AMENDMENT NO. 3 TO SERVICE AGREEMENT

This Amendment No. 3 to Service Agreement ("Amendment No. 3") is dated _____ and is between Turning Point of Central California, Inc., a private, nonprofit, 501(c)(3) corporation ("Contractor"), and the County of Fresno, a political subdivision of the State of California ("County").

Recitals

A. On June 20, 2023, the County and the Contractor entered into Agreement No. 23-296 ("Agreement"), for Adult Forensic Behavioral Health Full-Service Partnership (FSP) Continuum of Care services, as amended by County Agreement No. 24-533 effective October 8, 2024, and as amended by County Agreement No. 25-616 effective December 9, 2025.

B. In March 2024, California voters passed Proposition 1, which proposed statewide reform and expansion of California's behavioral health system, effectively replacing the Mental Health Services Act ("MHSA") of 2004 with the Behavioral Health Services Act ("BHSA").

C. Welfare and Institutions Code 5887 released on April 17, 2024 requires that Full-Service Partnerships are required to provide high-intensity Specialty Mental Health Services models to adults eighteen (18) years of age and older, and restructures the levels of care for adults eighteen (18) years of age and older effective July 1, 2026 as follows: Forensic Assertive Community Treatment, Full Service Partnership Intensive Case Management and Outpatient Specialty Mental Health Services.

D. The County and Contractor now desire to further amend the Agreement to revise the Scope of Work, Behavioral Health Requirements, Outcomes, Financial Terms and Conditions, Fee for Service Rates and the budget to align with BHSA requirements for Full-Service Partnerships and increase the maximum compensation by One Million Five Hundred Ninety-Three Thousand Four Hundred Ninety and No/100 Dollars ($1,593,490.00) The increase in compensation is due to the inclusion of BHSA funding.

The parties therefore agree as follows:

1. All references to Revised Exhibit A shall be deemed references to "Exhibit A-I". Exhibit A-I is attached and incorporated by this reference.

2. All references to Exhibit G shall be deemed references to “Revised Exhibit G”. Revised Exhibit G is attached and incorporated by this reference.

3. All references to Exhibit J shall be deemed references to “Revised Exhibit J”. Revised Exhibit J is attached and incorporated by this reference.

4. Section 2.1 of the Agreement, beginning on Page 8, Line 7 and ending on Page 9, Line 21, is deleted in its entirety and replaced with the following:

“**Reports.** The Contractor shall submit the following reports and data:

(A) Outcome Data. Contractor shall submit to County program performance outcome data, as requested. Outcome data and outcome requirements are listed in Exhibit G to this Agreement, titled “Program Outcomes and Performance Measurements”. Outcome data and outcome requirements are subject to change at County’s discretion.

(B) AB 109 Report. Contractor shall complete all reports mandated by the Community Corrections Partnership (CCP) including, but not limited to quarterly program statistics and fiscal reporting.

(C) DSH Diversion Reporting. County’s DBH is responsible for providing a report to the State which will describe and evaluate the DSH diversion funding for essential planning purposes, maintaining program accountability and program monitoring. Contractor is required to submit data to County’s DBH such statutory outcome data reporting in accordance to Exhibit H. Outcome data and report requirements are subject to change at State and County’s DBH discretion.

(D) Additional Reports. Contractor shall also furnish to County such statements, records, reports, data, and other information as County may request pertaining to matters covered by this Agreement. In the event that Contractor fails to provide such reports or other information required hereunder, it shall be deemed sufficient cause for County to withhold monthly payments until there is compliance. In addition, Contractor shall provide written notification and

explanation to County within five (5) days of any funds received from another source to conduct the same services covered by this Agreement."

5. Article 4 of the Agreement, beginning on Page 10, Line 17 and ending on Page 21, Line 12, is deleted in its entirety and replaced with the following:

"4.1 The County agrees to pay, and the Contractor agrees to receive compensation for the performance of its services under this Agreement as described in Exhibit J to this agreement, titled "Fresno County Department of Behavioral Health Financial Terms and Conditions.

4.2 **Additional Fiscal Requirements.** The Contractor shall comply with all additional requirements in Exhibit J to this Agreement."

6. Section 17.5 of the Agreement, beginning on Page 47, Line 5 and ending on Page 48, Line 2, is deleted in its entirety and replaced with the following:

"The County DBH has established a Compliance Office for purposes of ensuring adherence to all standards, rules and regulations related to the provision of services and expenditure of funds in Federal and State health care programs. Contractor shall either adopt DBH's Compliance Plan/Program or establish its own Compliance Plan/Program and provide documentation to County DBH to evaluate whether the Program is consistent with the elements of a Compliance Program as recommended by the United States Department of Health and Human Services, Office of Inspector General. Contractor's Compliance Program must include the following elements:

(A) Designation of a compliance officer who reports directly to the Chief Executive Officer and the Contactor's Board of Directors and compliance committee comprised of senior management who are charged with overseeing the Contractor's compliance program and compliance with the requirements of this account. The committee shall be accountable to the Contractor's Board of Directors.

(B) Contractor shall have written policies and procedures that articulate the Contractor's commitment to comply with all applicable Federal and State

standards. Contractor shall adhere to applicable County DBH Policies and Procedures relating to the Compliance Program or develop its own compliance-related policies and procedures.

(C) Contractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they arise, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

(D) Contractor shall implement and maintain written policies for all County DBH-funded employees, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.

(E) Contractor shall maintain documentation, verification or acknowledgement that the Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors are aware of these Policies and Procedures and the Contractor’s Compliance Program.

(F) Contractor shall have a Compliance Plan demonstrating the seven (7) elements of a Compliance Plan. Contractor has the option to develop its own or adopt County DBH's Compliance Plan. Should Contractor develop its own Plan, Contractor shall submit the Plan prior to implementation for review and approval to:

Fresno County DBH Compliance Office

1925 E. Dakota Ave. Ste A

Fresno, California 93726

Or send via email to: DBHCompliance@fresnocountyca.gov”

7. When both parties have signed this Amendment No. 3, the Agreement, Amendment No. 1, Amendment No. 2, and this Amendment No. 3 together constitute the Agreement.

8. 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.

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.

9. 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.

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

11. The Agreement as previously amended and as amended by this Amendment No. 3 is ratified and continued. All provisions of the Agreement as previously amended and not amended by this Amendment No. 3 remain in full force and effect.

[*SIGNATURE PAGE FOLLOWS*]

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The parties are signing this Amendment No. 3 on the date stated in the introductory clause.

Turing Point of Central California, Inc.	COUNTY OF FRESNO
Ryan Banks _____ Ryan Banks, Chief Executive Officer	_____ Garry Bredefeld, Chairman of the Board of Supervisors of the County of Fresno
Bruce Tyler _____ Bruce Tyler, Chief Information Officer (CIO)/Interim Chief Financial Officer (CFO)	**Attest:** Bernice E. Seidel Clerk of the Board of Supervisors County of Fresno, State of California
615 S. Atwood Street Visalia, CA 93277	By: _____ Deputy

For accounting use only:

Org No.:

56304525 (FACT)
56304784 (ICM)
56304784 (OP)
56302361 (DSH)
56302070 (AB109 OP/FSP/FACT)
56302081 (DMC)

Account No.: 7295
Fund No.: 0001
Subclass No.: 10000

FRESNO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCOPE OF WORK
Effective July 1, 2026

I. PROGRAM NAME

Turning Point of Central California, Inc. (Turning Point) – Forensic Behavioral Health Continuum of Care

II. BACKGROUND

The 2011 Public Safety Realignment contained in AB 109 specifies local responsibilities for managing certain adult offenders. The intent of realignment is to allow maximum local flexibility within the statutory framework for the adult population transfers set forth in AB 109. The authors of this bill have identified several community interventions to assist this population lead a productive crime-free life. It is recognized that a number of these people would benefit from mental health and/or substance use disorder treatment and support services.

Under Assembly Bill (AB) 1810 on June 27, 2018, pre-trial jail diversion is defined as the "postponement of prosecution, either temporarily or permanently, at any point in the judicial process from the point at which the accused is charged until adjudication, to allow the defendant to undergo mental health treatment." Essentially, pre-trial jail diversion will allow mental health services treatment in lieu of trial and sentencing by a jury or judge for those who have been deemed to have a mental health illness, which significantly contributed to the act of the crime.

Senate Bill (SB) 317 authorized the ability for the court to suspend proceedings and grant diversion to individuals charged with misdemeanors who have been found incompetent to stand trial. Currently individuals that are found incompetent to stand trial are either referred to an out-of-county inpatient facility for restoration services or a Full-Service Partnership (FSP) within the DBH system of care for mental health services. With the passing of SB 317, IST individuals are more likely to be diverted to community-based supports for both mental health and restoration services.

The Contractor shall operate an Adult Forensic Continuum of Care, including the high-intensity services models of Full-Service Partnership (FSP) Forensic Assertive Community Treatment (FACT), Full-Service Partnership Intensive Case Management (FSP ICM), and Outpatient (OP) levels of care services for adults and older adults with criminogenic needs. Additionally, Contractor will provide outreach and engagement to Persons Served referred to the program but not yet admitted for all populations.

The Contractor shall work with adults and older adults with criminogenic needs, including but not limited to individuals who qualify for AB 109 services, AB 1810 services, and those who have been declared Incompetent to Stand Trial (IST)who are experiencing a range of symptoms qualifying for Specialty Mental Health Services (SMHS) or co-occurring SMHS

and Substance Use Disorder (SUD), including those who have a serious disorder that is severe in degree and persistent in duration. As a result of the disorder the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms. Functional impairment may occur in the person's independent living, social relationships, vocational skills, or physical condition. Continuum of Care services are outpatient and voluntary. Enrolled persons served may withdraw consent at any time.

Contractor will have a capacity of 75 persons served for the FACT team and will maintain staffing in the FSP ICM level appropriate to serve up to 90 persons at a time, depending on the staff ratio, by fiscal year 2027. Contractor must refer to the Revised Exhibit J, Attachment B for the maximum census per fiscal year. Outpatient capacity is at the discretion of the Contractor, however, each site will provide sufficient capacity to serve persons currently enrolled in the Adult Forensic Continuum of Care programs with additional capacity to serve new persons while continuing to maintain a more intimate level of service to effectively stabilize persons served through engagement with the program. The total maximum capacity of all levels of care is at the Contractor's discretion. Additionally, there is no required ratio between FACT, FSP ICM and OP total persons served.

Services provided by FACT and FSP ICM teams will include comprehensive mental health, substance use disorder treatment, linkage to housing options and other community-based supports to persons served with a serious mental illness (SMI)/serious emotional disturbance (SED) and/or co-occurring SUD. Contractor is expected to build the OP caseload when stepping down FACT and FSP ICM persons and serving significant support persons.

"Whatever it takes": Using any method necessary to engage a person served, determine their needs for recovery, and creating personalized, collaborative services and supports to meet the wellness and recovery needs of the unique person served.

"Meeting the person served where they are": Being accessible and available to persons served at any time, meeting in a location convenient for them, communicating in a way that meets their cognitive and linguistic needs, and considering their stage of recovery when developing a treatment plan. Meeting persons served where they are also means tailoring services and approaches to align with the cultural identity of the person served. The term "culture" in this context, should not be limited to race and ethnicity, but should also extend to other cultural identities, including but not limited to: former foster youth, persons with disabilities, gender, LGBTQ persons, and persons with religious and spiritual affiliations.

Linkage to housing opportunities must be provided to the person served based on their need and level of recovery. The ultimate housing goal for each person served should be safe, affordable, and permanent housing. Contractor is expected to follow the Department of Behavioral Health (DBH) process for accessing housing options for persons served. FSP funds may not be used to pay for Housing Interventions.

III. TARGET POPULATION

The target population eligible for services under this Agreement includes adults (eighteen) 18 years and older adults with criminogenic needs, including but not limited to individuals who qualify for AB 109 services, AB 1810 services, and those who have been declared Incompetent to Stand Trial (IST) who meet specialty mental health criteria, present with severe impairment, persons over eighteen (18) but under twenty-one (21) with a diagnosable SED as set forth in the California Welfare and Institutions Codes, section 5600.3(a), or persons served who have a co-occurring moderate to severe SUD. The target population will include those who may have little to no criminogenic risk factors.

In addition, significant support persons involved in the well-being of the person enrolled in services may receive FSP ICM and OP SMHS from this program, as clinically appropriate and medically necessary, while the identified person served is enrolled, to optimize the person's ability to reach wellness and recovery. Persons served (including any significant support persons receiving SMHS must be enrolled, disenrolled, and/or re-enrolled in the electronic health record (EHR) program listing that aligns with the level of care in which they are receiving services (either FACT, FSP ICM, or OP), as that level changes.

Eligible children and youth means persons who are twenty-five (25) years of age or under who meet the following:

- Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance in Behavioral Health Information Notice (BHIN) 26-002 (includes individuals twenty-one (21) – twenty-five (25) years of age who meet this criteria), including BHIN Enclosure 1, DHCS Approved Youth Trauma Screening Tools, including any subsequent updates

Eligible adults and older adults mean persons who are twenty-six (26) years of age or older who meet the following:

- Meet SMHS access criteria specified in subdivision (c) of W&I Code section 14184.402 and implemented in SMHS guidance in BHIN 26-002 (only applies to individuals twenty-six (26) years of age and older), including any subsequent updates

A. Entry Criteria for FSP Level Services (FACT and FSP ICM)
   Identified persons served shall meet the following criteria for FSP level services:
   1. Be an eligible adult or older adult with an SMI or co-occurring SMI/SUD who meet the criteria above.
   2. Be an eligible child or youth with an SED, which includes transitional age youth (TAY).
   3. Meet one of the priority population criteria specified in WIC, section 5892, subdivision (d).

      For children and youth the priority populations are:

      a. Chronically homeless or experiencing homelessness or at risk of homelessness
      b. In, or at risk of being in, the juvenile justice system

c. Re-entering the community from a youth correctional facility
d. In the child welfare system pursuant to WIC sections 300, 601, and 602
e. At risk of institutionalization

For adults and older adults the priority populations are:

a. Chronically homeless or experiencing homelessness or at risk of homelessness
b. In, or at risk of being in, the justice system
c. Re-entering the community from a state prison or county jail
d. At risk of conservatorship
e. At risk of institutionalization

4. Persons selected for participation in the FSP Service Category must meet the eligibility criteria based on age group as found in California Code, WIC 5600.3.
5. Referrals to the FSP level services of FACT and FSP ICM shall be reviewed and approved by the County prior to program enrollment.
6. For FACT, eligible persons served must have:
   a. A diagnosis consistent with SMI or co-occurring SMI and SUD, according to current DSM and the International Statistical Classification of Diseases and Related Health Problems criteria and as determined by a person qualified to provide this diagnosis.
   b. High risk for reincarceration or detention.
   c. A primary psychotic disorder. FACT is not appropriate for individuals solely diagnosed with SUD, personality disorder(s), or intellectual/developmental disabilities (I/DD).
   d. A significant functional impairment, defined as one of the following:
      i. Consistent inability to perform practical daily tasks needed to function in the community such as maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal and housing services; recognizing and avoiding common dangers or hazards to oneself and one's possessions;
      ii. Persistent or recurring failure to perform daily living tasks, except with significant support or help from others such as friends, family or relatives (e.g., dependent on others for food, isolative, unable to use transportation independently);
      iii. Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles; and/or
      iv. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing, under a mental health (LPS) conservatorship).
   e. An indicator of continuous high-service needs, as evidenced by one or more of the following:
      i. High use of psychiatric hospitalization or psychiatric emergency services.
      ii. Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic, impulsive, suicidal);
      iii. Co-existing SUD of significant duration;
      iv. Inability to participate in office-based services;

v. Living in sub-standard housing, experiencing homelessness, or at imminent risk of becoming homeless;
vi. Clinically assessed to be able to live more independently if intensive services are provided.

