. Wrap team members shall utilize the IP-CANS process, monitoring verbal reports from CFT members, and personal observation, completion of action steps and achievement of short-term goals, proportionate increase in CFT composition of "natural supports," increased involvement of "natural supports" in completing action steps and managing the Wraparound process, engagement efforts related to pursuing viable alternative permanency plans for Persons Served in foster care, and decreased frequency, duration and/or intensity of target behaviors or areas of concern to assess transition readiness.
7. Implementation activities must clearly link service strategies back to the family's identified strengths, culture, and vision, ensuring that youth/family voice drives all CFT decisions.
8. Contractor shall ensure that data collected during implementation (e.g., IP-CANS updates, Plan of Care and Wrap Action Plan progress, family feedback) is used in real time to inform practice with the youth and family, provide timely feedback to staff, and identify additional staff training and coaching needs.
9. Contractor shall incorporate UC Davis HFW fidelity indicators by documenting how engagement, plan development, and implementation activities align with fidelity standards, and ensure this documentation is reviewed within Continuous Quality Improvement (CQI) processes.

iv. Transition: Approximately two (2) months prior to termination of Wrap services and support:

1. Facilitator, Support Counselor, and Family Partner as appropriate, shall ensure Persons Served and Caregivers have adequate support systems, both formal and "natural," to sustain progress achieved during Wrap, and that proper referrals have been made and no fewer than three (3) "warm handoffs" to ongoing formal service providers have been completed.
2. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that consensus exists among members of the CFT that Persons Served and Caregivers have made sufficient progress, and that adequate support systems, both formal and "natural," sufficient to sustain progress are in place such that Wrap services and support are no longer needed.
3. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that a plan is in place and agreed to by members of the CFT regarding how the team will respond when problems arise in the future.

4. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that the Person Served and Caregiver are provided an opportunity to celebrate success with other members of the CFT and say good-bye to members of the Wrap Team.
5. Transition planning shall begin early and be treated as an intentional fourth phase of Wraparound, with clear benchmarks tied to family readiness, natural supports, and permanency goals.
6. Contractor shall ensure transition plans document how the youth/family vision, culture, and identified strengths are sustained beyond Wrap services.
7. Transition activities shall include measurable goals for sustaining gains (e.g., educational stability, permanency connections, symptom reduction), and progress shall be reviewed at each CFT meeting during the transition phase.
8. Contractor shall ensure that data from transition (e.g., permanency outcomes, natural support involvement, family satisfaction surveys) is reported back to the Community Leadership Team to identify and address system barriers impacting HFW implementation.

5. For Indian Persons Served/families, the Contractor shall ensure that Tribes are engaged at the earliest point of referral, and that Tribal representatives are included in CFT meetings, plan development, and transition planning, in accordance with Indian Child Welfare Act (ICWA) requirements and HFW practice standards.
6. Throughout the course of the four phases of wraparound, Contractor will elicit continuous feedback from persons served/families and incorporate that feedback into service planning, CFT decision-making, and CQI processes.
7. It is likely that some youth in the Wraparound program will be placed in a highly intensive therapeutic placement setting such as Enhanced Intensive Services Foster Care (E-ISFC) or an Enhanced STRTP (E-STRTP). For youth dually enrolled in Wraparound and an intensive service setting, the Person-Served's CFT will determine which agency and which person is assigned as lead for the following tasks based on existing therapeutic relationships, treatment goals, and transition goals:
    i. Advanced clinical services (example: therapy and psychiatry)
    ii. Behavioral intervention/rehabilitation
    iii. Case coordination such as CFT facilitation, case management, plan development
    iv. Permanency work and family finding
8. Wraparound team members shall have the flexibility to adjust service levels based on the needs of the youth and family. When the youth is in an intensive service setting, the Wraparound team will remain engaged and responsible for care coordination and other tasks as identified by the CFT and may need to decrease service intensity to avoid duplication with the placement provider. Wraparound teams shall also be flexible to increase service intensity when needed and as determined by the CFT.
9. Contractor shall ensure that staff and their supervisors are provided with feedback on their ability to meet required service and reporting timelines. Such feedback shall be incorporated into CQI processes, including but not limited to monthly reports, performance monitoring meetings, and any County-requested CQI reports, to promote accountability, improve service delivery, and support staff development.

10. Contractor shall ensure that all requests, approvals, and expenditures of Flexible Funds are consistent with the County's Flex Fund Policy (Exhibit T). Contractors shall integrate Flex Fund utilization into the service planning process, including documentation of team recommendations, purpose of expenditure, and expected outcomes.
11. Length of Stay:

    i. The approximate length of stay for the traditional Wrap service line is nine (9) to twelve (12) months. While stated length of stay reflects general parameters, a youth and family's ongoing participation in the Wrap program is driven by their demonstrated need.

C. Super Wrap

1. In addition to the above-mentioned Wraparound services, the Contractor shall provide higher intensity Wrap services referred to as "Super Wrap" to four (4) youth, at any given time, who have been pre-authorized for these services by the County. Super Wrap team caseload size shall be one (1) youth per team. Contractor has discretion regarding team make-up.
2. Contractor shall ensure that the Super Wrap Team provides up to twenty-five (25) hours per week of care coordination and/or support services to the Person Served, on behalf of the Person Served, or to the Caregiver.
3. Contractor shall ensure that at least one staff person is available by phone and in person, if needed, 24 hours per day, 7 days per week during the service period to provide support and services to youth and their Caregivers on request.
4. Contractor shall ensure that each Super Wrap Team provides four (4) phases of effective Wrap care coordination and supportive services as outlined in Wraparound section 3 with these frequency modifications for Super Wrap participants:

    i. Initial plan development. (All timelines are determined by date of first contact, which is to occur within 24 hours of receiving the referral.)

        1. Facilitator, in collaboration with the CFT shall develop a WAP within 14 calendar days of commencing Wrap services that will be reviewed at each CFT meeting, delineating SMART goals and the specific action steps that each member of the CFT will take to put the plan into effect in order to achieve the goals, including: what is going to be done, who is going to do it, when it should be completed, and how the CFT will know the action step is completed and whether it was effective.

        2. Clinician shall collaborate with the Person Served and their Caregiver to complete an ecomap, genogram, PSC-35, and any other documentation required by the County within 14 calendar days of commencing Super Wrap services, unless otherwise noted.

    ii. Plan implementation: During the next three (3) months of Super Wrap services:

1. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that the CFT meets no less frequently than every two (2) weeks in order to monitor progress since the prior CFT meeting; support the inclusion on the CFT of “natural supports,” that is individuals in the ecologies of Person Served and their Caregiver who provide care and support; identify emerging skills and competencies, supports and resources that can be utilized to achieve objectives and foundational goals; develop hypotheses about how to achieve desired outcomes in short windows of time; and develop action steps designed to address larger foundational goals that can be accomplished weekly or monthly in order to maintain momentum by quickly demonstrating to Persons Served, their Caregiver(s), and other CFT members that progress is being made and there is hope for change.
2. Facilitator, and Family Partner as needed, shall meet at least two (2) times per week with the Person Served and their Caregiver to ensure that the action steps are taken, to troubleshoot difficulties they may have encountered, and provide assistance navigating systems as needed.
3. Support Counselor shall meet at least two (2) times per week with the Person served and their Caregiver to review, coach and support behavioral interventions that my help shift behaviors, support insight building around connection between emotions, thoughts, and behaviors, and support identity building and strengthening.
4. Therapist shall meet at least two (2) times per week with each Person Served and/or their Caregiver to provide individual or family therapy as indicated and, utilizing evidence-based practices (e.g., Motivational Interviewing, CBT, DBT, and IFS Therapy), to address the individual Person Served’s experience of relational and attachment trauma.
5. Family Partner shall meet at least one (1) time every week with the Caregiver to provide support navigating the numerous systems of care and service provision impacting their lives.

iii. Transition: Approximately 45 calendar days prior to termination of Super Wrap services and support:

1. Facilitator, Support Counselor, and Family Partner as appropriate, shall ensure the Person Served and their Caregiver have adequate support systems, both formal and “natural,” to sustain progress achieved during Super Wrap, and that proper referrals have been made and no fewer than six (6) “warm handoffs” to ongoing formal service providers have been completed.

5. Length of Stay:

i. The approximate length of stay for the Super Wrap service line is 90-days. While stated service timeline reflects general parameters, a youth and family’s length of stay in the Super Wrap program is driven by their demonstrated need.

ii. All extension requests for Super Wrap services would need to be presented to the County for approval. These presentations shall include the start date for Super Wrap services, the average frequency and duration of scheduled services, description of the youth's level of engagement and progress or lack of progress in treatment and any other relevant treatment information that would explain why this youth needs to remain at the Super Wrap level of service. The contractor shall also present a projected transition date for when the youth can return to traditional Wrap services.

D. Crisis Services

1. Contractor shall develop, document, and implement individualized crisis and safety plans for each youth and family in accordance with HFW standards. Contractor shall provide supports designed to reduce the need for professional crisis interventions by strengthening the family's and natural supports' capacity to manage crises.
    i. At the time of Engagement, the Wrap team shall discuss any immediate crisis or safety concerns raised by the youth or family. If pressing concerns are identified, the team will develop an immediate written crisis response plan, provide a copy of the plan to the family, and document it in the youth's chart.
    ii. The immediate crisis plan shall inform, but not replace, the formal HFW Safety Plan developed during the Plan Development phase.
    iii. All families shall be provided with clear information on how to access 24/7 crisis response when needed, including the on-call contact process.
    iv. Contractor shall ensure Wrap staff are trained to implement safety and preventive measures when responding to any self- harming and/or other behaviors that pose risk to the youth or others. Wrap staff shall be prepared to initiate mobile response services by contacting the treating provider, FURS, or 911, as clinically indicated. Should the youth require an emergency evaluation for acute psychiatric hospitalization, Wrap staff shall take the necessary steps to ensure the youth receives the appropriate intervention to address the mental health crisis.
2. Contractor shall ensure that Wrap staff or Wrap administrator notify the CWS hotline, the CSW, DPO and appropriate CWS Division Chief/Assistant Deputy Chief (ADC), or designee for all incidents that indicate a sign of threat or continued risk to the physical or mental health status of the Wrap youth including all such incidents that require a Critical Incident Report, as outlined in this agreement.
    i. The Contractor shall then follow up with the SW by phone within one business day of the incident.
3. Contractor shall comply with the following when youth are referred for psychiatric hospitalization:
    i. Notify the CWS hotline, the SW, DPO and appropriate CWS Division Chief/ADC, or designee as soon as it is reasonably safe to do so, but no later than the end of the day and complete a critical incident report.
        1. The Contractor shall then follow up with the SW by phone within one business day.
    ii. Participate in case conferences, hospital discharge conference and/or the CFT meetings for youth referred for psychiatric hospitalization.

iii. Continue to provide Wrap services, to the extent possible, during the youth's hospitalization.
iv. Initiate a CFT meeting within 24 hours of youth's return to the community.