7. For FSP ICM, eligible persons served must have:
   a. A current or suspected Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis consistent with a SMI, SED, or co-occurring SMI and SUD. Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP ICM.
   b. A moderate to significant functional impairment. Moderate to significant means that the impairment might be consistently problematic or that the impairment is occasionally significant (but the individual experiences more stability MOST of the time). Functional impairment can include:
      i. Difficulty performing practical daily tasks needed to function in the community such as maintaining personal hygiene, meeting nutritional needs, caring for personal business affairs, obtaining medical, legal and housing services, recognizing and avoiding common dangers or hazards to oneself and one's possessions;
      ii. Persistent or recurrent difficulty performing daily living tasks, except with moderate support or help from others such as friends, family or relatives;
      iii. Difficulty maintaining consistent employment at a self-sustaining level or to carry out homemaker roles; and/or
      iv. Difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
   c. An indicator of continuous moderately high service needs or relatively low service needs with occasional periods of high-service needs, as evidenced by one or more of the following:
      i. Risk of hospitalization or crisis/emergency care without this service;
      ii. Risk of returning to unsheltered homelessness after being placed in interim housing, or risk of returning to homelessness after being placed in permanent supportive housing without this service.
      iii. Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
      iv. Co-existing SUD of significant duration;
      v. High-risk or a recent history of being involved in the criminal justice system;
      vi. Living in substandard housing, experiencing homelessness, or at imminent risk of becoming homeless;
      vii. Living in housing, but clinically assessed to need more intensive services to maintain housing;
      viii. Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and/or
      ix. Inability to participate in traditional office-based services;

B. Entry Criteria for Outpatient Level Services

Persons shall meet SMHS eligibility criteria for OP as found in BHIN 26-002. Treatment services in the OP level of care focuses primarily on therapeutic appointments with occasional community case management services. Persons at this level of care have achieved some stability in their severe mental illness yet still require SMHS.

IV. DESCRIPTION OF SERVICE DELIVERY MODELS

A. Services Start Date: July 1, 2026

B. Summary of Services

Contractor shall provide a continuum of care, including the following high-intensity service models: FACT, FSP ICM, and OP. The expectations for each level of care are detailed below. While the service components may be the same or similar across FACT and FSP ICM, service delivery should be appropriately tailored based on level of care provided. In addition, the level of intensity of crisis services varies across FACT and FSP ICM. Contractors without an FACT team must provide referral and linkage to a contracted FACT provider.

Full-Service Partnership (FSP) programs provide individualized, team-based care to persons served living with significant behavioral health needs through a “whatever it takes” approach. Persons served benefit from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate and delivered in partnership with families or an individual’s natural supports.

FSPs provide the full spectrum of community services necessary to attain identified goals, as well as any services that may be deemed necessary through collaborative planning between the County, the person served and/or their family to address unforeseen circumstances in the person’s life. Each person served must have a Personal Services Coordinator (PSC) who acts as an ally and a “single point of responsibility” for the person served.

The FSP program services shall be provided utilizing the BHSA Policy Manual and the Evidence-Based Practices (EBPs) Policy Manual which is available at: https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/.

Contractor will adhere to FSP regulations, which can be found in their entirety in the California Code of Regulations, Title 9, Sections 3620, 3620.05 and 3620.10 which are available at: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I4F8301404C6B11EC93A8000D3A7C4BC3&transitionType=Default&contextData=%28sc.Default%29.

1. For all levels of care:

a. Contractor must have the capability of supporting persons in need of co-occurring SUD treatment services in addition to SMHS. Refer to the service descriptions below for minimum requirements by service model.
b. Provide appropriate age, culture, gender, sexual identity, and language services and accommodations for physical disabilities to persons served.
c. Make appropriate referrals and linkages to services that are beyond that of the Contractor's services. Contractor shall continue to coordinate services with any other community mental health, SUD, and non-mental health providers as well as other medical professionals. Methods for service coordination and communication between Contractor and other service providers for each person served shall be developed and implemented consistent with Fresno County confidentiality rules.
d. Provide support to the family of the person served and other members of the person's social network to help them support the person in managing symptoms and illness and reduce family and social stress associated with the illness.
e. Assist person served/family with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, Supplemental Security Income (SSI), Section 8 vouchers, etc.).
f. Develop family support and involvement whenever possible.
g. Refer persons to supported education and employment opportunities, as appropriate.
h. Provide or link to transportation services to access necessary support services or gain entitlements or benefits.
i. Provide and claim for peer support activities, as appropriate.
j. Ensure that clinically appropriate Evidence-Based Practices (EBP) are utilized to fidelity in service delivery.
k. Ongoing clinical assessment of the mental health and SUD symptoms of the person served and their response to treatment.
l. Provide services in the areas of medication evaluation, prescription, administration, monitoring, and documentation via in-person or telepsychiatry, including all psychiatric medications that are considered the standard of care in management of serious psychiatric conditions.
m. Educate the person served regarding their mental illness and the effects (including side effects) of prescribed medications.
n. Provide symptom management skills and help the person served identify the symptoms and their occurrence patterns, and develop methods (internal behavioral, adaptive) to lessen their effects.
o. Provide, both planned and on an "as needed" basis, psychological support as is necessary to help person served accomplish their personal goals and cope with the stresses of day-to-day living.
p. Assist persons to locate appropriate housing in the community.
q. Provide training, instruction, support, and assistance to the person served in developing personal skills such as personal hygiene, housekeeping, money management skills, use of community transportation, and to locate, finance and maintain safe, clean and affordable housing.

r. Develop and support the participation of the person served in social interactions, including, when possible, recreational social activities, and relationships. Priority shall be given to supporting persons served in establishing positive social relationships in normative community settings.
s. Act to minimize the involvement of the person served in the criminal justice system.
t. Assist the person served, family and other members of their social network to relate in a positive and supportive manner.
u. Monitor service outcomes to determine if the person served has meaningful use of their time, stays in school, maintains employment, has reduced numbers of hospitalizations, incarcerations, and periods of homelessness. DBH will use State-identified criteria for measuring these outcomes. The treatment services will be monitored to ensure appropriate service delivery and adherence to BHSA and other State regulations.
v. Provide comprehensive services, including intensive mental health treatment, rehabilitation, case management, and peer support with the goal of increasing adaptive functioning in the community and preventing unnecessary re-admissions to Institutes of Mental Disease (IMD), acute inpatient facilities, or other higher levels of care.
w. Assist the person served in accessing and participating in the employment and education programs offered in the community, as appropriate.
x. Assist persons served in accessing housing options and assist persons served in maintaining a stable residence by providing needed services, accessing resources, and encouraging persons served to be independent, productive, and responsible.
y. Services, publications, and buildings will be fully accessible to meet the physical and linguistic abilities of all persons served. Contractor must have the availability of language assistance for persons served when their language of choice is not available through existing staff. At a minimum, Contractor must offer interpreter services either in-person or through a contract with a language line provider.
z. Be responsible for developing a plan to continually engage targeted populations through outreach and engagement services. Contractor shall distribute literature and informational brochures in appropriate languages and request feedback as to how access to care could be improved for the intended population. Contractor will be expected to collaborate with agencies that are recognized and accepted by the target population.
aa. Comply with the documentation requirements established in BHIN 23-068, or subsequent updated guidance, which includes standardized assessment requirements; dynamic problem list; progress notes; and care planning.
bb. Deliver a comprehensive specialty mental health program. Contractor must ensure the following services are provided by appropriately credentialed staff:
    i. Assessment
    ii. Crisis Intervention
    iii. Medication Support Services
    iv. Peer Support Services

v. Psychosocial Rehabilitation
vi. Referral and linkages
vii. Therapy
viii. Treatment Planning
ix. Integrated SUD Co-Occurring Capable FACT or SUD referral and linkage process for FSP ICM

2. Forensic Assertive Community Treatment (FACT)
FACT is an evidence-based practice to support persons served living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalizations and emergency room visits, residential treatment, homelessness, lack of engagement with traditional outpatient services, have involvement with the criminal justice system and exhibit high risk for reincarceration or detention and require frequent, intensive, and community based services.

Typically, a person at this level of care would receive at least three (3) contacts per week, or more as clinically appropriate, with most contacts being face-to-face/in-person. Telehealth may be used judiciously for visits that exceed the three (3) contacts per week threshold. The actual type and frequency of FACT contacts should be determined based on the needs of each individual and the intensity of the service may be higher than the minimum contact expectation. Persons who do not require this frequency of contacts and in-person engagement are typically better suited for FSP ICM.

A person served appropriate for FACT may need support to recognize their need for help to remain out of crisis and out of the hospital and may be difficult to engage. FACT teams provide services to those in need of committed and persistent assertive engagement to deliver needed services.

A person who would benefit from FACT may not recognize functional limitations or needs as assessed by the treatment team. They may feel conflicted, distrustful, hesitant or ambivalent about engaging in treatment, particularly if they have had negative or traumatic experiences with behavioral health entities in the past. The FACT team and others may experience their presentation as challenging to engage. This suggests a need for consistent and persistent engagement to deliver necessary services while honoring the individual's perspective, experiences and goals.

FACT is a self-contained team-based service. FACT teams shall:
a. Screen individuals for criminogenic risk and needs and utilize cognitive behavioral approaches for addressing criminogenic needs for these individuals.
b. Be available to provide crisis assessment and intervention 24/7, including telephone and face-to-face in person contacts, as needed with a person known to the person served. FACT providers shall be responsive to persons served who may be admitted to emergency departments, crisis stabilization center, inpatient psychiatric facilities, or jail.

c. Provide whatever direct assistance is necessary and reasonable, including linkages, to ensure that the person served obtains the basic necessities of daily life, such as food, housing, transportation, clothing, medical and dental services.
d. Rarely, if ever, refer individuals to external behavioral health providers for management of their SMI or co-occurring SUD, unless the individual requires intensive SUD treatment (i.e., SUD residential or inpatient withdrawal management). FACT teams should include at least one AOD counselor or other practitioner with SUD training or experience that can provide co-occurring SUD treatment, including arranging for or providing Medications for Addiction Treatment (MAT) when appropriate. FACT teams should include a psychiatrist or other prescriber who is a fully integrated member of the team.
e. Participate in regular (generally daily) team meetings to help coordinate care, facilitate information sharing, and help team members remain apprised of an individual's treatment progress.
f. Be primarily field-based and teams are comprised of dedicated (i.e., full-time) team members.
g. Provide persistent and committed engagement.
h. Provide integrated, time-unlimited service delivery.
i. Provide linkages to physical health services, (i.e., hygiene, dental) and other supportive services (i.e., food, transportation, housing) as needed.
j. Ensure that each FACT team member shall have access to an adequate amount of financial resources to make emergency purchases of food, clothing, prescriptions, transportation, or other items for person served, as needed, during regular working hours (and appropriate on-call hours). The team shall have access to larger flexible funding accounts for assistance with furniture purchases and other items, with sound accounting practices for recording and monitoring the use of these funds to prevent fraud, waste and abuse. Contractor will collaborate with County in detailed categorizing of all expenditures.
k. Assist the person served with establishing a payee or payee services, as needed. The FACT team may utilize person served assistance funds to assist person served with short-term loans or grants, as necessary. The team shall link persons served to appropriate social services, provide transportation as necessary, and link the person served to appropriate legal advocacy representation.

FACT teams can provide unbundled SMHS before an FSP participant is authorized for FACT admission.

3. Full-Service Partnership Intensive Case Management (FSP ICM)
FSP ICM offers a comprehensive array of community-based services and can be provided either as a step-down from FACT or as an intervention to avert the need for FACT-level care. FSP ICM is delivered by a multidisciplinary team that incorporates core case management functions – such as assessment, planning, and linkage – with low staff-to-client ratios, assertive outreach, and direct service delivery, including peer services, crisis intervention, psychosocial rehabilitation, psychotherapy, medication management and more. FSP ICM is for individuals who may not meet

FACT eligibility criteria but still have significant behavioral health needs and can benefit from FSP supports.

Typically, a person at this level of care would receive at least one (1) contact per week, or more as clinically appropriate, with most contacts being face-to-face/in-person. Telehealth may be used judiciously for visits that exceed the once per week threshold. The actual type and frequency of FSP ICM contacts should be determined based on the needs of each individual and the intensity of the service may be higher than four (4) contacts per month. Persons who do not require this frequency of contacts and in-person engagement are typically better suited for OP. Contractor is responsible for transitioning the person served to OP.

FSP ICM is a self-contained, team-based service. FSP ICM teams shall:

a. Provide whatever direct assistance is necessary and reasonable, including linkages, to ensure that the person served obtains the basic necessities of daily life, such as food, housing, transportation, clothing, medical and dental services.
b. Provide services based on individual needs and may refer individuals to additional services the team cannot provide such as crisis services, supported employment, and care for co-occurring SUDs.
c. Be comprised of a mix of full-time and part-time team members.
d. Provide persistent and committed engagement to lower acuity individuals.
e. Provide integrated, time-unlimited service delivery.
f. Ensure that each FSP ICM team member shall have access to an adequate amount of financial resources to make emergency purchases of food clothing, prescriptions, transportation, or other items for person served, as needed, during regular working hours. The team shall have access to larger flexible funding accounts for assistance with furniture purchases and other items, with sound accounting practices for recording and monitoring the use of these funds to prevent fraud, waste and abuse. Contractor will collaborate with County in detailed categorizing of all expenditures.
g. Assist the person served with establishing a payee or payee services, as needed. The FSP ICM team may utilize person served assistance funds to assist person served with short-term loans or grants, as necessary. The team shall link persons served to appropriate social services, provide transportation as necessary, and link the person served to appropriate legal advocacy representation.

4. Outpatient (OP)
   Persons at this level of care have achieved some stability in their severe mental illness yet still require SMHS. Persons served at this level shall receive a minimum of one (1) contact per week with at least one (1) face-to-face contact per month. This can include but is not limited to individual therapy, group therapy, rehabilitation, case management, peer support services, and medication management. In the OP level of care, treatment focuses primarily on therapeutic appointments with occasional community case management and medication services.

Outpatient services are funded by Medi-Cal fee for service and persons served at this level of care are not eligible to receive additional supports through the Whatever It Takes activity.

C. MH and SUD Co-Occurring Capabilities
Co-occurring capability involves embedding integrated policies, procedures, practices and training in the program to make it routine for clinicians to successfully deliver integrated care. FSP programs are required to:
1. Conduct American Society of Addiction Medicine (ASAM) screenings as part of an integrated assessment upon intake into the FSP.
2. FACT program must make SUD services available within the program.
3. FSP ICM programs must have a referral mechanism in place to link persons served to necessary SUD services. FACT teams are expected to obtain a release of information (ROI) from person served to facilitate treatment collaboration and care coordination with the SUD treatment program.
4. Offer medications for addiction treatment (MAT) services directly or have an effective referral process in place.
5. Have memoranda of understanding (MOUs) with SUD providers to link persons served with outpatient, residential and MAT services.

D. Individual Placement and Support (IPS) Model of Supported Employment
The IPS model of Supported Employment is an evidence-based intervention that engages persons served living with significant behavioral health needs in finding and maintaining competitive employment, which can play a crucial role in their recovery and integration into the community. IPS provides structure, purpose, and social connection and is shown to reduce isolation and combat stigma for persons served living with mental health conditions.

Contractor must make IPS services available in conjunction with other FSP service models such as FACT and FSP ICM to offer a comprehensive approach to recovery that addresses both clinical and functional needs.

To meet this requirement, Contractor must enter into a memorandum of understanding (MOU) with County's current contracted IPS provider to facilitate referrals and engagement in IPS services. The MOU must define the responsibilities of Contractor and the IPS provider in the referral and engagement process for persons served. The executed MOU must be provided to County.

E. Non-Medi-Cal Services and Supports (Whatever It Takes)
The "whatever it takes" (WIT) approach refers to the commitment to provide comprehensive, low barrier, individualized, and flexible support services to help persons served with serious mental illness, including those with a co-occurring SUD, to achieve stability, recovery and reach their wellness goals. FSP programs are designed to remove barriers that prevent individuals from engaging in treatment, reaching recovery and maintaining their wellness. The "whatever it takes" model requires that all services and

supports are individualized and directly aligned with the person's wellness and recovery goals.

WIT funds, made available under this agreement, shall not be used for housing (rent, deposits, etc.) or activities and supports available under the community supports provided by the Medi-Cal Managed Care Plans (MCPs), which include Anthem Blue Cross, CalViva Health and Kaiser Permanente.

Contractor must keep record of items purchased under this service category to account for expenditures and must have policies and procedures in place to prevent fraud, waste and abuse.

F. Outreach and Engagement

Outreach and engagement shall refer to the assertive, persistent and person-centered efforts to identify and/or locate, engage, enroll and retain persons served who meet FSP-level criteria, but who are not currently connected or actively receiving behavioral health services.

Outreach and engagement must commence as soon as possible following the receipt of a referral. The number of outreach and engagement attempts, and the length of time it takes to engage a person served, will vary depending on the unique circumstances of the person served. For example, physical health, hospitalization, incarceration and current mental health may be factors that delay engagement. Provider shall make repeated attempts to contact persons served, in the method most likely to result in engagement and enrollment of the person served.

Acceptable outreach activities include, but are not limited to:

1. Field-based outreach, including visits to homes, shelters, public areas/streets where the person served is known to spend time, hospitals, schools, jails, and community settings;
2. Telephone calls;
3. Electronic messaging (text and email), if the person served is known to have access to electronic messaging; and in collaboration with community partners to coordinate care.

G. Collaboration

Collaboration with Probation

The Contractor shall collaborate with the Fresno County Probation Department (the "Probation Department") to provide screenings on-site at the AB 109 office to individuals who may need MH and/or SUD services. Individuals who are screened to need services are to be referred to the appropriate level of care for services. The Contractor shall also make arrangements to provide assessments to Enhanced Outpatient (EOP) individuals outside of regular business hours as needed.

The Contractor shall participate with the Probation Department in Pre-Release Coordinated Clinical Assessment Team (CCAT) teleconferences to discuss EOP incarcerated individual's case prior to release. This is most helpful as it is often the only time that there is direct access to California Department of Corrections and Rehabilitation (CDCR) doctors and clinicians to ask questions related to an EOP incarcerated individual. These teleconferences are done during regular business hours.

Collaboration with Court Services
All individuals who are placed in the Forensic Behavioral Health Continuum of Care (FBH-COC) will have intermittent requirements to report back to the collaborative treatment courts regarding the individual's progress. The Contractor shall identify an individual who will communicate and coordinate with court services and/or law enforcement, as needed. The Contractor shall work with court partners to create and use a standardized form for court reporting. Court reporting should be completed in a timely fashion and be submitted to the court a minimum of 48 hours in advance of the next scheduled court hearing.

The Contractor will need to be able to provide court attendance assistance to participants by hosting them in their office for Virtual Court sessions or helping the individual arrange transportation to hearings as necessary.

The Contractor shall designate staff to attend specialty treatment court hearings, including but not limited to Mental Health Diversion (MHD) Court and Mental Health Incompetent to Stand Trial (MIST) Court. Staff will attend hearings on a frequency to be determined by DBH.

Other Collaborative Relationships
The Contractor shall establish and maintain collaborative relationships with agencies and individuals who have frequent contact with hospitalized, homeless, or incarcerated adults. Examples of collaborative relationships include but are not limited to local law enforcement agencies, Veterans Administration, Marjorie Mason Center, Fresno County Human Services Departments, Faith Organization, acute psychiatric facilities, schools, community centers, etc. Letters of introduction, including a description of services and how to contact the FBH-COC program shall be distributed to potential community partners. There may be a need for a Memorandum of Understanding (MOU) or Data Use Agreement between the Contractor and one or more of the community partners if data is to be shared and collected. HIPAA regulations must always be considered and adhered to when discussing protected health information (PHI) with another agency.

At some point during the resulting contract, there may be an increased need for collaborative efforts initiated with other County Departments (such as the Public Defender ["PD"], District Attorney ["DA"], Sheriff-Coroner ["Sheriff"], Probation Department, Social Services, etc.) that will require full cooperation by the Contractor. The Contractor shall be willing to provide information on the program services through

trainings and infographics to our community and criminal justice partners (PD, DA, Sheriff, Probation, Jail, Social Services, etc.)

H. Location of Services
   1. Services shall be provided at the following clinic locations:
      a. 3636 N. First Street, Suites 135, Fresno, CA 93726
      b. 3636 N. First Street, Suites 162, Fresno, CA 93726

   2. FACT and FSP ICM
      FACT and FSP ICM level services shall be primarily provided within the community as opposed to services being performed at traditional clinical offices to increase the likelihood of persons served accepting services, as some persons served may be reluctant to seek services provided in traditional mental health settings. FACT and FSP ICM services can be delivered in the home, community, school, or other community-based settings as determined in collaboration with all relevant parties. Locations must provide easy access for the person served. Contractor should follow best practices and exercise clinical judgement to maintain confidentiality and will be responsible for obtaining any releases for disclosure to third parties necessary to gain access.

      Telehealth, mobile services, and co-location in natural supports and gathering places for the intended population are additional options to increase the frequency of persons served obtaining needed services.

      For office-based hours, Contractor must provide the hours of highest need for this target population. Contractor should have a plan for transportation or access to services for this target population. Services shall be delivered wherever the intended target population resides, throughout Fresno County.

   3. Outpatient (OP)
      Contractor shall provide Field-based and/or Clinic-based service delivery for OP level services as needed. Contractor should have a written plan to explain how OP level services would be provided with the following understanding of the difference between Field-based and Clinic-based service delivery:

      Clinic-based service delivery means less than fifty percent (50%) of services are in the field. Field-based service delivery are services that do not occur through telehealth and do not occur in designated sites in which the contractor is afforded regular access. Designated sites shall be identified by Contactor within their written plan.

I. Hours of Operation

The FACT, FSP and OP programs maintain office hours of operation Monday through Friday from 8:00 a.m. to 5:00 p.m. Each individual will have a single point of responsibility through a Mental Health Specialist (MHS). The caseload of each MHS will be low enough to ensure their availability to the individual and family is appropriate to their service needs; they are able to provide intensive services and supports when needed, and they can give the individual and/or family member considerable personal attention. Other members of the team the individual and/or family members will have access to will include a program psychiatrist, a nurse, social workers and marriage and family therapists, and peer supports.

The FACT program will have 24/7 crisis availability. A trained staff member is prepared to respond to all crisis situations through rotating scheduled staff of the day (like officer of the day) during normal work hours and on-call coverage for after-hours. All on-call staff are mental health professionals and management staff. Updates on person served are readily updated to these staff members and they have full access to the EHR to reference Plan of Care and recent intervention/medication support. These staff carry a cell phone and remain within 25 miles of the city to be able to respond to situations within one hour. Telephone interventions are utilized when sufficient to the purpose; however, staff provide face-to-face services to the extent necessary to ensure individual safety and resolve the crisis. Emergency housing is available, and staff are trained to access crisis services if needed. Staff are trained that use of crisis services should be avoided if safely preventable, as the goals of the program are to reduce/eliminate use of these services. Staff coordinate care with crisis service workers and residential program staff and seek to return persons served to supported independence as quickly as is appropriate. Services include the ability of the MHS, or other team members known to the individual or family to respond to persons served and family members 24 hours a day, seven days a week. This level of accessibility for the individual and/or family helps to reduce and prevent negative outcomes for persons served including unnecessary hospitalizations, incarcerations, or evictions.

The FSP-ICM program will establish a plan to ensure crisis availability for persons served which may include providing education on resources for 24/7 crisis services.

Contractors delivering an EBP modality that requires 24/7 services (FACT, etc.) must ensure services are available 24 hours a day, 7 days a week.

J. Schedule of Services

The hours of operation must ensure availability to persons served and their families, as needed. A minimum of eight (8) hours, five (5) days per week is required for routine operations. Should persons served or their family members require services during non-traditional office hours, Contractor will work to accommodate their needs in the most appropriate person-centered manner. Contractor shall provide accommodation for services outside of traditional business hours. The County strongly recommends the following standard office hours of Monday through Saturday from 7:00 AM – 7:00 PM.

Additionally, Contractor shall be expected to temporarily extend office hours, as needed, to accommodate and improve timeliness of services as needed.

FACT Contractor shall ensure that a Personal Services Coordinator (PSC), Case Manager, or other qualified person known to the FSP person served and/or their family is available to respond to the person served and their family 24 hours a day, 7 days a week to provide after-hours interventions (including weekends and holidays) as needed (other existing external resources such as 988, mobile crisis support, etc. will not suffice). Contractor shall provide a clinical response to persons served in the FACT level of care when the person experiences a crisis outside of traditional business hours.

K. Length of Stay
Length of stay in each level of care shall be determined based on eligibility criteria, and the clinical needs and progress of the persons served.

Contractor shall ensure periodic evaluation of persons served for appropriate placement or movement to another level of care. Contractor shall coordinate with DBH to ensure continuing eligibility for persons served.

L. Referral Sources and Referral Process

FACT
Referrals can be made from various sources, including but not limited to the Felony Incompetent to Stand Trial (FIST) court, Mental Health Diversion (MHD) court, Mental Health Incompetent to Stand Trial (MIST) court, and Probation. Approval of person served entry into the FACT and FSP ICM program shall be made by the County. The County will review and approve all referrals to the FACT and FSP ICM level of care only. Contractor can receive and admit referrals for OP without County approval. If a person served is admitted to OP and is later determined to need FACT or FSP ICM level of care, the provider must receive approval from DBH prior to moving the person served to the FSP ICM level.

Contractor must ensure that referrals received are processed in a timely manner, with no waitlist for services.

M. Care Coordination/Transition Plan
1. Intake and Initial Assessment
Contractor shall follow their established plans to process referrals and begin the intake process within the timeliness standards outlined below, including a plan for outreach and engagement activities as needed.

For all levels of care, Contractor shall adhere to the timeliness standards set forth by the state and County's DBH. An initial mental health assessment shall be completed within a clinically appropriate timeframe. If the timeframe exceeds thirty (30) days, justification for this delay shall be clearly represented in the clinical documentation.

2. Transition and Discharge

Contractor shall ensure that transition and discharge procedures are supportive, minimally disruptive, and clinically appropriate.

Persons referred for services may be denied services if the referred person does not meet medical necessity for specialty mental health services, with or without a co-occurring SUD, or meets medical necessity for a mental health diagnosis that is not covered by the County's MHP. Persons who are determined to be ineligible for services shall be assessed and linked to the appropriate level of care or care delivery system.

Persons served shall be transitioned between levels of care within the program as clinically appropriate. Transitional supports shall be provided (i.e., a warm handoff) to ensure that persons served are appropriately linked and engaged in services before terminating services from the program.

Discharge is determined on a case-by-case basis, as clinically appropriate. Reasons for discharge include: the person served, or caregiver refuses or terminates services; the person served is transferred to another program mutually agreed upon by the treatment team, person served (and their guardian, if applicable) agrees that the treatment goals have been met.

N. Level of Care/Modality
Persons served will be assigned to one of the following levels of care, as appropriate, upon completion of the intake/assessment:

1. Forensic Assertive Community Treatment (FACT)
Persons served in the FACT level of care benefit from the "Whatever It Takes" approach to services which includes therapy, crisis services when needed, supported employment and other recovery supports, care for co-occurring SUDs, and linkages to needed social services and supports.

Services at this level of care shall be accessible 24/7. A person receiving FACT services would receive at least three (3) contacts per week, or as clinically appropriate, with most contacts being face-to-face in-person unless individual person-centered clinical factors warrant contacts being delivered via alternative methods.
   a. Caseload: A full-sized FACT team should include at least 10 full-time equivalent (FTE) staff and serve a caseload of 75 persons served.
   b. Contractor will collaborate with DBH to evaluate program census and staffing.

2. Full-Service Partnership Intensive Case Management (FSP ICM)
Persons served in the FSP ICM level of care benefit from a comprehensive array of community-based services, including a "Whatever It Takes" approach, that incorporate core case management functions. Persons served at this level receive a minimum of one (1) contact per week, or more as clinically appropriate, with at least one of those contacts being face-to-face each month.

a. Caseload: 1:25 per FSP ICM team member
b. Contractor will collaborate with DBH to evaluate program census and staffing.
c. Length of Stay: Suggested length of stay is eighteen (18) to twenty-four (24) months, with the assigned provider evaluating the needs of each person served on an ongoing basis to ensure that the level of care is clinically appropriate.

3. Outpatient (OP)
Persons served in the OP level of care benefit from therapeutic appointments for individual/group treatment, and case management and medication services, as needed. Persons served at this level receive a minimum of one (1) contact per week with at least one (1) face-to-face contact per month.

Length of stay for persons served in an outpatient program is suggested to be twelve (12) to eighteen (18) months with assigned provider evaluating the needs of each person served on an ongoing basis to ensure that the level of care is clinically appropriate.