4. Contractor shall track and report all crisis incidents, including those averted through natural supports and those requiring professional intervention (e.g., mobile crisis, emergency department, psychiatric hospitalization, law enforcement involvement). A quarterly report summarizing crisis incidents, responses, and outcomes shall be submitted to the County.

E. Additional Responsibilities

1. Maintain responsibility for necessary testimony and/or providing County with information needed to generate court reports, as outlined below:
    i. Court Reports - Documented reports of assessment and evaluation findings, progress in treatment, recommendations for treatment and service plans regarding reunification, maintenance and termination of parental rights, and justification for recommendations.
    ii. Court Testimony - Provide care plan updates when a court is considering reunification, maintenance, and/or termination of parental rights.
2. Upon notification of a pending court hearing, Contractor agrees to complete and submit to the County a "Periodic Review Report" twenty-one (21) calendar days prior to the court date or seven (7) calendar days after notification.
3. Maintain electronic health records and supply their own personal computers, Internet access, printers, signature pads and other network devices to meet statistical reporting requirements, report Person-Served and program outcomes and any State or County data requirements of the Katie A. Implementation Plan. Contractor shall also maintain capability to enter electronic billing data into County's electronic health record system. A computer with Internet access is required for both office and field-based staff.
4. Cooperate and participate with the County MHP in Quality Assurance/Improvement and Utilization Review Programs and grievance procedures and comply with all final determinations rendered by County's Quality Assurance/Improvement and Utilization Review Programs, unless the decision is reversed on appeal as set forth in the County MHP Provider Manual, incorporated herein by this reference. County's adverse decisions regarding Contractor's services to Persons-Served may result in the disallowance of payment for services rendered; or may result in additional controls to the delivery of services; or may result in the termination of this Agreement. County shall have sole discretion in the determination of Quality Assurance/Improvement and Utilization Review outcomes, decisions and actions.
5. Obtain signatures, as required, regarding consent:
    i. Care provider can sign for day trips and other minor miscellaneous items.
    ii. Court Order should suffice for most other items.
6. Work collaboratively with other CWBC providers to develop and enter into Memorandum of Understanding or other business agreements between themselves that defines the processes and procedures for provision of services to foster youth, including, but not limited to the:
    i. Case Planning
    ii. Care Coordination

iii. Intensive Transition Planning
iv. Assessment
v. Transportation between service settings
vi. Information sharing
vii. Data collection and dissemination

7. Work with DPO on criminogenic risk factors for probation youth as addressed through contracted services as applicable.

F. Admission, Transition and Discharge

1. Entry Criteria

All youth referred to the Wrap and Super Wrap services will have pre-approval from the County. This includes STRTP aftercare and re-referrals. Equal access is required. Services shall not be denied or delayed based on the youth's placement, geographic location (including out-of-county placements under presumptive transfer), disability, or cultural needs.

Family First Prevention Services Act (FFPSA) Part IV mandates six months family-based aftercare services for children discharged from qualified residential treatment programs to family-based settings, including high-fidelity Wrap (ACL 21-116). Fresno County will be leveraging existing Wraparound services to meet this requirement.

2. Intake and Initial Assessment

Contractor shall respond to all Wrap and Super Wrap referrals within 24 hours of receipt. Youth referred to this program may have a current mental health assessment with their primary treatment provider. If that assessment was completed within the last six months and there have been no significant changes in the youth's symptoms, the Contractor shall obtain a copy of that assessment and use it to inform treatment planning. If there is no current mental health assessment, the youth's symptoms have changed significantly and/or the previous assessment was completed longer than six months ago, the Contractor shall complete a mental health assessment within 14 calendar days or as soon as clinically appropriate.

In instances where a youth is currently enrolled in Wraparound services and is subsequently identified as potentially eligible for Super Wraparound services, Contractor shall, in coordination with the County, evaluate the youth's eligibility for Super Wraparound within thirty (30) calendar days of identification. If deemed appropriate, Contractor shall implement Super Wraparound services within this timeframe. Ongoing communication with the County regarding the youth's status, eligibility determination, and service transition shall be maintained throughout this process.

3. Transition and Discharge

Youth referred to the Wrap/Super Wrap program may be denied services if the youth does not meet medical necessity for specialty mental health services and/or the

necessary criteria to be eligible for Wrap/Super Wrap services. Youth who are determined to be ineligible for these services will be linked to other appropriate services and resources.

Discharge is determined on a case-by-case basis depending on the youth's progress toward individualized treatment goals. Wraparound services operate with an unconditional care approach; services are not ended solely due to challenges in engagement, crisis events, or lack of progress. Instead, the team adapts strategies and persists in supporting the youth and family until transition readiness is achieved. Reasons for discharge include the youth or caregiver refuses or terminates services; the youth is transferred to another program mutually agreed upon by the youth, parent/caregiver, and Wrap; and/or mutual agreement that the treatment goals have been met. For youth and families who decline or terminate services, reasonable and documented efforts must reflect the team's attempts to engage and re-engage the family in alignment with HFW standards.

All transitions and discharges shall be discussed in a CFT to ensure all members of the youths' support system are aware of the recommendation being made by the Contractor.

Contractor shall administer a survey to youth and families at discharge, collect and track responses, and report data to the County. Surveys shall capture satisfaction with services, family voice and choice, and perceived readiness for transition in alignment with HFW standards. Aggregate results shall be incorporated into the Contractor's CQI process and reported to the County as required.

VI. STAFFING

A. Each Contractor shall provide the following staffing components, at minimum:

1. Staffing shall be appropriate and aligned with the HFW model, which would include the following roles: facilitator, family specialist, parent partner, youth partner, fidelity coach, HFW Supervisor/Manager, and clinical supervisor.

2. Each Wrap and Super Wrap Team shall be comprised of:

    a. One (1) Facilitator with a Mental Health Rehabilitation Specialist (MHRS) qualification or above who meets with the youth, their Caregiver, and other team members to complete assessments, individualized plans, and Wraparound Action Plans; organize and facilitate Family Team meetings; and ensure successful linkage of Persons Served and their Caregiver(s) to ongoing resources and support. The Facilitator shall also serve as a support and mentor to other members of the team, as needed.
        A. Frequency of service for Wrap: at least one (1) contact per week
        B. Frequency of service for Super Wrap: at least two (2) contacts per week
    b. A minimum of two (2) Support Counselors who are a bachelor's level paraprofessional who shall meet with the Person Served to provide one-on-one support for the Person Served, focusing on increasing the frequency of

desired behaviors, gaining access to pro-social activities and resources within the community, and developing effective relationship-building skills.
    A. Frequency of service for Wrap: at least one (1) contact per week
    B. Frequency of service for Super Wrap: at least two (2) contacts per week

c. One (1) Family/Parent Partner and One (1) Youth Partner, who has lived experience, to provide support to the Person Served and their Caregiver in navigating the numerous systems of care and service provision impacting their lives as needed.
    A. Frequency of service for Wrap: at least one (1) contact every 2 weeks
    B. Frequency of service for Super Wrap: at least one (1) contact per week

d. Fidelity coaching is to be provided to ensure services are delivered in accordance with High Fidelity Wraparound principles and standards. The position fulfilling this role will support staff through regular observation, coaching sessions, and review of fidelity tools, promotes continuous quality improvement, and ensures that facilitators, family partners, and youth partners are implementing the model with fidelity.

3. Ensure each Wrap and Super Wrap team has access to:
    a. One (1) Individual or Family Therapist to meet with the youth and their Caregiver to provide individual or family therapy and utilizing evidence-based practices (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Internal Family Systems Therapy) to address youth's experience of relational and attachment trauma as needed. If the youth choose to continue therapy with their current mental health provider, the Wrap/Super Wrap therapist shall continue to provide consultation to the other members of the WRAP/Super Wrap team and will work in collaboration with the existing therapist to ensure joint services are provided appropriately.
        A. Frequency of service for Wrap: at least one (1) contact per week as clinically appropriate
        B. Frequency of service for Super Wrap: at least two (2) contacts per week as clinically appropriate
    b. One (1) Psychiatrist to meet with the Person Served to provide evaluation and assessment for psychotropic medication, clinical consultation, and assistance linking the Person Served and their Caregiver to ongoing psychiatric services and support as needed and prioritizing continuity of care where possible.
        A. The frequency of psychiatry services will be at least one (1) time per month for Wrap and Super Wrap participants.
4. Workforce development, including recruitment, hiring, training, and coaching, shall be consistent with the California High Fidelity Wraparound (HFW) Standards and Toolkit (Staffing Wraparound).
5. Ensure there is no change to a youth's primary Wraparound team members when the youth transitions between the Wrap level of service and the Super Wrap level of service to preserve the therapeutic relationship and provide continuity of care.

6. Ensure that direct service staff reimbursed through this contract shall spend at least 65% of their paid work time providing and documenting direct service to clients or on behalf of clients. Administrative staff meetings, supervision meetings, and staff trainings shall not be included in the 65%.

VII. TRAINING:

A. The California Wrap Standards require providers to have a HFW training plan that incorporates initial, ongoing, and annual booster training to all staff as well as role specific training. Contractor shall ensure that all Wrap and Super Wrap staff receive comprehensive initial training and ongoing coaching consistent with the California HFW Standards (HFW Training) and Fresno County expectations.
    1. Foundational Training (Wraparound 101: Foundations for Fidelity)
        a. All staff shall receive orientation and training in the Ten Principles of Wraparound, the Four Phases of HFW (Engagement, Plan Development, Implementation, Transition), and the use of High Fidelity Wraparound fidelity indicators.
        b. Staff shall be trained in trauma-informed, culturally respectful, and linguistically competent practices.
        c. Staff are trained in timely engagement strategies, including alternate strategies when contact with families is difficult.
        d. Supervisors and staff receive training on meeting timelines and CQI processes tied to engagement, plan development, plan updates, and reporting.
    2. Needs-Driven, Strengths-Based and Solution-Focused Practices
        a. Staff are trained to identify underlying needs, develop needs statements that go beyond behaviors, and ensure plans are needs-focused rather than deficit-focused.
        b. Staff shall receive ongoing training and coaching in identifying functional strengths of youth, caregivers, families, and community supports, and in applying strengths to drive planning and service strategies.
        c. Staff shall receive training in solution-focused and evidence-based practices including, but not limited to, Motivational Interviewing, CBT, DBT, and IFS.
    3. IP-CANS and Assessment Tools
        a. Staff shall be trained to complete, interpret, and utilize the IP-CANS, PSC-35, and other County-required assessments to guide planning and CQI.
        b. Training includes requirements for timely completion (within 14 days of engagement, updated every 90 days or within 30 days of a triggering event) and integration into CFT decision-making.
    4. Facilitation and Teaming
        a. Facilitators shall be trained and coached in leading CFT meetings that are inclusive of family, natural supports, and Tribes in the case of an Indian child, and in ensuring family voice and choice are central to planning.
        b. Training shall include engagement strategies, team-building activities, and consensus-based decision-making.
    5. Individualized Services