O. Evidence-Based Practices (EBPs)
Contractor shall cooperate with DHCS-established Centers of Excellence (COE) which will offer training, technical assistance and fidelity monitoring to behavioral health delivery systems and behavioral health practitioners implementing EBPs.

Contractor must implement all EBPs to fidelity. The COEs will conduct assessments of FACT teams on an ongoing basis.

1. FACT fidelity designations will be assigned based on assessments conducted by the COE. FACT teams must meet fidelity designations as follows:
   a. Baseline fidelity within nine (9) months of establishing a team. Baseline fidelity is assessed using the Core Competency Checklist.
   b. Minimum fidelity within fifteen (15) months of establishing a team. Minimum fidelity is assessed using the Tool for Measurement of ACT (TMACT) with a score of 3.3 or higher.
   c. Full fidelity is assessed using the TMACT twelve (12) months after achieving minimum fidelity with a passing score of 3.7 or higher.
   d. FACT teams will be assessed biennially to demonstrate continued full fidelity designation status with a TMACT score of 3.7 or higher.
2. Contractor shall utilize additional EBPs and interventions to offer clinically appropriate, unduplicated services and maintain fidelity to the program model, including provision of psychiatric services.
3. Contractor must be prepared to utilize EBPs throughout their programming as clinically appropriate, to employ harm reduction and strength-based approaches.
4. FSP ICM programs: Submit to DBH a list of the EBPs that will be used in the program. DBH will review and approve the EBPs for this level of care and Contractor shall ensure the use of the EBPs is documented in treatment.
   a. Examples of EBPs include but are not limited to:
      i. Motivational Interviewing (MI)
      ii. Seeking Safety (SS)

iii. Cognitive Behavioral Therapy (CBT)
iv. Dialectical Behavior Therapy (DBT)
v. Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Other evidence-based practice models recognized as effective in improving functioning of the target population, and as befitting the Contractor's program vision may also be utilized if deemed appropriate.

5. County Shall:
   a. Assist Contractor's efforts to evaluate the needs of each person served on an ongoing basis to ensure that the level of care they are receiving is clinically appropriate.
   b. Provide oversight and collaborate with Contractor and other County Departments and community agencies to help achieve State program goals and outcomes. Oversight includes, but is not limited to, contract monitoring and coordination with DHCS and/or other oversight agencies in regard to program administration and outcomes.
   c. Assist Contractor in making linkages with the behavioral 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 be available to Contractor for ongoing consultation.
   e. Gather outcome information from target person served groups and Contractor throughout each term of this Agreement. County shall notify Contractor when their participation is required. The performance outcome measurement process shall not be limited to survey instruments but will also include, as appropriate, person served and staff interviews, chart reviews, data analysis and other methods of obtaining required information. To comply with changing regulations, outcome and data tracking requirements are expected to change and County will inform and work with the Contractor to adapt throughout the term of this agreement.
   f. Assist Contractor's efforts toward cultural and linguistic responsiveness by providing technical assistance regarding cultural responsiveness requirements.

6. Staffing
   Contractor shall utilize appropriate staffing plans/patterns sufficient to deliver the necessary levels of services and the volume of services necessary to meet the community's need. Clinical Supervisors and the clinical training program must meet the California Board of Behavioral Sciences and/or California Board of Psychology standards.

   Contractor will be encouraged to hire and recruit those with lived experience including persons served or their family members that have previously received behavioral health services. Contractor will be required to hire and recruit at least one practitioner with lived experience of the criminal justice system for the FACT treatment team. Peer support services are required as part of the program design.

7. Contractor Shall:
    a. Ensure staffing is appropriate for the high-intensity services models implemented.
    b. Have a job classification describing responsibilities, including supervision and team lead duties.
    c. At a minimum, have FACT and FSP ICM teams that include the following:
        i. FACT teams are required to have approximately ten (10) team members who will serve a shared caseload of eighty (80) to one-hundred ten (110) persons served. Actual team size may vary depending on the expected caseload. FACT teams consist of:
            - Psychiatrist or psychiatric prescriber, and
            - Licensed Practitioners, including the ACT team lead
            - Practitioner with lived experience (required for FACT)
            - Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Practitioners
            - Certified Peer Support Specialists
            - AOD Counselor or other practitioner with training or experience providing SUD services
            - Other Qualified Provider
        ii. FSP ICM teams are required to have a team lead, and should include a combination of part-time and full-time providers for a total of 8 to 10 staff such as:
            - Prescribers
            - LPHA (team lead)
            - Certified Peer support specialists
            - Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Practitioners
            - Other qualified providers
    d. Ensure all contacts with persons served are delivered with appropriate clinical oversight and supervision.
    e. Provide a sufficient number of licensed staffing and manage assignment of persons served within the program to ensure that all services for persons with dual coverage are claimable (e.g. Medicare/Medi-Cal dually enrolled persons).
    f. Consider the linguistic and cultural needs of the community when recruiting for all positions, as well as personal and professional experiences.
    g. Maintain an up-to-date caseload record of all persons enrolled in services, and provide person, programmatic, and other demographic information to the County.
    h. Ensure each enrolled person served is assigned to a Personal Service Coordinator, meet the community needs, ensure the program has no waitlists and keep referrals open at all times.
    i. Require staff members working directly with persons served to provide outreach outside of the office setting and have the capacity to provide as many contacts as needed with persons served to meet their recovery/resiliency and wellness goals.
    j. Have a plan for how they will minimize staff turnover and cultivate staff retention. Contractor will also do salary market research to assure competitive salaries for positions to curb staff turnover.

k. Offer Peer Support resources:
   BHSA funding incorporates a person served/family-focused peer support component that enhances bi-cultural and bilingual peer-centered services. Services will include but not be limited to: support groups, one-on-one assistance, linkages with a peer navigator, and support. The ISSP can include the use of Peer Support resources. Peer support services are Medi-Cal billable when the Peer Support Specialist has completed the County-approved Peer Support Specialist Training and has received their certification, and the designated supervisor has completed the County-approved Peer Support Supervisor training.
l. Ensure staff meet required trainings and training expectations.
   Contractor's employees, volunteers, interns, and student trainees or subcontractors of Contractor, in each case, are expected to perform professional services per an agreement with County. Contractor will comply with the training requirements and expectations referenced in Exhibit A-I, Attachment A, Training Requirements Reference Guide.

   Trainings are to be completed by Contractor's staff after contract execution, in a timely manner. Completion deadlines for trainings are listed in Exhibit A-I, Attachment A within the descriptions. Additionally, the execution of a new contract does not restart the timeline for required trainings for staff. If staff have recently completed a training under another contract, it will be accepted.
m. Comply with the FACT Training Requirements
   i. BH practitioners may begin delivering services on an FACT team as long as 40 initial training hours are completed within two years of starting to deliver FACT.
   ii. Each practitioner must complete 20 training hours per year on an ongoing basis.
   iii. Training topics are determined by the COE FACT Training Curricula
   iv. Training exemptions: Allowed for an equivalent training attained in the past 12 months and with COE review and approval based on documentation of completion provided by the clinician.
   v. Must meet FACT Fidelity by June 30, 2029.

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH CONTRACTOR TRAINING REQUIREMENTS REFERENCE GUIDE

This Training Requirements Reference Guide identifies the required trainings that Contractor is responsible for offering to all employees, volunteers, interns, and student trainees of Contractor or its subcontractors who, in each case, are expected to perform professional services while contracted by County. There are some trainings offered by the County at no cost to Contractor, and those are identified within this document. The remaining trainings are the responsibility of Contractor to provide and cover associated costs. The expectations for Contractor staff attending County-offered trainings are included within this guide, with the understanding additional trainings may be required that are not listed; in such cases, Contractor will be informed. Contractor must consider and include sufficient time and funds for required trainings.

I. Trainings Provided by the Department of Behavioral Health (DBH)

a. DBH New Hire General Compliance Training

Duration: 40 Minutes

Contractor shall have their employees, subcontractors, volunteers, interns, and student trainees who, in each case, are expected to provide services under this Agreement with County, complete the New Hire Compliance Training within thirty (30) business days of hire or effective date of this Agreement, per Compliance Exhibit N. If contract effective date is for a renewed agreement, existing staff will not need to retake the training if the staff member has already completed the training within the same calendar year as the effective date of the renewed agreement. New Hire General Compliance is self-paced and can be completed either through Relias Learning Management System (LMS) or on the DBH website. Additional information on how to complete the training can be found on the following webpage: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Care-Services/Behavioral-Health-Compliance/New-Hire-General-Compliance-Training
Contractor shall require its County-funded employees and subcontractors to complete this compliance training. After completion of this training, participants must sign the Contractor Acknowledgment and Agreement form and return this form to the DBH Compliance officer or designee. For additional questions about the training, please contact your contract analyst or the DBH Compliance team at: DBHCompliance@fresnocountyca.gov.

i. **DBH Annual General Compliance Refresher Training**

Duration: 30 Minutes

General Compliance Refresher Training is an annual requirement for all employees, contractors, volunteers, interns, and student trainees working in behavioral health programs who are in their second or more years of service. This training is a modified version of the self-paced General Compliance Training and Contractor shall be assigned this training in Quarter 4 of each calendar year. An announcement from the DBH Compliance Program, DBH Staff Development, or your contract analyst regarding this training will be made prior to the assignment of this training. Contractor will have the option to complete the training either through the Relias Learning Management System (LMS) or through the DBH website. Contractors are given approximately a sixty (60) day window to complete this training from the training announcement date.

b. **Mental Health Documentation & Billing Training**

Duration: 1 Hour 30 Minutes

All contracted provider organization employees, subcontractors, volunteers, interns, and students providing services are to complete Documentation & Billing Training within thirty (30) business days of hire or contract effective date. If contract effective date is a renewal, existing staff will not need to retake the training if they have already completed it with their agency. Contractor shall be required to complete this training as a prerequisite for providing direct services, processing billing, conducting quality assurance services, clinical supervision, or other similar services under this agreement. Contractor is expected to contact their assigned contract analysts if they are unsure about training requirements for any specific classifications.

Documentation & Billing is a training provided at least one time per month. Registration is completed via Eventbrite for each session; links to register can be found on the webpage below:

https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/Contract-Provider-Resources/New-Hire-ComplianceDoc-Billing-Training

The expectation is that Contractor will register their County-funded employees at least one week in advance of the training date. For any registration issues or other questions about the training, they can contact DBHStaffDevelopment@fresnocountyca.gov.

c. **Invoicing Training**

Contractor shall be responsible for collection and managing data in a manner to be determined by the California Department of Health Care Services (DHCS) and Behavioral Health Plan in accordance with applicable rules and regulations. DBH's Electronic Health Record (EHR) is a critical source of information for purposes of monitoring service volume and obtaining reimbursement. Contractor's staff responsible for checking Medi-Cal eligibility shall attend DBH's training on equipment reporting for assets, intangible and sensitive minor assets, DBH's EHR system and related cost reporting.

d. **Notice of Adverse Benefit Determination (NOABD) Training**

Duration: 8 Minutes

A Notice of Adverse Benefit Determination (NOABD) is a formal mechanism for notifying a person served of an adverse benefit determination in writing (e.g., denial or limited authorization of a requested service, denial of payment for a service, or failure to provide services in a timely manner).

This training outlines usage practices, timelines, and examples for each type of NOABD. Contractor can find the training in the Announcements section on the following webpage: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/Contract-Provider-Resources/Notifications-Associated-Documents. Contractor shall be responsible for DBH-funded providers completing this training within sixty (60) days of hire or contract effective date.

e. **SmartCare Full Electronic Health Record New User Mental Health Training***

Duration: 3.5 - 4 Hours

This is a basic training for new users who are direct clinical service providers employed by Contractors that will be using SmartCare as their full EHR. Participants will have the opportunity to apply CalMHSA's SmartCare training materials and review relevant SmartCare workflows, clinical documents, and forms.

Training dates and reference material can be found on the following link: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare

*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

f. **SmartCare Electronic Health Record New User Front Desk Training***

Duration: 4 Hours

This is a basic training for new users who are employed by Contractors who will be using SmartCare as their full EHR. Participants will have the opportunity to review how to navigate SmartCare, perform coverage information set up, error corrections, set up Appointments, and basic troubleshooting of common issues.
Training dates and reference material can be found on the following link:
https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare
*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

g. **SmartCare Lite Electronic Health Record Mental Health Training* (Provider Entry Only Training)**
Duration: Varies
This training is for select Contractors that do not intend to fully use County DBH's SmartCare EHR system but rather only some functions, otherwise referred to as a "SmartCare Lite User". This training is intended to supplement and reinforce the CalMHSA SmartCare trainings, user guide, and workflow information for SmartCare Lite Users. This supplemental training/technical support is offered by the DBH Planning and Quality Management Division's Quality Improvement Team upon request.
Required prerequisite material can be found on the following link:
https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare
*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

h. **Wellness, Hope and Recovery Training**
Duration: 3 Hours and 30 Minutes
This training is designed for direct mental health providers. It aims to enhance their understanding of wellness and recovery concepts, highlight the importance of hope in the healing process, and offer strategies for instilling hope in others. Additionally, the training will address providers' own personal wellness to support sustainable, compassionate care.

* This training is available to selected bidder at no cost and highly recommended. Contractor is responsible for understanding and incorporating these concepts in clinical practice as indicated once contracted with County DBH.

II. Trainings for Specialty Mental Health Providers by Specialization

a. **Mobile Crisis Services Trainings**

Duration: 21 Hours

Any contracted provider providing mobile crisis services shall complete the state-required training series. For example, the current training series is provided by the Medi-Cal Mobile Crisis Training and Technical Assistance Center (M-TAC). This ten-part training series is available on the DBH Relias learning management system. For assistance with assigning the trainings, please contact DBHRelias@Fresnocountyca.gov.

b. **California Integrated Practice Child & Adolescent Needs & Strengths (CA IP CANS)**

Duration: 8 Hours

The CA IP CANS is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth, ages zero (0) up to age twenty-one (21), and family information to inform planning, support decisions, and monitor outcomes.

Contracted providers are required to complete the CANS assessment for all persons served ages zero (0) up to age twenty-one (21) at the beginning of treatment, updated every six (6) months following the first administration, and at the end of treatment. DBH provides access for a virtual, self-paced training and certification testing for use of the tool. For any questions about the training or assistance with registration, please contact DBHStaffDevelopment@fresnocountyca.gov.

III. Contractor is Responsible for Ensuring and/or Providing These Trainings are Offered and Completed

a. **Cultural Responsiveness Trainings**

Contractor shall have DBH-funded providers complete annual trainings on cultural competency, awareness, and diversity as identified by Contractor, and/or via the

County's eLearning system. Contractor's DBH-funded providers shall be appropriately trained in providing services in a culturally sensitive manner and shall attend civil rights training as identified by Contractor, or online via the County's eLearning system.