   a. Facilitators and staff are trained to develop highly individualized plans of care, using flexible strategies tailored to youth and family strengths, needs, values, and culture.
6. Culturally Respectful and Relevant Services
   a. Staff receive ongoing training in eliciting, honoring, and incorporating family culture, traditions, and values into planning and service delivery.
   b. Contractor shall provide training for staff on ICWA requirements, Tribal sovereignty, and culturally responsive service delivery for Native American youth and families.
7. Crisis and Safety Planning
   a. Staff shall be trained in development and implementation of crisis and safety plans, including proactive and reactive strategies, safety interventions, and maximizing natural supports.
   b. Training includes immediate crisis response procedures, 24/7 access, and escalation protocols (FURS, mobile crisis, 911).
8. CQI and Fidelity Monitoring
   a. Staff and supervisors shall receive training on the use of fidelity and quality monitoring tools which may include but not limited to Wraparound Fidelity Index [WFI], Team Observation Measure [TOM 2.0]), Document Assessment Review Tool (DART), satisfaction surveys, and feedback loops to improve practice.
   b. Supervisors and coaches shall observe team meetings, review documentation, and provide feedback to staff for ongoing skill-building and adherence to HFW fidelity standards.
   c. All staff are trained on how family feedback and fidelity measures inform CQI processes.
9. Ongoing and Annual Requirements
   a. All staff must complete at least an annual refresher training on Wraparound principles, fidelity indicators, trauma-informed care, cultural competency, and County-specific requirements.
   b. Staff must attend County-offered trainings, which may include Quality Parenting Initiative (QPI), Neurosequential Model of Therapeutics (NMT), cultural competency, Civil Rights, and other System of Care initiatives.
   c. Contractor shall maintain training logs, curricula, and attendance records, and shall provide documentation of training completion to the County upon request.
10. Youth, families and peer partners with current or prior Wraparound experience are meaningfully incorporated into the delivery of required Wraparound trainings.
11. Community partners are invited to attend Wraparound trainings or are offered trainings on Wraparound to strengthen their participation on HFW teams or to strengthen their role in supporting HFW within the System of Care.
12. Develop training curriculum as County identifies a need.
13. Assist with training County staff and the community in Wraparound Service processes and service options.

VIII. COUNTY RESPONSIBILITIES:

COUNTY shall:

A. Assist Contractors' efforts to evaluate the needs of each enrolled youth on an ongoing basis to ensure each youth is receiving clinically appropriate services.

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

C. Assist Contractors in making linkages with the total mental health system of care. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

D. Participate in evaluating overall program progress and efficiency and remain available to contractors for ongoing consultation.

E. Gather outcome information from target Person Served groups and Contractors throughout each term of this Agreement. County shall notify Contractors when their participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, Person Served and staff interviews, chart reviews, and other methods of obtaining required information.

F. Assist Contractors' efforts toward cultural and linguistic competency by providing the following to contractors:

    B. Technical assistance and training regarding cultural competency requirements at no cost to contractors.

    C. Mandatory cultural competency training for contractors' personnel, on an annual basis, at minimum.

    D. Technical assistance for translating information into County's threshold languages (Spanish and Hmong). Translation services and costs associated will be the responsibility of contractors.

VIII. REPORTS

Contractor shall track data and provide reporting on the following items and send all applicable information and reports to the following distribution list for County staff: DSS Staff Analyst, DSS Division Chief, DSS Social Work Supervisor, DBH Contract Analyst, Probation Assistant Deputy Chief, and Probation Contract Analyst.

1) Contractors shall be expected to comply with all contract monitoring and compliance protocols, procedures, data collection methods, and reporting requirements conducted by County.
2) Contractors will be responsible for meeting with DBH and DSS on a monthly basis, or more often as agreed upon between DBH, DSS, and Contractors, for contract and performance monitoring.

3) Contractors will be required to submit monthly reports on performance measures to the County. Report formats will be established through County/Contractor collaboration. Outcome measures may change, based on information or measures needed. Required monthly reports include:
    a) DSS Monthly Activity Report (MAR); and
    b) Other reports as established by the County.
4) All reports will be due to the County by the 10th business day of each month and will be reviewed for accuracy. (If the 10th lands on a weekend or Holiday, reports will be due the next business day). Reimbursement for monthly expenses may be delayed in the event inaccurate reports are submitted.
5) Provide county with various reports through the length of the youth's enrollment in the program; a few of which are standardized and include: "Monthly Progress Report", "Discharge Presentation", "Individual Child and Family Plan Presentation Outline", and "Individual Child and Family Plan (ICFP)".
6) Contractor will report and document all major and/or sensitive incidents ("critical incidents") to the County pursuant to the procedures and timing outlined in Exhibit J "Fresno County Mental Health Plan Incident Report." The County, at its sole discretion, may require the Contractor to conduct all necessary follow-up activities after reporting critical incidents. If there is any doubt about whether an incident should be reported, the default shall be for the Contractor to report the incident to the County.
7) Contractors shall use collected data not only for compliance reporting but also in real time to improve practice with youth and families, including providing staff with timely feedback from data or reports relevant to their service provision.
8) Data shall be reviewed and analyzed at multiple levels (youth/family, program, and system) to identify staff training needs, address program effectiveness, and inform CQI processes.
9) Contractor shall ensure that data is collected, analyzed, and utilized to identify and communicate both outcomes of HFW implementation and system barriers that impact service delivery, including those that impact Tribal youth. Outcomes and barriers shall be elevated to the Community Leadership Team (CLT) for review, discussion, and resolution.
10) Contractor shall ensure all data collection and reporting is culturally responsive, ensuring outcomes are interpreted in the context of family culture, values, and vision.
11) Contractor shall participate in collaborative local CQI evaluation plans with County, Providers, and System of Care participant organizations, as required by UC Davis HFW fidelity indicators.
12) Additional reports and outcome information may be requested by County at a later date, as needed.

IX. GOALS/OUTCOMES

Contractor is required to submit measurable outcomes on a semi-annual, as identified in the DBH's Policy and Procedure Guide (PPG) 1.2.7 Performance Outcomes Measures. Performance outcome measures must be approved by DBH and DSS and satisfy all State and local mandates. County will provide technical assistance and support in defining measurable

outcomes. The outcome measures and indicators provided below represent County DBH and DSS program goals to be achieved by the Contractor in addition to Contractor's developed outcomes and the HFW Expected Outcomes. Outcomes for youth center on the following core areas: permanency, behavioral stability, symptom reduction, living situation stability, strengths development, and educational stability. Outcomes for Persons-Served vary based on their individual needs and challenges faced by the specific youth and their plans of care; however, common quantifiable outcomes at the program level include:

Fresno County Wraparound Contract Performance Expectations

Metric	Definition	Performance Indicator
Service utilization	Minimum service levels by the required staffing level in order to earn full payment	**Wraparound:** Ensure that the Wrap Team provides between **24 to 32 hours per month (about 6-8 per week)** of care coordination and/or support services to Persons Served or to Person's Served Caregiver. **Super Wrap:** Ensure that the Super Wrap Team provides approximately **100 hours a month (about 25 hours a week)** of care coordination and/or support services to the Person Served. In no case should the hours of service performed be less than the minimum above.
Service timeliness	**Wrap** · Make contact with referral source within **24 hours** · Initial face to face engagement meeting within **72 hours** of referral · Follow-up meeting within **48 hours** · IP-CANS completion within **14 calendar days** of initial meeting · Wrap Action Plan developed within **30 calendar days** of initial meeting · CFT meeting within **30 calendar days** of initial meeting (and w/n **24 hours** of discharge form inpatient admission)-	90% compliance with service timeliness as documented in Monthly Activity Reports (MARs)

	· Ecomap, genogram, PSC-35 created within **60 calendar days** of initial meeting · CFT meetings no less than **monthly**- · **Weekly** activity with facilitator, family partner, youth and caregiver · Support counselor meets at least **1 x per week** · Transition planning occurs **1-2 months** prior to end of Wrap **<u>Super Wrap</u>** · Make contact with referral source within **24 hours** · Initial face to face engagement meeting within **72 hours** of referral · Follow-up meeting within **48 hours** · IP-CANS completion within **14 calendar days** of initial meeting · Wrap Action Plan developed within **15 calendar days** of initial meeting · CFT meeting within **15 calendar days** of initial meeting (and w/n **24 hours** of discharge form inpatient admission)- · Ecomap, genogram, PSC-35 created within **15 calendar days** of initial meeting · CFT meetings no less than every **2 weeks**- · Activity with facilitator, youth and caregiver at least **2 x per week** · Activity with family partner at least **1 x per week** · Support counselor meets at least **2 x per week** · Transition planning occurs **45 calendar days** prior to end of Wrap	

Fresno County Wraparound Contract Outcomes

Metric	Definition	Performance Indicator
Improved behavioral/ emotional needs	Youth shall have a reduction in action items in the Behavioral/Emotional Needs Domain, Risk Behaviors Domain	90% of youth shall see a reduction in action items on IP-CANS over time
Improved Strengths	Youth will have improved scores in the Strengths domain of the IP-CANS	80% of youth shall show improvement on IP-CANS over time
School Improvement	Youth will demonstrate improved educational functioning from intake to discharge as measured by IP-CANS Life Functioning items related to school functioning including school behavior, school achievement, and school attendance.	80% of youth shall show improvement on IP-CANS over time
Increase Natural Supports	Natural Supports are actively involved across all phases of Wrap/Super Wrap.	At least one natural support attends 50% of all CFTs.
Permanency Planning	Youth will have improved scores in the Living Situation and Family Functioning items in the Life Functioning Domain	90% of youth shall show improvement on IP-CANS over time
Transition to less restrictive placements	Youth experience stability in their community-based living situation and do not experience a new placement in an institution (such as detention, psychiatric hospitalization, treatment center, or STRTP) upon discharge.	80% of youth accepted to the program will be transitioned to less restrictive placements including but not limited to legal or emotional/relational permanency or with their family for stabilization and preservation of their family placement.
Reduction in Inpatient, Emergency Department Admission for	Youth experience stability with regard to their behavioral health, necessitating fewer or no visits to the hospital.	At least 80% of youth enrolled in Wraparound will experience no more than one behavioral health-related inpatient or emergency department admission during the course of enrollment.

Behavioral Health Visits		
Improved Functioning in the Community	Youth experience improved functioning in the community as well as improved interpersonal functioning.	At least 75% of youth will show improved scores on IP-CANS items related to Community and School Functioning over time.
Client satisfaction	Youth and families are satisfied with their HFW experience and progress, including caregiver confidence in their ability to manage the youth's needs and access support.	At least 75% of youth and caregivers shall report a positive experience of services, perceived improvement in functioning, and increased caregiver confidence, as measured through post-service surveys

In addition to the outcomes above being tracked on the MAR and other County-designated reporting mechanisms (e.g., DOMO dashboards), Contractors shall utilize a computerized tracking system with which performance and outcome measures and other relevant Person Served data, such as demographics, will be maintained. The data tracking system may be incorporated into the Contractors' electronic health records (EHR) systems or in stand-alone databases (e.g., Access or Excel spreadsheets). County must be afforded read-only access to the data tracking system.