Information on annual cultural responsiveness training requirements will be provided by the DBH Division Manager serving as Ethnic Services Manager and Diversity Services Coordinator. Both parties are working locally and at the state level to address the need for thorough training to improve culturally responsive care and to meet the National Culturally and Linguistically Appropriate Services standards, while also understanding the impact that the training hours can have on productivity in fee-for-service programs.

For additional information, Contractors should contact their assigned contract analyst.

DBH is available to assist Contractor's efforts toward cultural and linguistic responsiveness by providing the following:

i. Technical assistance regarding culturally responsive training requirements.
ii. Mandatory cultural responsiveness training for Contractor's DBH-funded staff if training capacity allows.
iii. Technical assistance for translating information into County's threshold languages (currently Spanish and Hmong and subject to change). Contractors are responsible for securing translation services and all associated costs.

b. **Health Insurance Portability and Accountability Act (HIPAA) Training**

As a covered entity, or a business associate of a covered entity, providers shall meet the training requirements described in the HIPAA Privacy Rule 45 CFR § 164.530(b)(1) and the HIPAA Security Rule 45 CFR § 164.308(a)(5). Providers may use their discretion to select an appropriate HIPAA training. Training shall be completed by all DBH-funded staff within thirty (30) days of contract execution or hire and annually thereafter.

c. **Medi-Cal Eligibility Verification Training**

Contractor shall ensure their direct program staff receive training from DBH regarding person-served eligibility for Medi-Cal. The County will require the Contractor to verify the third-party payer of the person served (i.e., Medi-Cal) eligibility prior to starting services and every month thereafter, per the Provider

Manual. Claims may be rejected for services rendered to persons ineligible for Medi-Cal, unless prior payment arrangements have been made.

d. **CalMHSA Clinical Practice Training**

Duration: 8 hours

Any contracted clinical provider is required to complete the CalMHSA Clinical Practice Training Modules in CalMHSA's web-based training system called Moodle. Clinical providers are expected to complete training within sixty (60) days of beginning employment.

CalMHSA's web-based training system, https://moodle.calmhsalearns.org.

e. **Language Assistance Program Training**

Contractor shall be responsible for implementing policies and procedures and training staff to ensure access and appropriate use of trained interpreters and material translation services for all Limited English Proficient (LEP) persons served. This includes, but is not limited to, assessing the cultural and linguistic needs of its persons served. The Contractor's procedures shall include ensuring compliance of any sub-contracted providers with these requirements.

IV. Training Expectations for County-Provided Trainings

a. Attendees are to adhere to wearing business casual attire, broadly defined as a code of dress that blends traditional business wear with a more relaxed style that is still professional and appropriate for an office environment, unless specifically directed otherwise or instructed by Trainers. Attendees are expected to dress in respectful, culturally inclusive attire.

b. Interested attendees shall register at least one week in advance of the training date.

c. Attendees shall be expected to be ready and prepared to be engaged by the training start time. Attendees are also expected to arrive back on time from breaks, including lunch, and attend the training through completion.

d. Attendees who arrive fifteen (15) minutes late, or more, shall be requested to return to their work site and their organization will be notified. Similarly, attendees may not leave a training prior to the scheduled end time. Those who miss fifteen (15) minutes or more of training in total throughout the day may be asked to re-enroll for a later training date if one is available.

e. Personal use of cell phones, laptops and tablets, except for in cases of emergency, should not be used during training and should be set to silent. Any calls shall be

taken outside of the training space. Attendees shall inform trainers and/or Staff Development if they are expecting to be contacted for any reason; this shall be done before the training begins, if possible. Other cell phone use, such as texting, playing games or browsing the internet shall not be permitted while training is in session. If conduct is deemed disruptive to colleagues and/or trainer(s), attendees shall be asked to leave the training and return to their work site. Organizations will be notified.

f. At times, attendees shall be required to complete pre- and post-training class assignments, as part of the learning objectives. Attendees shall be required to complete assigned activities to receive Continuing Education Credits, certification, and training credit, if applicable.

g. Attendees shall be expected to complete pre- and/or post-training evaluations, when available.

h. Attendees shall notify Staff Development with their supervisor copied at (559) 600-9680 or DBHStaffDevelopment@fresnocountyca.gov at the earliest possible date if they can no longer attend a training for which they have registered.

V. Use of DBH Training Facilities

a. **Parking**

Attendees shall park in undesignated stalls at DBH training sites. Any parking restrictions shall be communicated prior to the training date or prior to the training start time.

b. **Use of Facilities**

Attendees shall be respectful while occupying the training space, keeping it and the surrounding area neat and clean. Attendees are encouraged to bring a reusable water bottle but shall be cognizant of and clean any spills. If the training allows for food, attendees shall ensure that their area is clean and dispose of any waste prior to leaving the training space.

PROGRAM OUTCOMES AND PERFORMANCE MEASUREMENTS

I. Behavioral Health Transformation Goals

Following the passage of Proposition 1 and the implementation of the Behavioral Health Services Act (BHSA), the Department of Health Care Services (DHCS) established fourteen (14) Behavioral Health Goals as a key requirement of Behavioral Health Transformation (BHT). Counties were provided with six (6) priority measures, as well as the requirement to choose one of eight (8) additional measures. These measures are the following:

Priority Measures

- Reducing Homelessness
- Reducing Institutionalization
- Reduce Justice-Involvement
- Reduce Child Removals
- Reduce Untreated Behavioral Health Conditions
- Increasing Access to Care

Additional Measures

- Reduce Suicides
- Reduce Overdoses
- Increase Care Experience
- Increase Quality of Life
- Increase Social Connection
- Increase Engagement in Work **(DBH SELECTED)**
- Increase Engagement in School
- Prevention and Treatment of Co-Occurring Physical Health Conditions

In accordance with those requirements, the Contractor shall align services with one, or more, of the BHT Behavioral Health Goal(s) as determined by DBH. The Contractor shall be evaluated according to the performance measures associated with the individual BHT goals determined by DBH to be relevant to the level of care being provided.

All BHT goals and performance measures are contingent upon DHCS policy and guidelines and may be subject to change.

DHCS shall establish specific measures and data sets to be used for assessing the progress and or attainment each BHT goal.

II. Behavioral Health Accountability Set

In alignment with the DHCS Behavioral Health Quality & Equity Policy, DBH shall review performance in applicable measures from the Behavioral Health Accountability Set, when available. Contractor shall be required to align services with these measures to ensure a high level of performance. These measures include:

- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Hospitalization for Mental Illness
- Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications[1]

BHSA alignment is contingent upon DHCS policy and guidelines and may be subject to change; Contractor will be expected to continue to align services with any future added measures during the life of the service contract.

III. Network Adequacy

Contractor will be expected to comply with all applicable Network Adequacy requirements established by DHCS. Among these requirements is the Timely Access Data Tool (TADT). DBH shall review Contractor performance in accordance with the DHCS requirements. These timeliness requirements include:

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric SMHS	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All Urgent SMHS Appointments	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[30]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[31]	

IV. Other Mandated Performance Measures

DBH will monitor the Contractor for other performance measures that are mandated by DHCS or evaluate essential processes. Measures may include, but are not limited to:

- Timeliness to first offered/kept service
- Enhanced Care Management and Community Support referrals
- Service volume
- Discharge reason
- Length of stay
- Consumer Perception Survey completion
- Hospital and Emergency Department follow-up timeliness
- Successful transition to lower/higher level of care
- Other mandated and essential measures

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
FINANCIAL TERMS AND CONDITIONS

This Exhibit sets forth the financial terms and conditions, including compensation, invoicing, billing, audits, and other fiscal requirements, and is incorporated into the Specialty Mental Health Services (SMHS) Agreement between County and Contractor. County shall ensure timely and accurate compensation for services delivered and fulfill all responsibilities associated with funding sources under this Agreement.

I. Compensation

County shall compensate Contractor for services rendered under this Agreement, subject to the limitations and conditions herein. Compensation under this Agreement shall be paid only for services performed in accordance with its terms, while the Agreement is in effect, and subject to the amounts stated in this section. County employees have no authority to authorize payment beyond what is expressly provided in this Agreement.

a. Total Maximum Compensation

In no event shall total compensation payable to Contractor for all services provided under this Agreement exceed Twenty-Nine Million One Hundred Ninety-Five Thousand Two Hundred Forty-Three and No/100 Dollars ($29,195,243.00), during the entire term of this Agreement.

The maximum compensation may be increased only through a written amendment, contingent on the availability of sufficient funds.

1.1 Illustrative Tables

Specialty Mental Health Services Maximum Compensation					
Fiscal Year (FY)	**ACT/FSP SMHS Maximum Compensation**	**FACT FY SMHS Maximum Compensation**	**FSP-ICM FY SMHS Maximum Compensation**	**OP FY SMHS Maximum Compensation**	**Total FY SMHS Maximum Compensation**
FY 2023-24	$2,398,310.00	$0.00	$0.00	$1,728,838.00	$4,127,148.00
FY 2024-25	$2,398,310.00	$0.00	$0.00	$1,728,838.00	$4,127,148.00
FY 2025-26	$2,398,310.00	$0.00	$0.00	$1,728,838.00	$4,127,148.00
FY 2026-27	$0.00	$1,625,000.00	$1,890,000.00	$1,728,838.00	$5,243,838.00

Fiscal Year (FY)	Transition Optimization Funds	Whole Person Care	ACT/FSP AB 109	FACT/FSP-ICM AB 109	OP AB 109	ACT/FSP MHSA	FACT Fidelity (BHSA)	FACT WIT (BHSA)	FSP ICM WIT (BHSA)	ACT.FSP DSH	FACT/FSP -ICM DSH	Total FY Non-Treatment Supports
FY 2023-24	$250,000	$357,751	$797,621	$0	$658,250	$754,483	$0		$0	$195,379	$0	$3,013,484
FY 2024-25	$0	$357,751	$993,000	$0	$658,250	$754,483	$0		$0	$195,379	$0	$2,958,863
FY 2025-26	$0	$0	$993,000	$0	$658,250	$754,483	$0		$0	$130,252	$0	$2,535,985
FY 2026-27	$0	$0	$0	$993,000	$658,250	$0	$900,000	$225,000	$90,000	$0	$195,379	$3,061,629

Total Contract Maximum Compensation			
Fiscal Year (FY)	SMHS Total Maximum Compensation	Non-Treatment Supports Total Maximum Compensation	Total FY Contract Maximum
FY 2023-24	$4,127,148.00	$3,013,484.00	$7,140,632.00
FY 2024-25	$4,127,148.00	$2,958,863.00	$7,086,011.00
FY 2025-26	$4,127,148.00	$2,535,985.00	$6,663,133.00
FY 2026-27	$5,243,838.00	$3,061,629.00	$8,305,467.00

Maximum Compensation for SMHS

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for SMHS shall be as follows:

July 1, 2023 – June 30, 2024: Four Million, One Hundred Twenty-Seven Thousand, One Hundred Forty-Eight and No/100 Dollars ($4,127,148.00)

July 1, 2024 – June 30, 2025: Four Million, One Hundred Twenty-Seven Thousand, One Hundred Forty-Eight and No/100 Dollars ($4,127,148.00)

July 1, 2025 – June 30, 2026: Four Million, One Hundred Twenty-Seven Thousand, One Hundred Forty-Eight and No/100 Dollars ($4,127,148.00)

July 1, 2026 – June 30, 2027: Five Million Two Hundred Forty-Three Thousand Eight Hundred Thirty-Eight and No/100 Dollars ($5,243,838.00)

This amount is not guaranteed and shall be paid only for approved services rendered and claims submitted and approved through the Electronic Health Record (EHR).

b. Maximum Compensation for Non-Treatment Supports

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for non-treatment supports shall be as follows:

July 1, 2023 – June 30, 2024: Three Million, Thirteen Thousand, Four Hundred Eighty-Four and No/100 Dollars ($3,013,484.00)

July 1, 2024 – June 30, 2025: Two Million, Nine Hundred Fifty-Eight Thousand, Eight Hundred Sixty-Three and No/100 Dollars ($2,958,863.00)

July 1, 2025 – June 30, 2026: Two Million, Five Hundred Thirty-Five Thousand, Nine Hundred Eighty-Five and No/100 Dollars ($2,535,985.00)

July 1, 2026 – June 30, 2027: Three Million Sixty-One Thousand Six Hundred Twenty-Nine and No/100 Dollars ($3,061,629.00)

These amounts will be reimbursed based on actual costs in accordance with the approved budget in Revised Exhibit J – Attachment B, up to the FY maximum listed above.

II. <u>Performance Incentives for SMHS Fee-For-Service</u>

Contractor may be eligible to receive performance-based incentives intended to encourage program growth, enhance service delivery, and improve overall wellness outcomes in unserved and underserved communities. The determination of eligibility and the calculation of such incentives shall be at the discretion of County's DBH Director or designee and governed by the following conditions:

a. Eligibility

i. Incentives shall be available only after the completion of two full fiscal years under this Agreement for Contractors providing SMHS reimbursed under County's Fee-for-Service structure.

ii. A baseline cannot be established using partial fiscal year data; therefore, eligibility requires two consecutive complete fiscal years of performance data.

iii. Contractors entering this Agreement after the initial contract fiscal year shall become eligible upon completion of two consecutive fiscal years under this Agreement.

b. Performance Baseline

i. The initial performance baseline shall be established based on the Contractor's State-approved claimed dollar amount for services performed, claimed, and approved by the State in fiscal year one (1), as recorded by County.

ii. This baseline shall be adjusted for any subsequent State rate changes to finalize the performance baseline for fiscal year two (2).

c. Incentive Calculation

i. Upon completion of fiscal year two (2), if Contractor exceeds the established performance baseline, Contractor shall be eligible for an incentive payment equal to eight percent (8%) of the Medi-Cal reimbursements generated above the baseline amount.

d. Annual Adjustments

i. Each subsequent fiscal year's performance baseline shall be adjusted annually to the higher of:

1. The prior fiscal year's actual State-approved claimed amount plus any State rate increases; or
2. The previously established performance baseline amount plus any State rate increases.

ii. Under no circumstances shall the performance baseline decrease from one fiscal year to the next.

e. Illustrative Table

The table below provides an example of annual baseline adjustments. This table is for reference only and is not binding. Actual details will be finalized between both parties at the conclusion of fiscal year one (1).

Fiscal Year	Prior Baseline (Before Adjustment)	State Rate Adjustment	New Performance Baseline (After Adjustment)	Actual Claimed Amount	Amount Above Baseline	Performance Incentive (8%)
Year 1	N/A	N/A	N/A	$500,000	$0	$0
Year 2	$500,000	+3%	$515,000	$550,000	$35,000	$2,800
Year 3	$550,000	+2%	$561,000	$520,000	$0	$0
Year 4	$561,000	+2%	$572,220	$600,000	$27,780	$2,222
Year 5	$600,000	+2%	$612,000	$650,000	$38,000	$3,040

Contractor must be in satisfactory standing with all performance outcomes and reporting requirements under this Agreement prior to receiving any performance-based incentive payment. All required reports must be submitted in full and on time. Failure to meet these requirements may result in County's DBH Director or designee, at their sole discretion, deeming Contractor ineligible for performance incentives or withhold payments until compliance is achieved.

County will calculate and provide written notification of any incentive award within ninety (90) calendar days after all State-approved claimed services for the targeted fiscal year have been received and recorded by County, or within nine (9) months following the end of the targeted fiscal year, whichever is later. Payment of any approved incentive will be made within forty-five (45) days after final approval.

Payment of performance incentives is contingent upon compliance with all applicable regulations and the availability of funds.

III. Rate Categories for Fee-For-Service

The Forensic Continuum of Care services provided by the Contractor under this Agreement shall be reimbursed in accordance with the rate schedule set forth in Revised Exhibit J – Attachment A, which is incorporated herein by reference and made part of this Agreement.

Services shall be categorized as Clinic-Site Based, and the Contractor shall be compensated according to the applicable rate schedule specified at the end of this exhibit.

a. Clinic-Site Based:

Clinic-Site programs are defined as programs that provide less than fifty percent (50%) of services in the field. For purposes of this calculation, only billable services will be considered. “In the field” refers to services that do not occur through telehealth and do not occur at designated sites where Contractor is afforded regular access. Designated sites shall be identified by Contractor and approved in writing by County’s DBH Director or designee. County retains the sole discretion to classify a program as Clinic-Site Based.

For the purposes of this Agreement, Clinic-Site Based locations are defined as the following SmartCare (EHR) Locations (CMS Places of Service):

i. Office
ii. Telehealth Provided Other than in Persons Served Home
iii. Telehealth Provided in Patient’s Home
iv. Any location where the mode of delivery is Video Conference, Telephone, or Written communication

These locations will be used to calculate the ratio of Clinic-Site Based to Field Based services.

b. Field Based:

Field Based programs are defined as programs that provide more than fifty percent (50%) of services in the field. “In the field” refers to services that do not occur through telehealth and do not occur at designated sites where the Contractor is afforded regular access. The County retains sole discretion to classify a program as Field-Based.

During the term of this Agreement, Contractor may submit a written proposal to County requesting compensation under the Field-Based reimbursement rate category. Such proposals must be submitted at least ninety (90) calendar days prior to the start of each new fiscal year. County shall provide a written decision prior to the start of the next fiscal year. If approved, County’s DBH Director or designee will issue a rate change notification in accordance with the modification provisions of this Agreement, and Contractor’s performance will be monitored for compliance with Field-Based service delivery requirements as outlined above.

If Contractor is deemed eligible to receive compensation at the Field-Based reimbursement rates and subsequently fails to meet the Field-Based service delivery

requirements, Contractor shall be subject to recoupment of payments at the sole discretion of County's DBH Director or designee, upon written notice.

County shall complete Field-Based service delivery analysis and any recoupment reconciliation within ninety (90) calendar days following the end of the targeted quarter, or within ninety (90) calendar days after all billable services for that quarter have been entered into in the EHR by the Contractor, whichever is later. The recoupment amount shall equal the difference between payments made to Contractor during the targeted quarter and the amount recalculated at the respective fiscal year's Clinic-Site Based rate schedule, after applying any claiming adjustments. County shall provide written notice to Contractor of the analysis results and, if applicable, process the recoupment in accordance with the terms and conditions of this Agreement.

County shall monitor Contractor on an ongoing basis and analyze data to ensure the accuracy of assigned rate categories. County retains authority to reassign rate categories as necessary and will provide written notice of any such changes in accordance with the modification provisions outlined in Article 15 of this Agreement. Contractor may appeal the category reassignment in writing within thirty (30) calendar days of receiving written notice. If no appeal is submitted within this timeframe, the reassignment will stand.

IV. Invoices

County shall process and pay Contractor's invoices for services rendered under this Agreement, subject to the limitations and conditions herein. Payment under this Agreement shall be made only for invoices submitted in accordance with its terms, while the Agreement is in effect, and subject to the deadlines and requirements stated in this section. County employees have no authority to authorize payment beyond what is expressly provided in this Agreement.

a. Definition of Acceptable Invoice

Definition

An Acceptable Invoice is a complete, itemized invoice submitted in accordance with the submission requirements set forth in Section IV(b) of this Exhibit. Each invoice shall include, at a minimum:

i. Contractor's legal name and remit-to address;
ii. Invoice number and date;
iii. Contract or Purchase Order (PO) number;
iv. Service period, including start and end dates;

v. Itemized description of services, including units, rates, and applicable codes;

vi. Total amount due, reflecting any credits or adjustments; and

vii. County department or cost center, if applicable.

b. Invoice Submission Deadlines

Contractor shall comply with the following requirements for invoice submission and processing:

i. Monthly Submission

1. Contractor shall use best efforts to submit monthly invoices, in arrears, by the fifteenth (15th) calendar day of each month.
2. Invoices shall be submitted in the format prescribed by County. This timeline is intended to facilitate prompt processing and does not supersede the final submission deadline specified below.

ii. Submission Method

All invoices shall be submitted electronically to the following recipients:

1. dbhinvoicereview@fresnocountyca.gov
2. dbh-invoices@fresnocountyca.gov
3. County's assigned DBH Staff Analyst

iii. Illustrative Table

The table below provides an example of FY 2026-2027 invoice deadlines.

Service Month	Target Submission	Initial Invoice Deadline	Supplemental*/ OHC Deadline
Jul 2026	Aug 15, 2026	Sep 29, 2026	Nov 28, 2026
Aug 2026	Sep 15, 2026	Oct 30, 2026	Dec 29, 2026
Sep 2026	Oct 15, 2026	Nov 29, 2026	Jan 28, 2027
Oct 2026	Nov 15, 2026	Dec 30, 2026	Feb 28, 2027
Nov 2026	Dec 15, 2026	Jan 29, 2027	Mar 30, 2027
Dec 2026	Jan 15, 2027	Mar 01, 2027	Apr 30, 2027
Jan 2027	Feb 15, 2027	Apr 01, 2027	May 31, 2027
Feb 2027	Mar 15, 2027	Apr 29, 2027	Jun 28, 2027
Mar 2027	Apr 15, 2027	May 30, 2027	Jul 29, 2027
Apr 2027	May 15, 2027	Jun 29, 2027	Aug 28, 2027
May 2027	Jun 15, 2027	Jul 30, 2027	Supplemental – Aug 29, 2027 OHC – Sep 28, 2027
June 2027	Jul 15, 2027	Aug 29, 2027	Supplemental – Aug 29, 2027 OHC – Oct 28, 2027

*Supplemental allowed if initial invoice submission is timely

c. Invoice Review and Withholding

At the discretion of County, if an invoice is found to be incorrect or is otherwise not in proper form or substance, County may withhold payment for only the portion of the invoice deemed incorrect or improper. Prior to withholding payment, County shall provide Contractor with at least five (5) calendar days' written notice. Contractor shall continue providing services for up to ninety (90) calendar days after receiving notice of the invoice issue while resolution efforts are ongoing. If the invoice remains unresolved to County's satisfaction after the ninety (90) day period, County may elect to terminate this Agreement, in accordance with the termination provisions outlined in Article 6.

If County fails to provide notice of an incorrect or improper invoice and this results in delay in reimbursement, Contractor may initiate the escalation process through County's DBH Finance Division's Invoice Review Team. This process may include escalation to the DBH Finance Division Manager and ultimately County's DBH Director or designee to ensure timely reimbursement.

If County withholds any portion of an invoice due to incorrect or improper form or substance, Contractor shall resolve the issue and communicate any delays in resolution to County's DBH Finance Division Manager within ninety (90) calendar days of receiving notice of the withholding. Failure to resolve or communicate within this timeframe may result in the withholding being deemed final and non-payable at the sole discretion of County.

Contractor shall submit all initial invoices for services rendered within a given calendar month no later than sixty (60) calendar days following the end of the month in which services are provided. Invoices submitted after this 60-day period may be rejected and not processed for payment.

If the initial invoice is submitted within the required timeframe, supplemental or revised invoices may be submitted within one hundred twenty (120) calendar days following the end of the month in which services were provided. Supplemental invoices will not be accepted if the initial invoice is not submitted timely.

All billing related to Other Health Coverage (OHC) must be submitted within one hundred twenty (120) calendar days following the month in which services were provided.

The County shall not process or pay any invoices submitted more than sixty (60) calendar days after the end of the fiscal year in which the services were performed, except for

claims related to Other Health Coverage (OHC), which must be submitted within one hundred twenty (120) calendar days following the month in which services were provided.

d. Fee-For-Service Invoice Calculation

Invoices for specialty mental health services shall be calculated based on the units of time associated with each CPT or HCPCS code entered into the County billing system, multiplied by the practitioner service rates specified in Revised Exhibit J – Attachment A.

Services pending determination from Medicare, OHC, or any other third-party payers shall not be reimbursed until Explanation of Benefits (EOB) is processed and any remaining balance is transferred to Medi-Cal or other applicable coverage, in accordance with this Agreement's funding requirements.

Notwithstanding the foregoing, County may, at its sole discretion, authorize payment for services provided to individuals with OHC when such services are not fully covered by the primary payer. This discretionary payment shall only apply to the remaining balance after all applicable third-party reimbursements have been applied and upon receipt of the EOB, unless DBH expressly approves earlier payment in writing. Such approval shall be documented and remain subject to all funding requirements under this Agreement.

County payments are provisional and subject to adjustment upon completion of all cost settlement and reconciliation activities. Adjustments, including recoupments, shall be made in accordance with this Agreement. County shall provide written notice of any adjustments. Final settlement will be based on audit findings and compliance with all applicable regulations.

Revenue reporting requirements are outlined in Section VII(f) (Financial Compliance and Enforcement).

e. Cost Reimbursement Invoice Calculation

Invoices for cost reimbursement services shall be calculated based on actual expenses incurred during the applicable service month. Contractor shall submit monthly invoices in arrears, accompanied by detailed general ledgers itemizing program costs for that month. These documents shall serve as verification to ensure costs align with the approved budget in Revised Exhibit J – Attachment B.

Contractor shall maintain supporting documentation for all claimed costs and make such records available for audit by County, State, or Federal authorities upon request. Failure to submit required reports and documentation may result in County withholding payment until compliance is achieved, upon written notice.

Monthly invoices shall reflect the total amount due for allowable costs, reduced by any revenue collected from third-party payers, client-pay, or private-pay sources, and shall exclude unallowable cost such as lobbying or political contributions.

f. Fidelity Invoice Calculation

Invoices for Fidelity funds shall be calculated based on census in total days filled per month divided by total days within the month, rounded to nearest whole number. Payments shall be based in accordance with the approved budget in Revised Exhibit J – Attachment B, up to the FY year maximum.

For the purpose of Fidelity payment calculation, a day shall be defined as any portion of a twenty-four (24) hour clock day. A day filled may be counted if the person is admitted and discharged during the same day provided that such admission and discharge is not within twenty-four (24) hours of a prior discharge.

Contractor shall maintain supporting documentation for census and make such records available for audit by County, State, or Federal authorities upon request. Failure to submit required reports and documentation may result in County withholding payment until compliance is achieved, upon written notice.

Example 1:

Person Served (PS) 1 – Admitted 5/1 (Enrolled 31 days)

PS 2 – Admitted 5/10 (Enrolled 21 days)

PS 3 – Admitted 5/15 (Enrolled 16 days)

Total Days Filled: 68 Days

Days in Month	Total Days Filled	Average Monthly Census (Rounded)	Invoice Amount ($1,000 x Average Monthly Census)
31	68	68/31 = 2	$2,000

Example 2:

PS 1 – Admitted 6/1 (Enrolled 30 days)

PS 2 – Admitted 6/5 (Enrolled 25 days)

PS 3 – Admitted 6/15 (Enrolled 15 days)

PS 4 – Admitted 6/16 (Enrolled 14 days)

Total Days Filled: 84 Days

Days in Month	Total Days Filled	Average Monthly Census (Rounded)	Invoice Amount ($1,000 x Average Monthly Census)
30	84	84/30 = 3	$3,000

g. Corrective Action Plans

Contractor shall enter all services into the County EHR and submit invoices in accordance with the deadlines and requirements specified in this Agreement, ensuring accuracy and completeness of all information.

Failure to comply with these requirements may result in the implementation of a corrective action plan at the discretion of the County. Corrective action plans may include, but are not limited to, financial penalties or termination of this Agreement in accordance with the termination provisions outlined in Article 6.

h. Payment

County shall make payment to Contractor in arrears for services provided during the preceding month, within forty-five (45) calendar days after receipt, verification, and approval of the invoice by County.

Payments shall be made upon certification or other proof satisfactory to County that services have been performed or actual expenditures incurred in accordance with this Agreement. Any compensation not expended by Contractor pursuant to this Agreement shall automatically revert to County.

i. Incidental Expenses

Contractor shall be solely responsible for all costs and expenses not identified as reimbursable by County under this Agreement. Such costs include, but not limited to, administrative overhead, travel, and other incidental expenses.

i. Applicable Fees

Contractor shall not charge any person served or third-party payers for services provided under this Agreement unless expressly directed to do so by County at the time of referral. When directed to charge for services, Contractor shall use the uniform billing and collection guidelines prescribed by DHCS.

Contractor shall perform eligibility and financial determinations in accordance with DHCS' Uniform Method of Determining Ability to Pay (UMDAP), as outlined in BHIN 98-13 (available at dhcs.ca.gov), unless directed otherwise by County.

Contractor shall not submit claims to, or demand or collect reimbursement from, persons served or their representatives for specialty mental health or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments, as permitted under California Code of Regulations, Title 9, §1810.365(c).

Under no circumstances shall Contractor bill persons served for covered services any amount greater than would be owed if the County provided the services directly. Contractor shall comply with all applicable requirements, including 42 C.F.R. § 438.106.

j. Claiming Responsibilities for SMHS

Contractor shall enter all claims data into the County's EHR using the California Mental Health Services Authority (CalMHSA) Smart Care Procedure Codes (available at https://2023.calmhsa.org/procedure-code-definitions/) by the fifteenth (15th) calendar day of each month for services rendered in the previous month. County's EHR system will convert these codes to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, in accordance with the DHCS Billing Manual (available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx), as amended from time to time.

All claims shall be accurate, complete, and error-free, and must include all required information. Contractor is responsible for monitoring and correcting any errors within thirty (30) calendar days from the date of service to ensure timely payment. County will monitor service volume, billing amounts, and service types entered into the EHR. Any audit exceptions resulting from Contractor' reporting shall be the sole responsibility of Contractor.

Contractor shall provide all necessary data to enable County to bill Medi-Cal and meet State and Federal reporting requirements. Data may be provided through direct EHR entry, electronic file submission compatible with County systems, or system integration. Contractor shall maximize Federal Financial Participation (FFP) by claiming all eligible Medi-Cal services and correcting denied claims for resubmission.