County may adjust the performance and outcome measures periodically throughout the duration of the Agreement, as needed, to best measure the program as determined by County and/or CDSS/DHCS.

Revised Exhibit B-2

SCOPE OF SERVICES

ORGANIZATION:	Central Star Behavioral Health, Inc.
ADDRESS:	1501 Hughes Way, Suite 150 Long Beach, CA 90810
SERVICE ADDRESS:	3433 W. Shaw Ave, Suite 107 Fresno CA, 93711
SERVICES:	**Senate Bill 163 Wraparound and Super Wraparound Services**
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CONTRACT PERIOD:	Upon execution - June 30, 2027 with two (2) optional one-year extensions Year 1: Upon execution – June 30, 2025 Year 2: July 1, 2025 – June 30, 2026 Year 3: July 1, 2026 – June 30, 2027 Year 4: July 1, 2027 – June 30, 2028 Year 5: July 1, 2028 – June 30, 2029

I. BACKGROUND

The California Department of Social Services (CDSS) describes Wraparound as a strengths-based planning process that occurs in a team setting to engage with children, youth, and their families. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve well-being. Wraparound is also a team-driven process. From the start, a child and family team (CFT) is formed and works directly with the family as they identify their own needs and strengths. The team develops a service plan that describes specific strategies for meeting the needs identified by the family. The service plan is individualized, with strategies that reflect the youth and family's culture and preferences. California Wraparound is intended to allow youth to live and grow up in a safe, stable, permanent family environment with access to formal and natural supports, tribes when applicable, and services consistent with the High Fidelity Wraparound (HFW) model.

The Fresno County Children’s Wellbeing Continuum (CWBC) is designed to offer a seamless service delivery model across multiple service levels and settings for Fresno youth with complex

behavioral and emotional needs. The Wraparound program will have a key role in ensuring consistency as the youth moves through the continuum.

II. PROGRAM GOALS AND OUTCOMES

Wraparound services in Fresno County are designed to provide individualized and comprehensive supports that reflect true partnership with families and full adherence to the HFW values, principles, and fidelity indicators. Services aim to achieve permanent placement in safe and stable family-based settings, decrease behaviors that may lead to out-of-home placement, and support families in meeting their needs and vision for a better future.

The program also seeks to promote equitable access, cultural responsiveness, cost-effective, successful outcomes across multiple life domains while increasing family social supports and resources.

This Scope of Services is based on the current understanding of the needs of Fresno County (County) youth and the initial conceptualization of program design to best meet the needs of youth. The County and Central Star Behavioral Health, Inc. (Contractor) acknowledge that circumstances may arise that necessitate adjustments to the program design. In such cases, both parties agree to work together in good faith to review and, if necessary, revise this Scope of Services provided that any modifications remain consistent with HFW Standards, including fidelity indicators and State and County requirements .

Any changes to this Scope of Services shall be documented in writing and agreed upon by both parties. These changes may include additions, deletions, or modifications to the services originally agreed upon, so long as they maintain alignment with HFW principles, phases, and required fidelity monitoring processes. Any adjustments to this Scope of Services may have an impact on the project timeline and deliverables, which will be discussed and agreed upon by both parties before implementation.

III. TARGET POPULATION

Youth considered eligible for **Wraparound** will meet the following criteria:

1. Must be California Welfare and Institutions Code (WIC) 300, 601, 602; and
2. Currently placed in, at risk of being placed in, or recently discharged from a Qualified Residential Treatment Program (QRTP), a licensed Short-Term Residential Therapeutic Program (STRTP) or otherwise determined at risk of congregate care placement through a CFT;
3. Must be approved for Wraparound through the Interagency Placement Committee (IPC) and/or Enhanced Interagency Placement Committee (E-IPC) process.
4. Must be receiving services through Fresno County or be eligible to receive services in Fresno County through presumptive transfer in accordance with Assembly Bill No. 1299 and Assembly Bill 1051. Presumptive transfer only transfers Medi-Cal benefits; selected provider(s) will be expected to contract directly with the youth's county of origin.
5. Youth considered eligible for **Super Wraparound** will meet the following criteria:

1. Must be California Welfare and Institutions Code (WIC) 300, 601, 602; and

2. Currently placed, or at risk of being placed, in a licensed Short-Term Residential Therapeutic Program (STRTP); and

3. Must be receiving services through Fresno County and/or be eligible for Fresno County Medi-Cal; and

4. Must be identified as eligible to receive Super Wrap services through the Children's Well-Being Continuum enrollment process, including approval by IPC and/or E-IPC, to meet the following criteria, but not limited to:

    a) Requires enhanced level of service, care coordination and support beyond traditional Wrap due to more acute and urgent needs.
    b) The child or family demonstrates a need for more robust support across multiple areas, such as crisis stabilization or intensive mental health services.

IV. LOCATION OF SERVICES

Services will be provided at Contractor's clinic site, in the community, at home and education locations, whichever is most comfortable for the youth and family. Services must be family-driven, community-based, and culturally responsive.

Contractor must also be capable of offering services through telehealth-phone and telehealth-video, when clinically appropriate or when access barriers (e.g., transportation, safety, geography) prevent in-person participation. Telehealth services must meet all State and County requirements for confidentiality, accessibility, and informed consent.

V. HOURS OF OPERATION

Contractors' office(s) shall be open Monday through Friday, 8:00 a.m. to 5:00 p.m., with services available on evenings and weekends, if required to meet the unique needs of the youth and family. Scheduling shall prioritize family convenience and accessibility, including accommodations for cultural, linguistic, and disability-related needs. At least fifty percent (50%) of services will be provided in the community and shall be scheduled on days and times that are convenient for the families, including evenings and weekends. consistent with the (HFW) requirement that services occur in the most natural and supportive environments.

Youth/families also have access to on-call crisis support twenty-four hours a day, seven days a week (24/7). The Contractor's on-call worker, in consultation with a supervisor and Fresno County CWS Supervisor if needed, will determine the level of support needed to address the crisis. Support ranges from telephone support and coaching to an immediate in-person response by staff.

For crisis services, the telephonic response time is 10 minutes or less and the in-person response time for an emergency is 30 minutes or less; staff are required to respond in-person when the Persons Served identify an urgent need. Crisis services must be trauma-informed, culturally responsive, and coordinated with other County and State crisis systems (e.g., Family Urgent Response Service (FURS), mobile crisis, 911, inpatient psychiatric services) as clinically indicated.

VI. DESCRIPTION OF SERVICES - CONTRACTOR RESPONSIBILITIES

All services in this section shall be delivered in alignment with UC Davis HFW Standards, including fidelity indicators and the four HFW phases (Engagement, Plan Development, Implementation, Transition). Services must be family-driven, youth-guided, needs-driven, culturally and linguistically responsive, and accessible to youth with disabilities. Contractor shall provide a level of service and support that will reflect each youth's unique and individual needs.

A. Specialty Mental Health Services

1. Specialty Mental Health Services (SMHS) shall meet all MHP documentation, medical necessity, and claiming standards. Contractor shall provide the following services to all youth in the program. Services will include but are not limited to the following:

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

    ii. Make appropriate referrals and linkages to services that are beyond that of Contractor's services under this Agreement, or as appropriate when discharging/transitioning a youth from the program;

    iii. Coordinate services with any other community mental health and non-mental health providers as well as other medical professionals including behavioral health programs for Indian children.

    iv. Assist youth/family with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, SSI, Section 8 vouchers, etc.);

    v. Develop and Identify family support. Involvement whenever possible to engage with natural support early

    vi. Refer youth/family to supported education and employment opportunities, as appropriate;

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

    viii. Provide peer support activities, as appropriate; and

    ix. Ensure language access (interpreter/translation) and disability accommodations for all contacts (in-person and telehealth), and obtain informed consent consistent with State/County policy.

2. Contractor shall deliver a comprehensive Specialty Mental Health program. Behavioral Health services include, but are not limited to:

    i. Assessment;

    ii. Treatment or care planning/goal setting;

    iii. Pediatric Symptom Checklist (PSC) 35 and the clinically appropriate version of the Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) assessment;

iv. Individual therapy;

v. Group therapy;

vi. Family therapy;

vii. Case management;

viii. Consultation;

ix. Medication support services;

x. Hospitalization/Post Hospitalization Support;

xi. Certified Peer Support Services; and

xii. Intensive Home-Based Services (IHBS), as appropriate.

3. Contractor will ensure that all services:

   i. Are determined in collaboration with youth and family and reflect the voice, choice, and cultural practices;

   ii. Be values-driven, strengths-based, individual-driven, trauma-informed and co-occurring capable;

   iii. Be culturally and linguistically competent;

   iv. Be age, culture, gender, and language appropriate; and

   v. Include accommodations for youth with physical disability(ies).

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

5. Contractor shall maintain up-to-date caseload records of all youth enrolled in services, and provide individual, programmatic, and other demographic information to County as requested.

6. Contractor shall ensure billable Specialty Mental Health Services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards and provide all pertinent and appropriate information in a timely manner to Fresno County Department of Behavioral Health (DBH) for the purpose of billing Medi-Cal for services rendered.

7. Staffing should be appropriate for services needed by the youth and family, and shall include a Wraparound trained clinician, Wraparound coach, Family Specialist, Facilitator, Parent Partner, and Youth Peer Partner. Wraparound Role Descriptions (ca.gov)

B. SB 163 Wraparound (Wrap)

1. Contractor shall provide Wraparound services for up to fifty (50) youth at any given time, with Wrap team caseload size of eight (8) to twelve (12) youth per team. Services shall be

family driven, youth-guided, highly coordinated, individualized, trauma-informed, unconditional, and assist youth and families in addressing identified needs consistent with the HFW Standards.

2. Contractor shall ensure that at least one staff person is available by phone and in person, if needed, 24 hours per day, 7 days per week during the service period to provide support and services to youth and their Caregivers on request.

3. Contractor shall provide services based on the ten (10) foundational principles of Wraparound:

    i. Family voice and choice
    ii. Team-based
    iii. Natural supports
    iv. Collaborative
    v. Community-based
    vi. Culturally competent
    vii. Individualized
    viii. Strengths-based
    ix. Persistence
    x. Outcome-based

4. Ensure that each Wrap team provides four (4) phases of effective Wrap care coordination and supportive services, including:

    i. Engagement:
        1. Within 24 hours of receiving the referral, Facilitator or Parent Partner shall make voice-to-voice contact with the referral source and Caregiver to clarify the reason for the referral, ascertain any permanency plans for foster/probation youth, determine the referral source's anticipated outcomes, and to explain the Wrap process.
        2. At the start of Wrap and Super Wrap services, the HFW team shall provide a comprehensive orientation to the youth and family, which shall be documented in the case record and revisited as needed to ensure continued clarity for the youth, family, and team members. Orientation ensures that all participants understand the HFW process and their role within it. At minimum, the orientation shall include:
            a. Overview of the HFW principles and phases so that youth and families understand the foundation of services and what to expect over time.
            b. Legal and ethical considerations, including confidentiality limits and mandated reporter obligations.
            c. Roles of all team members, including the youth and family themselves, formal team members, natural supports, and Tribes in the case of an Indian child.
            d. Expectations for participation, including how the family's voice and choice will guide service planning and implementation.
        3. Within 72 hours of receiving the referral, Facilitator, Support Counselor, and Family Partner, as needed, engage in a face-to-face

meeting with the Person Served and Caregiver to clarify expectations, explain the role and principles of Wrap, discuss the overall timeline, review family culture, values, and traditions, and begin to explore strengths, needs, and vision for the future using UC Davis HFW engagement tools and fidelity indicators.

4. Within 48 hours of the initial meeting, Facilitator, Support Counselor, and Family Partner, as needed, meet with Person Served and caregiver to briefly identify or re-state referral areas of concern, explain the obligations of Wrap Team members as mandated reporters, identify any safety concerns, and develop an Initial Safety Plan as necessary. Engagement efforts shall also ensure that natural supports, cultural representatives, and Tribes (when applicable) are invited early into the process, in alignment with HFW practice standards.
5. Youth referred to this program may have a current mental health assessment with their primary treatment provider. If that assessment was completed within the last six months and there have been no significant changes in the youth's symptoms, the Contractor shall obtain a copy of that assessment and use it to inform treatment planning. If there is no current mental health assessment, the youth's symptoms have changed significantly, and/or the previous assessment was completed longer than six months ago, the Contractor shall complete a mental health assessment within 14 calendar days or as soon as clinically appropriate.
6. Each youth in Wrap and Super Wrap shall have access to an individual and/or family therapist utilizing evidence-based practices (e.g., Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Internal Family Systems (IFS)) to address relational and attachment trauma. Youth may continue with an existing mental health provider, in which case the Wrap/Super Wrap therapist will collaborate and provide consultation to the team to ensure coordinated services. Service frequency shall be at least one (1) contact per week for Wrap and two (2) contacts per week for Super Wrap, as clinically appropriate. In addition, a psychiatrist shall provide evaluation, assessment, and ongoing support for psychotropic medication management, clinical consultation, and linkage to psychiatric services, prioritizing continuity of care.
7. Contractor will ensure staff are trained to timely engagement strategies that include encouraging alternate strategies when contact with the family is difficult.

ii. Initial plan development. (All timelines are determined by date of first contact, which is to occur within 24 hours of receiving the referral.) The objective of the Plan Development phase is to create a comprehensive, individualized plan of care that addresses the prioritized needs and goals of the youth and family.

1. The Wrap team will review the current IP-CANS to identify the youth and caregiver's needs and strengths, determine medical necessity for

Specialty Mental Health Services (SMHS), and drive the development of the individualized plan of care. The completion of the IP-CANS, and any subsequent updates, is generally the responsibility of the County Social Worker (CSW) or Probation Social Worker (PSW) unless otherwise directed by the County. The person identified as responsible for completing the IP-CANS will also be responsible for ensuring compliance with the timelines and parameters specified in the All County Letter (ACL) 25-10. This includes reviewing and updating, as needed, the IP-CANS at least every 90 days for youth receiving certain Specialty Mental Health Services (SMHS) such as ICC and IHBS, as well as updating the document within 30 days following any triggering conditions such as a significant change in the youth's behavior, placement, or service needs. Specific examples of triggering conditions are provided in All County Letter (ACL) 25-10. The Wrap team should be knowledgeable about what types of triggering conditions prompt an IP-CANS update, and should notify the CFT, including the person responsible for completing the IP-CANS, within 24 hours of any event or condition that warrants an update to the document.

2. Facilitator, in collaboration with the referring CSW or Deputy Probation Officer (DPO), shall convene a CFT meeting within 30 calendar days of commencing Wrap services to engage all existing and potential sources of support and connection for the Person Served and Caregiver. By including them in the Wrap process from the outset, the goal is to build and strengthen a team that can sustain the Person Served and Caregiver after termination of Wrap services.
3. Facilitator, in collaboration with Person Served and Caregiver, referring CWS or DPO, and representative(s) of the MHP, develops individualized Plans that are in the language of the Person Served and Caregiver, and that include goals that are specific, measurable, achievable, relevant, and time-bound (i.e., SMART goals). The plan of care shall be completed within 30 calendar days from the start of services. The Wrap team will update the plan of care, distribute to all team members, and document the updated plan in the child or youth's file at least every 90 days and more often as needed.
4. Additionally, the Facilitator, in collaboration with the CFT, shall develop a Wraparound Action Plan (WAP) within 30 calendar days of commencing Wrap services that will be reviewed at each CFT meeting, delineating SMART goals and the specific action steps that each member of the CFT will take to put the plan into effect in order to achieve the goals, including: what is going to be done, who is going to do it, when it should be completed, and how the CFT will know the action step is completed and whether it was effective.
5. Clinician shall collaborate with the Person Served and Caregiver to complete an ecomap, genogram, PSC-35, and any other documentation required by the County within 60 calendar days of commencing Wrap services.

a. Ecomaps and genograms will be used to identify and document known relatives, kin, and other lifelong supports as part of family finding engagement and efforts.

6. The Wrap team shall collaborate with the assigned CSW, DSS Family Finding Unit and/or DPO to support family finding, engagement, and reunification efforts in alignment with HFW principles of family voice, choice, and permanency. The Contractor shall actively participate in coordinated planning and information-sharing to identify, engage, and strengthen connections with birth family members and other natural supports who can contribute to the youth's long-term stability. The Wrap team shall document its engagement and support efforts and incorporate the County's findings and direction into the individualized plan of care and Wrap Action Plan, ensuring alignment with case plan goals and permanency objectives. Progress toward family finding and reunification shall be reviewed and updated during CFT meetings.

iii. Plan implementation: During the next three to four (3-4) months of Wrap services:

1. Facilitator and Support Counselor, in collaboration with the Person Served and Caregiver, shall conduct a more thorough functional analysis of particular target behavior.
2. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that a CFT meets no less frequently than every four (4) weeks in order to monitor progress since the prior CFT meeting; support the inclusion on the CFT of "natural supports," that is individuals in the ecologies of Persons Served and Caregivers who provide care and support; identify emerging skills and competencies, supports and resources that can be utilized to achieve objectives and foundational goals; develop hypotheses about how to achieve desired outcomes in short windows of time; and develop action steps designed to address larger foundational goals that can be accomplished weekly or monthly, in order to maintain momentum by quickly demonstrating to Person Served, Caregiver, and other CFT members that progress is being made and there is hope for change.
3. Facilitator, and Family Partner as needed, shall meet at least once a week with Person Served and Caregiver to ensure that the action steps are taken, to troubleshoot difficulties they may have encountered, and provide assistance navigating systems as needed.
4. Support Counselor shall meet at least once a week with Person Served and Caregiver to review, coach and support behavioral interventions that may help shift behaviors, support insight building around connection between emotions, thoughts, behaviors, and support identity building and strengthening.
5. Contractor shall ensure that Wrap and Super Wrap services are delivered with persistence and unconditional commitment throughout the implementation phase. The Wrap Team shall continue engagement and service delivery even in the face of barriers, limited progress, or setbacks. Plans shall be revised, alternative strategies

developed, and natural supports engaged rather than discontinuing services. When teams encounter barriers to implementation, they shall seek assistance from County partners, including the assigned CSW or DPO, the Wraparound County Coordinator, Court Connected Care Justice Services (CCCJS) team, and/or other designated County resources.

6. Facilitator, Support Counselor, and Peer Partner as appropriate, shall monitor progress to identify when the Person Served and Caregiver are ready to begin the transition out of formal Wrap services and support. Wrap team members shall utilize the IP-CANS process, monitoring verbal reports from CFT members, and personal observation, completion of action steps and achievement of short-term goals, proportionate increase in CFT composition of "natural supports," increased involvement of "natural supports" in completing action steps and managing the Wraparound process, engagement efforts related to pursuing viable alternative permanency plans for Persons Served in foster care, and decreased frequency, duration and/or intensity of target behaviors or areas of concern to assess transition readiness.
7. Implementation activities must clearly link service strategies back to the family's identified strengths, culture, and vision, ensuring that youth/family voice drives all CFT decisions.
8. Contractor shall ensure that data collected during implementation (e.g., IP-CANS updates, Plan of Care and Wrap Action Plan progress, family feedback) is used in real time to inform practice with the youth and family, provide timely feedback to staff, and identify additional staff training and coaching needs.
9. Contractor shall incorporate UC Davis HFW fidelity indicators by documenting how engagement, plan development, and implementation activities align with fidelity standards, and ensure this documentation is reviewed within Continuous Quality Improvement (CQI) processes.

iv. Transition: Approximately two (2) months prior to termination of Wrap services and support:

1. Facilitator, Support Counselor, and Family Partner as appropriate, shall ensure Persons Served and Caregivers have adequate support systems, both formal and "natural," to sustain progress achieved during Wrap, and that proper referrals have been made and no fewer than three (3) "warm handoffs" to ongoing formal service providers have been completed.
2. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that consensus exists among members of the CFT that Persons Served and Caregivers have made sufficient progress, and that adequate support systems, both formal and "natural," sufficient to sustain progress are in place such that Wrap services and support are no longer needed.

3. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that a plan is in place and agreed to by members of the CFT regarding how the team will respond when problems arise in the future.
4. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that the Person Served and Caregiver are provided an opportunity to celebrate success with other members of the CFT and say good-bye to members of the Wrap Team
5. Transition planning shall begin early and be treated as an intentional fourth phase of Wraparound, with clear benchmarks tied to family readiness, natural supports, and permanency goals.
6. Contractor shall ensure transition plans document how the youth/family vision, culture, and identified strengths are sustained beyond Wrap services.
7. Transition activities shall include measurable goals for sustaining gains (e.g., educational stability, permanency connections, symptom reduction), and progress shall be reviewed at each CFT meeting during the transition phase.
8. Contractor shall ensure that data from transition (e.g., permanency outcomes, natural support involvement, family satisfaction surveys) is reported back to the Community Leadership Team to identify and address system barriers impacting HFW implementation.

5. For Indian Persons Served/families, the Contractor shall ensure that Tribes are engaged at the earliest point of referral, and that Tribal representatives are included in CFT meetings, plan development, and transition planning, in accordance with Indian Child Welfare Act (ICWA) requirements and HFW practice standards.
6. Throughout the course of the four phases of wraparound, Contractor will elicit continuous feedback from persons served/families and incorporate that feedback into service planning, CFT decision-making, and CQI processes.
7. It is likely that some youth in the Wraparound program will be placed in a highly intensive therapeutic placement setting such as Enhanced Intensive Services Foster Care (E-ISFC) or an Enhanced STRTP (E-STRTP). For youth dually enrolled in Wraparound and an intensive service setting, the Person-Served's CFT will determine which agency and which person is assigned as lead for the following tasks based on existing therapeutic relationships, treatment goals, and transition goals:
    i. Advanced clinical services (example: therapy and psychiatry)
    ii. Behavioral intervention/rehabilitation
    iii. Case coordination such as CFT facilitation, case management, plan development
    iv. Permanency work and family finding
8. Wraparound team members shall have the flexibility to adjust service levels based on the needs of the youth and family. When the youth is in an intensive service setting, the Wraparound team will remain engaged and responsible for care coordination and other tasks as identified by the CFT and may need to decrease service intensity to avoid duplication with the placement provider. Wraparound teams shall also be flexible to increase service intensity when needed and as determined by the CFT.
9. Contractor shall ensure that staff and their supervisors are provided with feedback on their ability to meet required service and reporting timelines. Such feedback shall be

incorporated into CQI processes, including but not limited to monthly reports, performance monitoring meetings, and any County-requested CQI reports, to promote accountability, improve service delivery, and support staff development.