Contractor is responsible for billing all SMHS for persons served with OHC and/or Medicare. For individuals with OHC and/or Medicare, Contractor shall bill the carrier and obtain payment or denial, or validate non-response after ninety (90) calendar days from claim submission. Contractor must report all third-party collections monthly and submit copies of EOBs or CMS 1500 forms to: DBHAccountsReceivable@fresnocountyca.gov. EOBs shall be submitted in batches by service month, with email subject lines including Contractor Name, Program Name, and Payment or Denial status.

V. Recoupments and Audits Requirements

a. Recoupment Process

County shall recapture from Contractor the value of any services or expenditures determined to be ineligible based on County or State monitoring results. County may enter into a repayment agreement with Contractor for up to twelve (12) months, with the option to extend

to a total of twenty-four (24) months at County discretion. Repayment agreements require written signed approval by County's DBH Director, or designee, and Contractor. County may offset repayment amounts against future invoices or recoup all funds immediately. These remedies are not exclusive, and County may pursue other means of recovery.

Contractor shall be financially liable for all disallowances or audit exceptions identified through State audits, County utilization reviews, or other oversight processes. Disallowed amounts must be remitted within forty-five (45) calendar days or will be withheld from subsequent payments. Contractor shall not receive reimbursement for any services disallowed or denied by County or State review processes.

County will conduct periodic audits to verify clinical documentation, validate costs invoiced under cost reimbursement agreements, and ensure compliance with applicable regulations. Audits may require Contractor to reimburse County for previously paid services under circumstances including, but not limited to:

i. Fraud, Waste, or Abuse as defined in federal regulations.
ii. Overpayment due to errors in claiming or documentation
iii. Other reasons specified by DHCS in the SMHS Reasons for Recoupment guidance.

Contractor shall reimburse County for all overpayments identified by any oversight entity within required timeframes. Funds owed must be paid within forty-five (45) calendar days of notification or will be offset against future payments.

b. Audit Requirements

The following requirements apply to all audits and reviews conducted under this Agreement.

Contractor is responsible for ensuring the accuracy of all claims submitted, including proper documentation, coding, and compliance with SMHS standards. Contractor shall maintain confidentiality of all records in accordance with HIPAA and applicable State and Federal laws.

Contractor shall cooperate fully with County, DHCS, or other regulatory bodies in any audit or review, including providing access to records, documents, and facilities. Contractor shall allow inspection and audit for ten (10) years following the Agreement's end date or until any audit or investigation is resolved, whichever is later, pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(i)(3)(i-iii).

c. Single Audit Clause

If Contractor expends One Million Dollars ($1,000,000.00) or more in Federal or Federal flow-through funds in any fiscal year, Contractor shall conduct an annual audit in accordance

with the Single Audit Standards as set forth in Office of Management and Budget (OMB) 2 CFR 200. The audit report and management letter shall be submitted to County within nine (9) months of the fiscal year end. The audit must include either a statement of findings or a statement that no findings were identified. If findings exist, Contractor shall provide a corrective action plan signed by an authorized representative and take prompt action to address any material non-compliance or weakness.

Failure to perform the required audit may result in County conducting the audit or contracting with a public accountant to perform the audit at Contractor's expense. Audit costs related to this Agreement are the sole responsibility of Contractor.

If Contractor's Federal expenditures do not meet the Single Audit Clause threshold, Contractor shall perform a program audit and submit to County within nine (9) months of the fiscal year end. The program audit must attest to Contractor's financial solvency and compliance with Agreement requirements.

Contractor shall make all records and accounts available for inspection by County, the State, the Controller General of the United States, the Federal Grantor Agency, or their authorized representatives at all reasonable times for a period of at least three (3) years following the final payment under this Agreement or until all pending matters are resolved, whichever is later.

d. Audit Requirements for Pass-Through Entities

If County determines that Contractor is a "subrecipient" or pass-through entity as defined in 2 C.F.R. § 200, Contractor shall comply with all applicable cost principles, administrative requirements, and audit standards, including those governing claims for payment or reimbursement.

Financial audit reports must include a separate schedule identifying all funds received from or passed through the County. This schedule shall specify the Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the County's DBH Director or designee. The County's Director or designee is responsible for providing the audit report to the County Auditor.

Contractor shall submit the financial audit report, including all attachments, the management letter, and any corresponding response to County within six (6) months of the end of the audit year. The County will forward the report to the County Auditor.

Any required corrective action plan must be submitted to County at the same time as the audit report or as soon thereafter as available. County shall monitor implementation of the corrective action plan as it relates to services provided under this Agreement.

VI. County-Owned Property Requirements

This section shall only apply to the program components and services provided under Cost Reimbursement. County and Contractor recognize that fixed assets are tangible and intangible property obtained or controlled under County for use in operational capacity and will benefit County for a period more than one (1) year.

a. Agreement Assets

Assets shall be tracked on an agreement-by-agreement basis. Unless otherwise permitted by the funding source, all assets shall fall under the "Equipment" category. Items of a sensitive nature, including those containing HIPAA Protected Health Information (PHI), must be purchased and allocated to a single Agreement. Examples of assets include, but are not limited to:

i. Computers (desktops and laptops);
ii. Copiers, cell phones, tablets, and other devices with any HIPAA data;
iii. Modular furniture;
iv. Land;
v. Any items over $5,000;
vi. Items of $500 or more with a lifespan of at least two (2) years (e.g., televisions, washers/dryers, printers, digital cameras, other equipment/furniture).

Contractor shall maintain an asset tracking system that includes, at a minimum:

i. Asset description and unique identifier (e.g., serial number);
ii. Acquisition date and cost;
iii. Quantity and location or assigned user;
iv. Source of grant funding (if applicable);
v. The disposition date and method (surplus, transfer, destruction, loss).

b. Retention and Maintenance

All assets shall remain County property upon expiration of this Agreement. Contractor shall participate in annual inventory and ensure return of all County-owned, undepreciated assets or reimburse County for their monetary value if unable to return them. Contractor shall:

i. Maintain equipment in good working order, normal wear and tear excepted;

ii. Label equipment with County-assigned program number and maintain inventory list as required;

Report loss or theft immediately in writing and provide a police report for stolen items.

c. Equipment Purchase

Any equipment purchased with funds under this Agreement requires prior written approval from County. Purchases must directly relate to services under this Agreement. County may deny reimbursement for unauthorized purchases.

d. Modification of Assets

Contractor must obtain prior written approval from County for any modification or change in use of property acquired or improved with Agreement funds. If such property is sold or used for non-qualifying purposes, Contractor shall reimburse County for its current fair market value, less any portion funded by non-County sources. These requirements remain in effect for the life of the property unless relieved by State action.

VII. Additional Compliance and Reporting Requirements

Contractor acknowledges and agrees that its obligations under this Agreement are subject to all applicable local, State, and Federal laws and regulations, including but not limited to those governing Medi-Cal, HIPAA, and the False Claims Act.

a. Notification of Changes

Contractor shall provide written notice to County of any material change affecting the performance of this Agreement, including but not limited to:

i. Organizational Changes
Changes in organizational name, Head of Service, or principal business address.

ii. Service Location Changes
Change in any service-delivery location. Notice shall be provided at least six (6) months in advance to allow County sufficient time to comply with site certification requirements. Such notice will become part of this Agreement upon written acknowledgment by the County, provided the change of address does not conflict with any other provisions of this Agreement.

iii. Ownership, Licensure, or Capacity Changes

Any change in ownership, organizational status, licensure, or Contractor's ability to provide the quantity or quality of the contracted services. Notice shall be provided immediately and no later than fifteen (15) calendar days following the change.

Failure to provide timely notice as required herein may result in corrective action, including withholding of payment or termination of this Agreement, in accordance with the provisions outlined in Article 6.

b. Record Maintenance and Retention

Contractor shall maintain complete, accurate, and current records to demonstrate accountability for all services and fiscal activities under this Agreement. Records include, but are not limited to:

i. Service Delivery Documentation
   Monthly summary sheets, sign-in sheets, and other primary source documents supporting services provided.
ii. Fiscal Records
   All financial records shall be maintained in accordance with Generally Accepted Accounting Principles (GAAP) and must account for all funds, tangible assets, revenues, and expenditures. Fiscal records shall also comply with the requirements set forth in 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
iii. Retention Requirements
   Contractor shall retain all service and financial records for a minimum of ten (10) years from the date of final payment, the final date of this Agreement, final settlement, or until all audit findings are resolved, whichever is later.
iv. Access and Compliance
   Contractor shall provide County access to all records upon request and comply with all applicable local, State, and Federal laws regarding the maintenance and relinquishment of medical records.

Failure to maintain records in accordance with these requirements may result in withholding of payments or termination of this Agreement, as outlined in Article 6.

c. Financial Reports

Contractor shall submit audited financial reports to County on an annual basis. The audit shall:

i. Standards
   Be conducted in accordance with GAAP and generally accepted auditing standards.
ii. Submission Timeline

The audit report, including all attachments, the management letter, and any corresponding response, must be submitted to County within six (6) months of the end of the audit year.

iii. Corrective Action

If findings are identified, Contractor shall provide a corrective action plan signed by an authorized representative at the time of submission or as soon thereafter as available. County shall monitor implementation of the corrective action plan as it relates to services provided under this Agreement.

Failure to submit required financial reports within the specified timeframe may result in corrective action, including withholding of payment or termination of this Agreement, in accordance with Article 6.

d. Agreement Termination

In the event this Agreement is terminated, reaches its designated term, or Contractor ceases operations, Contractor shall:

i. Delivery of Records

Provide or make available to County all financial and service records accumulated under this Agreement, whether completed, partially completed, or in progress, within seven (7) calendar days of the termination or end date.

ii. Final Compensation

Contractor shall be entitled to payment for all SMHS satisfactorily provided through and including the effective date of termination, subject to the terms and conditions of this Agreement.

This provision shall not limit or reduce any damages owed to County resulting from Contractor's breach of this Agreement.

Failure to comply with these requirements may result in withholding payment or other remedies available to the County under Article 6.

e. Restrictions and Limitations

This Agreement is subject to all restrictions, limitations, and conditions imposed by County, State, or Federal funding sources that may affect the fiscal provisions or funding for this Agreement. Key provisions include:

i. Funding Contingency

This Agreement is contingent upon sufficient funds being made available by County, State, or Federal sources for the term of this Agreement. If the State or Federal governments reduce financial participation in the Medi-Cal program,

County shall meet with Contractor to discuss renegotiating the services required.

ii. Fiscal Year Funding

Funding is allocated by fiscal year. Any unspent appropriation for a fiscal year does not roll over and is not available for services provided in subsequent years.

iii. Delayed Payments

In the event funding for these services is delayed by the State Controller, County may defer payments to Contractor. The deferred amount shall not exceed the amount of funding delayed by the State Controller to County. The deferral period shall not exceed the duration of the State Controller's delay plus forty-five (45) calendar days.

f. Financial Compliance and Enforcement

County maintains the right to monitor Contractor's performance under this Agreement to ensure accuracy of claims for reimbursement and compliance with all applicable laws and regulations.

Contractor shall claim and collect all other available revenues, including but not limited to Medicare, private insurance, grants, client rent/fees, and any other third-party funding sources. Contractor shall maintain accurate records of all such revenues collected and report them to County in the format and frequency specified by County. Reports shall be submitted concurrently with monthly invoices or as otherwise directed and must include sufficient detail to support reconciliation and verification of revenue sources.

No federal funds provided under this Agreement shall be used to pay the salary of an individual at a rate exceeding Level 1 of the Executive Schedule, as published by U.S. Office of Personnel Management and amended from time to time amended.

Federal Financial Participation shall not be available for any amount furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or should have known of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud, pursuant to 42 U.S.C. section 1396b(i)(2).

Contractor shall be responsible for any disallowances resulting from inadequate documentation.

Failure by either party to enforce any provision of this Agreement shall not constitute a waiver of that provision or any other provision.

If Contractor fails to comply with any provision of this Agreement, County may, upon written notice, be relieved of its obligation to provide further compensation.

g. Compliance with Federal and State Laws

Contractor shall comply with all applicable Federal and State laws and regulations governing the provision of services and the use of funds under this Agreement, including but not limited to:

i. The False Claims Act employee training and policy requirements set forth in 42 U.S.C. §1396a(a)(68) and any related guidance issued by the U.S. Department of Health and Human Services;
ii. Medi-Cal program requirements;
iii. HIPAA privacy and security standards;
iv. Any other applicable statutes, regulations, and administrative rules.

Contractor shall maintain documentation demonstrating compliance with these requirements and make such documentation available to County upon request.

h. Restrictions on Fund Redirection

Contractor shall not redirect or transfer funds from one funded program to another funded program under this Agreement, except through a duly executed amendment approved by County.

Contractor shall not allocate or charge services provided to an eligible person under one funded program to another funded program unless the person served is also eligible for services under the second funded program.

i. Record Retention and Access

Contractor shall maintain complete, accurate, and current records to demonstrate accountability for all services and fiscal activities under this Agreement. Records shall include, but are not limited to:

i. Service delivery documentation (e.g., monthly summary sheets, sign-in sheets, and other primary source documents);
ii. Fiscal records maintained in accordance with Generally Accepted Accounting Principles (GAAP), accounting for all funds, tangible assets, revenues, and expenditures;
iii. Documentation required under 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Retention Requirements:

Contractor shall retain all service and financial records for a minimum of ten (10) years from the date of final payment, the final date of this Agreement, final settlement, or until all audit findings are resolved, whichever is later.

Access and Compliance:

Contractor shall provide County access to all records upon request and comply with all applicable local, State, and Federal laws regarding the maintenance and relinquishment of medical records.

Failure to maintain records in accordance with these requirements may result in withholding of payments or termination of this Agreement, as outlined in Article 6.

FEE-FOR-SERVICE RATES

**Fee-for-Service rates are established by the Department of Health Care Services. Contractor acknowledges that the rates listed in the table below are all-inclusive rates and cover all program operating expenses, including but is not limited to:

i. Direct and indirect staff time (e.g., patient care, documentation, travel, and paid time off);
ii. Total staff compensation (e.g., salaries, wages, benefits, bonuses, incentives);
iii. Vehicle expenses (e.g. gas, maintenance, insurance);
iv. Training and professional development;
v. Assets and capital equipment;
vi. Utilities overhead costs.

Indirect cost expenses shall be determined by the Contractor under the Fee-for-Service reimbursement structure.