10. Contractor shall ensure that all requests, approvals, and expenditures of Flexible Funds are consistent with the County's Flex Fund Policy (Exhibit T). Contractors shall integrate Flex Fund utilization into the service planning process, including documentation of team recommendations, purpose of expenditure, and expected outcomes.
11. Length of Stay:

    i. The approximate length of stay for the traditional Wrap service line is nine (9) to twelve (12) months. While stated length of stay reflects general parameters, a youth and family's ongoing participation in the Wrap program is driven by their demonstrated need.

C. Super Wrap

1. In addition to the above-mentioned Wraparound services, the Contractor shall provide higher intensity Wrap services referred to as "Super Wrap" to four (4) youth, at any given time, who have been pre-authorized for these services by the County. Super Wrap team caseload size shall be one (1) youth per team. Contractor has discretion regarding team make-up.
2. Contractor shall ensure that the Super Wrap Team provides up to twenty-five (25) hours per week of care coordination and/or support services to the Person Served, on behalf of the Person Served, or to the Caregiver.
3. Contractor shall ensure that at least one staff person is available by phone and in person, if needed, 24 hours per day, 7 days per week during the service period to provide support and services to youth and their Caregivers on request.
4. Contractor shall ensure that each Super Wrap Team provides four (4) phases of effective Wrap care coordination and supportive services as outlined in Wraparound section 3 with these frequency modifications for Super Wrap participants:

    i. Initial plan development. (All timelines are determined by date of first contact, which is to occur within 24 hours of receiving the referral.)

        1. Facilitator, in collaboration with the CFT shall develop a WAP within 14 calendar days of commencing Wrap services that will be reviewed at each CFT meeting, delineating SMART goals and the specific action steps that each member of the CFT will take to put the plan into effect in order to achieve the goals, including: what is going to be done, who is going to do it, when it should be completed, and how the CFT will know the action step is completed and whether it was effective.
        2. Clinician shall collaborate with the Person Served and their Caregiver to complete an ecomap, genogram, PSC-35, and any other

documentation required by the County within 14 calendar days of commencing Super Wrap services, unless otherwise noted.

ii. Plan implementation: During the next three (3) months of Super Wrap services:
    1. Facilitator, in collaboration with the referring CSW or DPO, shall ensure that the CFT meets no less frequently than every two (2) weeks in order to monitor progress since the prior CFT meeting; support the inclusion on the CFT of "natural supports," that is individuals in the ecologies of Person Served and their Caregiver who provide care and support; identify emerging skills and competencies, supports and resources that can be utilized to achieve objectives and foundational goals; develop hypotheses about how to achieve desired outcomes in short windows of time; and develop action steps designed to address larger foundational goals that can be accomplished weekly or monthly in order to maintain momentum by quickly demonstrating to Persons Served, their Caregiver(s), and other CFT members that progress is being made and there is hope for change.
    2. Facilitator, and Family Partner as needed, shall meet at least two (2) times per week with the Person Served and their Caregiver to ensure that the action steps are taken, to troubleshoot difficulties they may have encountered, and provide assistance navigating systems as needed.
    3. Support Counselor shall meet at least two (2) times per week with the Person served and their Caregiver to review, coach and support behavioral interventions that my help shift behaviors, support insight building around connection between emotions, thoughts, and behaviors, and support identity building and strengthening.
    4. Therapist shall meet at least two (2) times per week with each Person Served and/or their Caregiver to provide individual or family therapy as indicated and, utilizing evidence-based practices (e.g., Motivational Interviewing, CBT, DBT, IFS Therapy), to address the individual Person Served's experience of relational and attachment trauma.
    5. Family Partner shall meet at least one (1) time every week with the Caregiver to provide support navigating the numerous systems of care and service provision impacting their lives.

iii. Transition: Approximately 45 calendar days prior to termination of Super Wrap services and support:
    1. Facilitator, Support Counselor, and Family Partner as appropriate, shall ensure the Person Served and their Caregiver have adequate support systems, both formal and "natural," to sustain progress achieved during Super Wrap, and that proper referrals have been made and no fewer than six (6) "warm handoffs" to ongoing formal service providers have been completed.

5. Length of Stay:

i. The approximate length of stay for the Super Wrap service line is 90-days. While stated service timeline reflects general parameters, a youth and family's length of stay in the Super Wrap program is driven by their demonstrated need.

ii. All extension requests for Super Wrap services would need to be presented to the County for approval. These presentations shall include the start date for Super Wrap services, the average frequency and duration of scheduled services, description of the youth's level of engagement and progress or lack of progress in treatment and any other relevant treatment information that would explain why this youth needs to remain at the Super Wrap level of service. The contractor shall also present a projected transition date for when the youth can return to traditional Wrap services.

D. Crisis Services

1. Contractor shall develop, document, and implement individualized crisis and safety plans for each youth and family in accordance with HFW standards. Contractor shall provide supports designed to reduce the need for professional crisis interventions by strengthening the family's and natural supports' capacity to manage crises.
    i. At the time of Engagement, the Wrap team shall discuss any immediate crisis or safety concerns raised by the youth or family. If pressing concerns are identified, the team will develop an immediate written crisis response plan, provide a copy of the plan to the family, and document it in the youth's chart.
    ii. The immediate crisis plan shall inform, but not replace, the formal HFW Safety Plan developed during the Plan Development phase.
    iii. All families shall be provided with clear information on how to access 24/7 crisis response when needed, including the on-call contact process.
    iv. Contractor shall ensure Wrap staff are trained to implement safety and preventive measures when responding to any self- harming and/or other behaviors that pose risk to the youth or others. Wrap staff shall be prepared to initiate mobile response services by contacting the treating provider, FURS, or 911, as clinically indicated. Should the youth require an emergency evaluation for acute psychiatric hospitalization, Wrap staff shall take the necessary steps to ensure the youth receives the appropriate intervention to address the mental health crisis.
2. Contractor shall ensure that Wrap staff or Wrap administrator notify the CWS hotline, the CSW), DPO and appropriate CWS Division Chief/Assistant Deputy Chief (ADC), or designee for all incidents that indicate a sign of threat or continued risk to the physical or mental health status of the Wrap youth including all such incidents that require a Critical Incident Report, as outlined in this agreement.
    i. The Contractor shall then follow up with the SW by phone within one business day of the incident.
3. Contractor shall comply with the following when youth are referred for psychiatric hospitalization:
    i. Notify the CWS hotline, the SW, DPO and appropriate CWS Division Chief/ADC, or designee as soon as it is reasonably safe to do so, but no later than the end of the day and complete a critical incident report.
        1. The Contractor shall then follow up with the SW by phone within one business day.

ii. Participate in case conferences, hospital discharge conference and/or the CFT meetings for youth referred for psychiatric hospitalization.
iii. Continue to provide Wrap services, to the extent possible, during the youth's hospitalization.
iv. Initiate a CFT meeting within 24 hours of youth's return to the community.

4. Contractor shall track and report all crisis incidents, including those averted through natural supports and those requiring professional intervention (e.g., mobile crisis, emergency department, psychiatric hospitalization, law enforcement involvement). A quarterly report summarizing crisis incidents, responses, and outcomes shall be submitted to the County.

E. Additional Responsibilities

1. Maintain responsibility for necessary testimony and/or providing County with information needed to generate court reports, as outlined below:
    i. Court Reports - Documented reports of assessment and evaluation findings, progress in treatment, recommendations for treatment and service plans regarding reunification, maintenance and termination of parental rights, and justification for recommendations.
    ii. Court Testimony - Provide care plan updates when a court is considering reunification, maintenance, and/or termination of parental rights.
2. Upon notification of a pending court hearing, Contractor agrees to complete and submit to the County a "Periodic Review Report" twenty-one (21) calendar days prior to the court date or seven (7) calendar days after notification.
3. Maintain electronic health records and supply their own personal computers, Internet access, printers, signature pads and other network devices to meet statistical reporting requirements, report Person-Served and program outcomes and any State or County data requirements of the Katie A. Implementation Plan. Contractor shall also maintain capability to enter electronic billing data into County's electronic health record system. A computer with Internet access is required for both office and field-based staff.
4. Cooperate and participate with the County MHP in Quality Assurance/Improvement and Utilization Review Programs and grievance procedures and comply with all final determinations rendered by County's Quality Assurance/Improvement and Utilization Review Programs, unless the decision is reversed on appeal as set forth in the County MHP Provider Manual, incorporated herein by this reference. County's adverse decisions regarding Contractor's services to Persons-Served may result in the disallowance of payment for services rendered; or may result in additional controls to the delivery of services; or may result in the termination of this Agreement. County shall have sole discretion in the determination of Quality Assurance/Improvement and Utilization Review outcomes, decisions and actions.
5. Obtain signatures, as required, regarding consent:
    i. Care provider can sign for day trips and other minor miscellaneous items.
    ii. Court Order should suffice for most other items.

6. Work collaboratively with other CWBC providers to develop and enter into Memorandum of Understanding or other business agreements between themselves that defines the processes and procedures for provision of services to foster youth, including, but not limited to the:

i. Case Planning
ii. Care Coordination
iii. Intensive Transition Planning
iv. Assessment
v. Transportation between service settings
vi. Information sharing
vii. Data collection and dissemination

7. Work with DPO on criminogenic risk factors for probation youth as addressed through contracted services as applicable.

F. Admission, Transition and Discharge

1. Entry Criteria

All youth referred to the Wrap and Super Wrap services will have pre-approval from the County. This includes STRTP aftercare and re-referrals. Equal access is required. Services shall not be denied or delayed based on the youth's placement, geographic location (including out-of-county placements under presumptive transfer), disability, or cultural needs.

Family First Prevention Services Act (FFPSA) Part IV mandates six months family-based aftercare services for children discharged from qualified residential treatment programs to family-based settings, including high-fidelity Wrap (ACL 21-116). Fresno County will be leveraging existing Wraparound services to meet this requirement.

2. Intake and Initial Assessment

Contractor shall respond to all Wrap and Super Wrap referrals within 24 hours of receipt. Youth referred to this program may have a current mental health assessment with their primary treatment provider. If that assessment was completed within the last six months and there have been no significant changes in the youth's symptoms, the Contractor shall obtain a copy of that assessment and use it to inform treatment planning. If there is no current mental health assessment, the youth's symptoms have changed significantly and/or the previous assessment was completed longer than six months ago, the Contractor shall complete a mental health assessment within 14 calendar days or as soon as clinically appropriate.

In instances where a youth is currently enrolled in Wraparound services and is subsequently identified as potentially eligible for Super Wraparound services, Contractor shall, in coordination with the County, evaluate the youth's eligibility for Super Wraparound within thirty (30) calendar days of identification. If deemed appropriate, Contractor shall implement Super Wraparound services within this timeframe. Ongoing communication with the County regarding the youth's status, eligibility determination, and service transition shall be maintained throughout this process.

3. Transition and Discharge

Youth referred to the Wrap/Super Wrap program may be denied services if the youth does not meet medical necessity for specialty mental health services and/or the necessary criteria to be eligible for Wrap/Super Wrap services. Youth who are determined to be ineligible for these services will be linked to other appropriate services and resources.

Discharge is determined on a case-by-case basis depending on the youth's progress toward individualized treatment goals. Wraparound services operate with an unconditional care approach; services are not ended solely due to challenges in engagement, crisis events, or lack of progress. Instead, the team adapts strategies and persists in supporting the youth and family until transition readiness is achieved. Reasons for discharge include the youth or caregiver refuses or terminates services; the youth is transferred to another program mutually agreed upon by the youth, parent/caregiver, and Wrap; and/or mutual agreement that the treatment goals have been met. For youth and families who decline or terminate services, reasonable and documented efforts must reflect the team's attempts to engage and re-engage the family in alignment with HFW standards.

All transitions and discharges shall be discussed in a CFT to ensure all members of the youths' support system are aware of the recommendation being made by the Contractor.

Contractor shall administer a survey to youth and families at discharge, collect and track responses, and report data to the County. Surveys shall capture satisfaction with services, family voice and choice, and perceived readiness for transition in alignment with HFW standards. Aggregate results shall be incorporated into the Contractor's CQI process and reported to the County as required.

VI. STAFFING

A. Each Contractor shall provide the following staffing components, at minimum:

1. Staffing shall be appropriate and aligned with the HFW model, which would include the following roles: facilitator, family specialist, parent partner, youth partner, fidelity coach, HFW Supervisor/Manager, and clinical supervisor.

2. Each Wrap and Super Wrap Team shall be comprised of:

    a. One (1) Facilitator with a Mental Health Rehabilitation Specialist (MHRS) qualification or above who meets with the youth, their Caregiver, and other team members to complete assessments, individualized plans, and Wraparound Action Plans; organize and facilitate Family Team meetings; and ensure successful linkage of Persons Served and their Caregiver(s) to ongoing resources and support. The Facilitator shall also serve as a support and mentor to other members of the team, as needed.
        A. Frequency of service for Wrap: at least one (1) contact per week
        B. Frequency of service for Super Wrap: at least two (2) contacts per week
    b. A minimum of two (2) Support Counselors who are a bachelor's level paraprofessional who shall meet with the Person Served to provide one-on-

one support for the Person Served, focusing on increasing the frequency of desired behaviors, gaining access to pro-social activities and resources within the community, and developing effective relationship-building skills.
    A. Frequency of service for Wrap: at least one (1) contact per week
    B. Frequency of service for Super Wrap: at least two (2) contacts per week
c. One (1) Family/Parent Partner and One (1) Youth Partner, who has lived experience, to provide support to the Person Served and their Caregiver in navigating the numerous systems of care and service provision impacting their lives as needed.
    A. Frequency of service for Wrap: at least one (1) contact every 2 weeks
    B. Frequency of service for Super Wrap: at least one (1) contact per week
d. Fidelity coaching is to be provided to ensure services are delivered in accordance with High Fidelity Wraparound principles and standards. The position fulfilling this role will support staff through regular observation, coaching sessions, and review of fidelity tools, promotes continuous quality improvement, and ensures that facilitators, family partners, and youth partners are implementing the model with fidelity.

3. Ensure each Wrap and Super Wrap team has access to:
    a. One (1) Individual or Family Therapist to meet with the youth and their Caregiver to provide individual or family therapy and utilizing evidence-based practices (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Internal Family Systems Therapy) to address youth's experience of relational and attachment trauma as needed. If the youth choose to continue therapy with their current mental health provider, the Wrap/Super Wrap therapist shall continue to provide consultation to the other members of the WRAP/Super Wrap team and will work in collaboration with the existing therapist to ensure joint services are provided appropriately.
        A. Frequency of service for Wrap: at least one (1) contact per week as clinically appropriate
        B. Frequency of service for Super Wrap: at least two (2) contacts per week as clinically appropriate
    b. One (1) Psychiatrist to meet with the Person Served to provide evaluation and assessment for psychotropic medication, clinical consultation, and assistance linking the Person Served and their Caregiver to ongoing psychiatric services and support as needed and prioritizing continuity of care where possible.
        A. The frequency of psychiatry services will be at least one (1) time per month for Wrap and Super Wrap participants.
4. Workforce development, including recruitment, hiring, training, and coaching, shall be consistent with the California High Fidelity Wraparound (HFW) Standards and Toolkit (Staffing Wraparound).

5. Ensure there is no change to a youth's primary Wraparound team members when the youth transitions between the Wrap level of service and the Super Wrap level of service to preserve the therapeutic relationship and provide continuity of care.
6. Ensure that direct service staff reimbursed through this contract shall spend at least 65% of their paid work time providing and documenting direct service to clients or on behalf of clients. Administrative staff meetings, supervision meetings, and staff trainings shall not be included in the 65%.

VII. TRAINING:

A. The California Wrap Standards require providers to have a HFW training plan that incorporates initial, ongoing, and annual booster training to all staff as well as role specific training. Contractor shall ensure that all Wrap and Super Wrap staff receive comprehensive initial training and ongoing coaching consistent with the California HFW Standards (HFW Training) and Fresno County expectations.
    1. Foundational Training (Wraparound 101: Foundations for Fidelity)
        a. All staff shall receive orientation and training in the Ten Principles of Wraparound, the Four Phases of HFW (Engagement, Plan Development, Implementation, Transition), and the use of High Fidelity Wraparound fidelity indicators.
        b. Staff shall be trained in trauma-informed, culturally respectful, and linguistically competent practices.
        c. Staff are trained in timely engagement strategies, including alternate strategies when contact with families is difficult.
        d. Supervisors and staff receive training on meeting timelines and CQI processes tied to engagement, plan development, plan updates, and reporting.
    2. Needs-Driven, Strengths-Based and Solution-Focused Practices
        a. Staff are trained to identify underlying needs, develop needs statements that go beyond behaviors, and ensure plans are needs-focused rather than deficit-focused.
        b. Staff shall receive ongoing training and coaching in identifying functional strengths of youth, caregivers, families, and community supports, and in applying strengths to drive planning and service strategies.
        c. Staff shall receive training in solution-focused and evidence-based practices including, but not limited to, Motivational Interviewing, CBT, DBT, and IFS.
    3. IP-CANS and Assessment Tools
        a. Staff shall be trained to complete, interpret, and utilize the IP-CANS, PSC-35, and other County-required assessments to guide planning and CQI.
        b. Training includes requirements for timely completion (within 14 days of engagement, updated every 90 days or within 30 days of a triggering event) and integration into CFT decision-making.
    4. Facilitation and Teaming
        a. Facilitators shall be trained and coached in leading CFT meetings that are inclusive of family, natural supports, and Tribes in the case of an Indian child, and in ensuring family voice and choice are central to planning.

   b. Training shall include engagement strategies, team-building activities, and consensus-based decision-making.
5. Individualized Services
   a. Facilitators and staff are trained to develop highly individualized plans of care, using flexible strategies tailored to youth and family strengths, needs, values, and culture.
6. Culturally Respectful and Relevant Services
   a. Staff receive ongoing training in eliciting, honoring, and incorporating family culture, traditions, and values into planning and service delivery.
   b. Contractor shall provide training for staff on ICWA requirements, Tribal sovereignty, and culturally responsive service delivery for Native American youth and families.
7. Crisis and Safety Planning
   a. Staff shall be trained in development and implementation of crisis and safety plans, including proactive and reactive strategies, safety interventions, and maximizing natural supports.
   b. Training includes immediate crisis response procedures, 24/7 access, and escalation protocols (FURS, mobile crisis, 911).
8. CQI and Fidelity Monitoring
   a. Staff and supervisors shall receive training on the use of fidelity and quality monitoring tools which may include but not limited to Wraparound Fidelity Index [WFI], Team Observation Measure [TOM 2.0]), Document Assessment Review Tool (DART), satisfaction surveys, and feedback loops to improve practice.
   b. Supervisors and coaches shall observe team meetings, review documentation, and provide feedback to staff for ongoing skill-building and adherence to HFW fidelity standards.
   c. All staff are trained on how family feedback and fidelity measures inform CQI processes.
9. Ongoing and Annual Requirements
   a. All staff must complete at least an annual refresher training on Wraparound principles, fidelity indicators, trauma-informed care, cultural competency, and County-specific requirements.
   b. Staff must attend County-offered trainings, which may include Quality Parenting Initiative (QPI), Neurosequential Model of Therapeutics (NMT), cultural competency, Civil Rights, and other System of Care initiatives.
   c. Contractor shall maintain training logs, curricula, and attendance records, and shall provide documentation of training completion to the County upon request.
10. Youth, families and peer partners with current or prior Wraparound experience are meaningfully incorporated into the delivery of required Wraparound trainings.
11. Community partners are invited to attend Wraparound trainings or are offered trainings on Wraparound to strengthen their participation on HFW teams or to strengthen their role in supporting HFW within the System of Care.
12. Develop training curriculum as County identifies a need.
13. Assist with training County staff and the community in Wraparound Service processes and service options.

VIII. COUNTY RESPONSIBILITIES:

COUNTY shall:

A. Assist Contractors' efforts to evaluate the needs of each enrolled youth on an ongoing basis to ensure each youth is receiving clinically appropriate services.

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

C. Assist Contractors in making linkages with the total mental health system of care. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

D. Participate in evaluating overall program progress and efficiency and remain available to contractors for ongoing consultation.

E. Gather outcome information from target Person Served groups and Contractors throughout each term of this Agreement. County shall notify Contractors when their participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, Person Served and staff interviews, chart reviews, and other methods of obtaining required information.

F. Assist Contractors' efforts toward cultural and linguistic competency by providing the following to contractors:

    B. Technical assistance and training regarding cultural competency requirements at no cost to contractors.

    C. Mandatory cultural competency training for contractors' personnel, on an annual basis, at minimum.

    D. Technical assistance for translating information into County's threshold languages (Spanish and Hmong). Translation services and costs associated will be the responsibility of contractors.

VIII. REPORTS

Contractor shall track data and provide reporting on the following items and send all applicable information and reports to the following distribution list for County staff: DSS Staff Analyst, DSS Division Chief, DSS Social Work Supervisor, DBH Contract Analyst, Probation Assistant Deputy Chief, and Probation Contract Analyst.

1) Contractors shall be expected to comply with all contract monitoring and compliance protocols, procedures, data collection methods, and reporting requirements conducted by County.

2) Contractors will be responsible for meeting with DBH and DSS on a monthly basis, or more often as agreed upon between DBH, DSS, and Contractors, for contract and performance monitoring.
3) Contractors will be required to submit monthly reports on performance measures to the County. Report formats will be established through County/Contractor collaboration. Outcome measures may change, based on information or measures needed. Required monthly reports include:
    a) DSS Monthly Activity Report (MAR); and
    b) Other reports as established by the County.
4) All reports will be due to the County by the 10th business day of each month and will be reviewed for accuracy. (If the 10th lands on a weekend or Holiday, reports will be due the next business day). Reimbursement for monthly expenses may be delayed in the event inaccurate reports are submitted.
5) Provide county with various reports through the length of the youth's enrollment in the program; a few of which are standardized and include: "Monthly Progress Report", "Discharge Presentation", "Individual Child and Family Plan Presentation Outline", and "Individual Child and Family Plan (ICFP)".
6) Contractor will report and document all major and/or sensitive incidents ("critical incidents") to the County pursuant to the procedures and timing outlined in Exhibit J "Fresno County Mental Health Plan Incident Report." The County, at its sole discretion, may require the Contractor to conduct all necessary follow-up activities after reporting critical incidents. If there is any doubt about whether an incident should be reported, the default shall be for the Contractor to report the incident to the County.
7) Contractors shall use collected data not only for compliance reporting but also in real time to improve practice with youth and families, including providing staff with timely feedback from data or reports relevant to their service provision.
8) Data shall be reviewed and analyzed at multiple levels (youth/family, program, and system) to identify staff training needs, address program effectiveness, and inform CQI processes.
9) Contractor shall ensure that data is collected, analyzed, and utilized to identify and communicate both outcomes of HFW implementation and system barriers that impact service delivery, including those that impact Tribal youth. Outcomes and barriers shall be elevated to the Community Leadership Team (CLT) for review, discussion, and resolution.
10) Contractor shall ensure all data collection and reporting is culturally responsive, ensuring outcomes are interpreted in the context of family culture, values, and vision.
11) Contractor shall participate in collaborative local CQI evaluation plans with County, Providers, and System of Care participant organizations, as required by UC Davis HFW fidelity indicators.
12) Additional reports and outcome information may be requested by County at a later date, as needed.

IX. GOALS/OUTCOMES

Contractor is required to submit measurable outcomes on a semi-annual, as identified in the DBH's Policy and Procedure Guide (PPG) 1.2.7 Performance Outcomes Measures. Performance outcome measures must be approved by DBH and DSS and satisfy all State and

local mandates. County will provide technical assistance and support in defining measurable outcomes. The outcome measures and indicators provided below represent County DBH and DSS program goals to be achieved by the Contractor in addition to Contractor's developed outcomes and the HFW Expected Outcomes. Outcomes for youth center on the following core areas: permanency, behavioral stability, symptom reduction, living situation stability, strengths development, and educational stability. Outcomes for Persons-Served vary based on their individual needs and challenges faced by the specific youth and their plans of care; however, common quantifiable outcomes at the program level include:

Fresno County Wraparound Contract Performance Expectations

Metric	Definition	Performance Indicator
Service utilization	Minimum service levels by the required staffing level in order to earn full payment	**Wraparound:** Ensure that the Wrap Team provides between **24 to 32 hours per month (about 6-8 per week)** of care coordination and/or support services to Persons Served or to Person's Served Caregiver. **Super Wrap:** Ensure that the Super Wrap Team provides approximately **100 hours a month (about 25 hours a week)** of care coordination and/or support services to the Person Served. In no case should the hours of service performed be less than the minimum above.
Service timeliness	**Wrap** · Make contact with referral source within **24 hours** · Initial face to face engagement meeting within **72 hours** of referral · Follow-up meeting within **48 hours** · IP-CANS completion within **14 calendar days** of initial meeting · Wrap Action Plan developed within **30 calendar days** of initial meeting · CFT meeting within **30 calendar days** of initial meeting	90% compliance with service timeliness as documented in Monthly Activity Reports (MARs)

	(and w/n **24 hours** of discharge form inpatient admission)- · Ecomap, genogram, PSC-35 created within **60 calendar days** of initial meeting · CFT meetings no less than **monthly**- · **Weekly** activity with facilitator, family partner, youth and caregiver · Support counselor meets at least **1 x per week** · Transition planning occurs **1-2 months** prior to end of Wrap **<u>Super Wrap</u>** · Make contact with referral source within **24 hours** · Initial face to face engagement meeting within **72 hours** of referral · Follow-up meeting within **48 hours** · IP-CANS completion within **14 calendar days** of initial meeting · Wrap Action Plan developed within **15 calendar days** of initial meeting · CFT meeting within **15 calendar days** of initial meeting (and w/n **24 hours** of discharge form inpatient admission)- · Ecomap, genogram, PSC-35 created within **15 calendar days** of initial meeting · CFT meetings no less than every **2 weeks**- · Activity with facilitator, youth and caregiver at least **2 x per week** · Activity with family partner at least **1 x per week** · Support counselor meets at least **2 x per week**	

	· Transition planning occurs **45 calendar days** prior to end of Wrap	

Fresno County Wraparound Contract Outcomes

Metric	Definition	Performance Indicator
Improved behavioral/ emotional needs	Youth shall have a reduction in action items in the Behavioral/Emotional Needs Domain, Risk Behaviors Domain	90% of youth shall see a reduction in action items on IP-CANS over time
Improved Strengths	Youth will have improved scores in the Strengths domain of the IP-CANS	80% of youth shall show improvement on IP-CANS over time
School Improvement	Youth will demonstrate improved educational functioning from intake to discharge as measured by IP-CANS Life Functioning items related to school functioning including school behavior, school achievement, and school attendance.	80% of youth shall show improvement on IP-CANS over time
Increase Natural Supports	Natural Supports are actively involved across all phases of Wrap/Super Wrap.	At least one natural support attends 50% of all CFTs.
Permanency Planning	Youth will have improved scores in the Living Situation and	90% of youth shall show improvement on IP-CANS over time

	Family Functioning items in the Life Functioning Domain	
Transition to less restrictive placements	Youth experience stability in their community-based living situation and do not experience a new placement in an institution (such as detention, psychiatric hospitalization, treatment center, or STRTP) upon discharge.	80% of youth accepted to the program will be transitioned to less restrictive placements including but not limited to legal or emotional/relational permanency or with their family for stabilization and preservation of their family placement.
Reduction in Inpatient, Emergency Department Admission for Behavioral Health Visits	Youth experience stability with regard to their behavioral health, necessitating fewer or no visits to the hospital.	At least 80% of youth enrolled in Wraparound will experience no more than one behavioral health-related inpatient or emergency department admission during the course of enrollment.
Improved Functioning in the Community	Youth experience improved functioning in the community as well as improved interpersonal functioning.	At least 75% of youth will show improved scores on IP-CANS items related to Community and School Functioning over time.
Client satisfaction	Youth and families are satisfied with their HFW experience and progress, including caregiver confidence in their ability to manage the youth's needs and access support.	At least 75% of youth and caregivers shall report a positive experience of services, perceived improvement in functioning, and increased caregiver confidence, as measured through post-service surveys

In addition to the outcomes above being tracked on the MAR and other County-designated reporting mechanisms (e.g., DOMO dashboards), Contractors shall utilize a computerized tracking system with which performance and outcome measures and other relevant Person Served data, such as demographics, will be maintained. The data tracking system may be incorporated into the Contractors' electronic health records (EHR) systems or in stand-alone databases (e.g., Access or Excel spreadsheets). County must be afforded read-only access to the data tracking system.

County may adjust the performance and outcome measures periodically throughout the duration of the Agreement, as needed, to best measure the program as determined by County and/or CDSS/DHCS.

Fresno County Wraparound
Flex Fund Policy

Preamble

This policy establishes guidance for the use of flexible funds within the High Fidelity Wraparound (HFW) program. Flex funds are included in the program's funding plan and are intended to support children, youth, and families in overcoming barriers, achieving stability, and building on strengths. They are not supplemental money for general use, but a resource to creatively and responsibly meet individualized needs when no other funding or resource is available.

Policy

Flexible fund expenditures must be tied to the Wraparound Plan of Care and evaluated based on the recommendation of the HFW team. Expenditures should add value to the team mission and the individualized care plan, build on family strengths, meet identified youth and family needs, be culturally relevant, build on natural supports and/or community capacity, represent a good deal for the investment, and include a plan for sustainability. Requests should be discussed and identified in the Child and Family Team (CFT) process and documented in the CFT summary. In emergency situations where waiting for a CFT would create a barrier to timely access, requests may be approved at the program level but must be presented to the CFT at the next meeting. If the CFT denies the expenditure, the cost will be unallowable and cannot be included in monthly invoices.

Allowable Uses

Examples include basic needs (food, clothing, utilities, housing-related costs), wellness or enrichment activities (sports fees, music lessons, family outings), milestone or cultural celebrations (birthdays, graduations), and tribal activities identified as important by the youth, family, or Tribe. Flex funds may also be used for short-term crisis prevention and stabilization to prevent placement disruption, hospitalization, or entry into higher levels of care.

Non-Allowable Uses

Flex funds may not be used to provide cash directly to families or youth. They may not be applied toward services or expenses already covered by Medi-Cal, insurance, or separate line items within approved budget, nor for luxury or entertainment items that are not tied to the Wraparound Plan of Care.

Fiscal Cap

Flex fund requests should remain modest, with expenditures limited to an average amount of $35 per youth, per month, not to exceed $420 per youth annually, unless prior Department of

Social Services (DSS) approval and justification are obtained. This annualized cap allows flexibility in utilization, recognizing that some youth may require less support in certain months and more in others. Providers must ensure that funds are used equitably across all youth and that expenditures remain within their approved line-item budget amounts.

Providers are responsible for monitoring their flex fund line item to ensure sufficient funds remain available for the duration of the contract period. If it becomes evident that the approved budget line item is insufficient to meet projected needs, providers must submit a timely budget modification request to DSS for review and approval.

As part of documentation, each vendor must maintain individual cost tracking of flex funds spent per youth to ensure expenditures are transparent, equitable, and aligned with this policy.

Timely Access
Providers must maintain processes that allow for urgent family needs to be addressed promptly, even outside of regular CFT meetings.

Approval Process
All requests must be reviewed through the provider's established approval process, using the evaluation criteria outlined in this policy. Providers are expected to maintain their own internal policies and procedures that ensure timely access to flex funds and a clear approval process that aligns with this policy. Requests may be approved at the program level as long as expenditures remain within the fiscal cap described above. Any request that would exceed those limits, or that raises questions of appropriateness, requires prior DSS approval with documented justification.

Appeals Process
If a request is denied, the provider must document the reason, communicate the denial to the youth, family, and team, and inform them of an appeal process. Appeals include review by program management and consultation with the DSS.

Monitoring
DSS will review flex fund expenditures during contract monitoring. Providers must maintain documentation of all requests, approvals, denials, receipts, and outcomes. Unallowable or undocumented costs may not be reimbursed by DSS.

County Authority
DSS reserves the right to adjust the monthly cap, allowable ranges, or other policy elements based on available funding and program needs.