Assigned Fee-For-Service Rate Category:

FSP-FACT: FSP Rate

FSP-ICM: FSP Rate

Outpatient: Field-Based Rate

Fee-For-Service Rate Table:

FSP	
Provider Type	**Provider Rate Per Hour**
Licensed Physician	$1,250.00
Physicians Assistant	$560.62
Nurse Practitioner	$621.59
Registered Nurse	$507.73
Certified Nurse Specialist	$621.59
Licensed Vocational Nurse	$266.72
Registered Pharmacist	$598.34
Licensed Psychiatric Technician	$228.66
Psychologist (Licensed or Waivered)	$502.71
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$325.31
Occupational Therapist	$433.04
Mental Health Rehab Specialist	$244.76
Peer Support Specialists	$256.99

Community Health Worker	$250.88
Medical Assistant	$183.35
Other Qualified Providers	$244.76
Certified AOD Counselor	$269.84

Flat Rate Type	Unit	Maximum Units That Can Be Billed	Rate
Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Field Based
(at least 50% of services are provided in the field)

Provider Type	Provider Rate Per Hour
Licensed Physician	$1,083.33
Physicians Assistant	$485.87
Nurse Practitioner	$538.71
Registered Nurse	$440.03
Certified Nurse Specialist	$538.71
Licensed Vocational Nurse	$231.16
Registered Pharmacist	$518.56
Licensed Psychiatric Technician	$198.17
Psychologist (Licensed or Waivered)	$435.68
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$281.94
Occupational Therapist	$375.30
Mental Health Rehab Specialist	$212.12
Peer Support Specialists	$222.72
Community Health Worker	$217.43
Medical Assistant	$158.91
Other Qualified Providers	$212.12
Certified AOD Counselor	$233.86

Flat Rate Type	Unit	Maximum Units That Can Be Billed	Rate

Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Clinic/Site Based
(less than 50% of services are provided in the field)

Provider Type	Provider Rate Per Hour
Licensed Physician	$1,000.00
Physicians Assistant	$448.49
Nurse Practitioner	$497.27
Registered Nurse	$406.18
Certified Nurse Specialist	$497.27
Licensed Vocational Nurse	$213.38
Registered Pharmacist	$478.67
Licensed Psychiatric Technician	$182.93
Psychologist (Licensed or Waivered)	$402.17
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$260.25
Occupational Therapist	$346.43
Mental Health Rehab Specialist	$195.80
Peer Support Specialists	$205.59
Community Health Worker	$200.70
Medical Assistant	$146.68
Other Qualified Providers	$195.80
Certified AOD Counselor	$215.87

Flat Rate Type	Unit	Maximum Units That Can Be Billed	Rate
Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Forensic Continuum of Care
Turning Point of Central California, Inc.
FSP FACT/ACT FFS Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.
For each Specialty Mental Health Services FY, please provide your proposed maximum compensation based upon estimated services provided within the corresponding blue cells.

Specialty Mental Health Services	
Maximum Compensation FY 26-27	$ 1,625,000
Maximum Compensation FY 27-28	
Maximum Compensation FY 28-29	
Maximum Compensation FY 29-30	

Specialty Mental Health Services Maximum Compensation	$ 1,625,000

Forensic Continuum of Care
Turning Point of Central California, Inc.
Whatever It Takes Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.

Whatever it Takes Fund	
Maximum Compensation FY 26-27	**$ 225,000**
Maximum Compensation FY 27-28	
Maximum Compensation FY 28-29	
Maximum Compensation FY 29-30	

Whatever It Takes Maximum Compensation	**$ 225,000**

1000: Whatever It Takes	
Acct #	**Line Item Description**
1001	Child Care
1002	Client Housing Support
1003	Client Transportation & Support
1004	Clothing, Food, & Hygiene
1005	Education Support
1006	Employment Support
1007	Household Items for Clients
1008	Medication Supports
1009	Program Supplies - Medical
1010	Utility Vouchers
1011	Other (specify)

Forensic Continuum of Care
Turning Point of Central California, Inc.
Fidelity Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.

Fidelity Fund	
Maximum Compensation FY 26-27	$ 900,000
Maximum Compensation FY 27-28	
Maximum Compensation FY 28-29	
Maximum Compensation FY 29-30	

Fidelity Maximum Compensation	$ 900,000

Forensic Continuum of Care
Turning Point of Central California, Inc.
FSP ICM FFS Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.
For each Specialty Mental Health Services FY, please provide your proposed maximum compensation based upon estimated services provided within the corresponding blue cells.

Specialty Mental Health Services	
Maximum Compensation FY 26-27	$ 1,890,000
Maximum Compensation FY 27-28	
Maximum Compensation FY 28-29	
Maximum Compensation FY 29-30	

Specialty Mental Health Services Maximum Compensation	$ 1,890,000

Forensic Continuum of Care
Turning Point of Central California, Inc.
Whatever It Takes Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.

Whatever it Takes Fund	
Maximum Compensation FY 26-27	**$ 90,000**
Maximum Compensation FY 27-28	
Maximum Compensation FY 28-29	
Maximum Compensation FY 29-30	

Whatever It Takes Maximum Compensation	**$ 90,000**

1000: Whatever It Takes	
Acct #	**Line Item Description**
1001	Child Care
1002	Client Housing Support
1003	Client Transportation & Support
1004	Clothing, Food, & Hygiene
1005	Education Support
1006	Employment Support
1007	Household Items for Clients
1008	Medication Supports
1009	Program Supplies - Medical
1010	Utility Vouchers
1011	Other (specify)

Forensic Continuum of Care FACT
Turning Point Forensic Continuum of Care
Fiscal Year (FY) 2026-27

PROGRAM EXPENSES

1000: DIRECT SALARIES & BENEFITS

Direct Employee Salaries

Acct #	Administrative Position	FTE	Admin	Program	Total
1101	Records Technician	0.69	$ 4,215		$ 4,215
1102	Administrative Assistant	0.60	7,405		7,405
1103	Program Bookkeeper	0.60	7,405		7,405
1104	Secretary	0.60	5,933		5,933
1105			-		-
1106			-		-
1107			-		-
1108			-		-
1109			-		-
1110			-		-
1111			-		-
1112			-		-
1113			-		-
1114			-		-
1115			-		-
	Direct Personnel Admin Salaries Subtotal	**2.49**	**$ 24,958**		**$ 24,958**
Acct #	**Program Position**	**FTE**	**Admin**	**Program**	**Total**
1116	Assistant Program Director	0.60		$ 16,416	$ 16,416
1117	Program Director	0.60		20,029	20,029
1118	Mental Health Specialist	0.69		95,253	95,253
1119	Supervising Personal Services Coordinator	0.60		11,587	11,587
1120	Peer Support	0.69		18,769	18,769
1121	Mental Health Professional	0.69		41,087	41,087
1122	Nurse	0.69		17,139	17,139
1123				-	-
1124				-	-
1125				-	-
1126				-	-
1127				-	-
1128				-	-
1129				-	-
1130				-	-
1131				-	-
1132				-	-
1133				-	-
1134				-	-
	Direct Personnel Program Salaries Subtotal	**4.56**		**$ 220,280**	**$ 220,280**
			Admin	**Program**	**Total**
	Direct Personnel Salaries Subtotal	**7.05**	**$ 24,958**	**$ 220,280**	**$ 245,238**

Direct Employee Benefits

Acct #	Description	Admin	Program	Total
1201	Retirement	$ 831	$ 7,342	$ 8,173
1202	Worker's Compensation	295	2,612	2,907
1203	Health Insurance	3,696	32,628	36,324
1204	Other (Dental)	290	2,559	2,849
1205	Other (ACI)	8	73	81
1206	Other (Accrued Paid Leave)	2,773	24,473	27,246
	Direct Employee Benefits Subtotal:	**$ 7,893**	**$ 69,687**	**$ 77,580**

Direct Payroll Taxes & Expenses:

Acct #	Description	Admin	Program	Total
1301	OASDI	$ 465	$ 3,548	$ 4,013
1302	FICA/MEDICARE	205	15,297	15,502
1303	SUI	469	3,573	4,042
1304	Other (specify)	-	-	-
1305	Other (specify)	-	-	-
1306	Other (specify)	-	-	-
	Direct Payroll Taxes & Expenses Subtotal:	**$ 1,139**	**$ 22,418**	**$ 23,557**

DIRECT EMPLOYEE SALARIES & BENEFITS TOTAL:	**Admin**	**Program**	**Total**
	$ 33,990	**$ 312,385**	**$ 346,375**

DIRECT EMPLOYEE SALARIES & BENEFITS PERCENTAGE:	**Admin**	**Program**
	10%	**90%**

2000: DIRECT CLIENT SUPPORT		
Acct #	**Line Item Description**	**Amount**
2001	Child Care	$ -
2002	Client Housing Support	
2003	Client Transportation & Support	1,782
2004	Clothing & Hygiene	1,274
2005	Education Support	2,547
2006	Employment Support	816
2007	Household Items for Clients	-
2008	Medication Supports	21,897
2009	Program Supplies - Medical	561
2010	Utility Vouchers	4,888
2011	Client Activities	2,547
2012	Client Personal Needs	561
2013	Client Food	1,340
2014	Client Physical Exams	2,483
2015	Client Testing Materials	408
2016	Other (specify)	-
	DIRECT CLIENT CARE TOTAL	**$ 41,104**

3000: DIRECT OPERATING EXPENSES		
Acct #	**Line Item Description**	**Amount**
3001	Telecommunications	$ 1,776
3002	Printing/Postage	185
3003	Office, Household & Program Supplies	1,704
3004	Advertising	-
3005	Staff Development & Training	1,536
3006	Staff Mileage	201
3007	Subscriptions & Memberships	151
3008	Vehicle Maintenance/Fuel/Insurance	5,187
3009	Recruitment	1,243
3010	Other (specify)	-
3011	Other (specify)	-
3012	Other (specify)	-
	DIRECT OPERATING EXPENSES TOTAL:	**$ 11,983**

4000: DIRECT FACILITIES & EQUIPMENT		
Acct #	**Line Item Description**	**Amount**
4001	Building Maintenance	$ 160
4002	Rent/Lease Building	26,424
4003	Rent/Lease Equipment	168
4004	Rent/Lease Vehicles	4,878
4005	Security	277
4006	Utilities	5,622
4007	Equipment Maintenance	201
4008	Other (specify)	-
4009	Other (specify)	-
4010	Other (specify)	-
	DIRECT FACILITIES/EQUIPMENT TOTAL:	**$ 37,730**

5000: DIRECT SPECIAL EXPENSES		
Acct #	**Line Item Description**	**Amount**
5001	Consultant (Network & Data Management)	$ 100
5002	HMIS (Health Management Information System)	-
5003	Contractual/Consulting Services (Specify)	-
5004	Translation Services	764
5005	O/S Labor Phychiatrist	23,708
5006	Other (specify)	-
5007	Other (specify)	-
5008	Other (specify)	-
	DIRECT SPECIAL EXPENSES TOTAL:	**$ 24,572**

6000: INDIRECT EXPENSES		
Acct #	**Line Item Description**	**Amount**
	Administrative Overhead	
6001	Use this line and only this line for approved indirect cost rate	$ -
	Administrative Overhead	
6002	Professional Liability Insurance	1,030
6003	Accounting/Bookkeeping	-
6004	External Audit	209
6005	Insurance (Specify):	-
6006	Payroll Services	1,175
6007	Depreciation *(Provider-Owned Equipment to be Used for Program Purposes)*	-
6008	Personnel (Indirect Salaries & Benefits)	-
6009	Licenses	486
6010	Indirect	126,312
6011	Other (specify)	-
6012	Other (specify)	-
6013	Other (specify)	-
	INDIRECT EXPENSES TOTAL	**$ 129,212**

INDIRECT COST RATE	**27.79%**

7000: DIRECT FIXED ASSETS		
Acct #	**Line Item Description**	**Amount**
7001	Computer Equipment & Software	$ -
7002	Copiers, Cell Phones, Tablets, Devices to Contain HIPAA Data	-
7003	Furniture & Fixtures	336
7004	Leasehold/Tenant/Building Improvements	-
7005	Other Assets over $500 with Lifespan of 2 Years +	-
7006	Assets over $5,000/unit (Specify)	-
7007	Expendable Equipment	2,887
7008	Other (specify)	-
	FIXED ASSETS EXPENSES TOTAL	**$ 3,223**

TOTAL PROGRAM EXPENSES	**$ 594,199**

PROGRAM FUNDING SOURCES

8000: TOTAL PROGRAM REVENUES		
Acct #	**Line Item Description**	**Amount**
8001	Revenue Allocated by DBH	-
8002	Client Fees	-
8003	Client Insurance	-
8004	Grants (Specify) - CCP AB109	496,500
8005	Other (Specify) - DSH Diversion	97,699
8006	Other (Specify)	-
	TOTAL PROGRAM REVENUES	**$ 594,199**

TOTAL PROGRAM ESTIMATED REVENUES:	**$ 594,199**

NET PROGRAM COST:	**$ -**

Forensic Continuum of Care FACT
Turning Point Forensic Continuum of Care
Fiscal Year (FY) 2026-27

PARTIAL FTE DETAIL

For all positions with FTE's split among multiple programs/contracts the below must be filled out

Position	Contract #/Name/Department/County	FTE %
Records Technician	Allocation to CCP & DSH	0.38
	Allocation to FSC FACT/FSP FFP	0.17
	OP	0.45
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Administrative Assistant	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Program Bookkeeper	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Secretary	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Assistant Program Director	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Program Director	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Case Manager	Allocation to CCP & DSH	0.69
	Allocation to FSC FACT/FSP FFP	0.31

	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Supervising Personal Services Coordinator	Allocation to CCP & DSH	0.60
	Allocation to FSC FACT/FSP FFP	0.40
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Peer Support	Allocation to CCP & DSH	0.69
	Allocation to FSC FACT/FSP FFP	0.31
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Mental Health Professional	Allocation to CCP & DSH	0.69
	Allocation to FSC FSP FFP	0.31
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Nurse	Allocation to CCP & DSH	0.52
	Allocation to FSC FSP FFP	0.23
	OP	0.25
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
	Total	**0.00**

Position	Contract #/Name/Department/County	FTE %
	Total	**0.00**

Position	Contract #/Name/Department/County	FTE %

	Total	0.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Forensic Continuum of Care FACT
Turning Point Forensic Continuum of Care
Fiscal Year (FY) 2026-27 Budget Narrative

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
1000: DIRECT SALARIES & BENEFITS			**346,375**	
Administrative Positions			**24,958**	
	1101	Records Technician	4,215	The Records Technician will keep track of the Medical Records and will do the billing for the program. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1102	Administrative Assistant	7,405	The Administrative Assistant will oversee the support staff and will help with all support staff duties. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1103	Program Bookkeeper	7,405	The Program Bookkeeper will be assisting the clients with their client fees for their portion of rent if necessary and keeping track of all the incoming and outgoing of petty cash as needed. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1104	Secretary	5,933	Provides direct services to the program by data entry, phone calls, checking in clients, etc. Any additional funds outside of Medi-Cal are used for this/these positions for nontreatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1105	0	-	
	1106	0	-	
	1107	0	-	
	1108	0	-	
	1109	0	-	
	1110	0	-	
	1111	0	-	
	1112	0	-	
	1113	0	-	
	1114	0	-	
	1115	0	-	
Program Positions			**220,280**	
	1116	Assistant Program Director	16,416	The Asssitant Program Director will supervise staff and assist the Program Director. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1117	Program Director	20,029	The Program Director oversees the program and the hiring, training and supervising of staff. When a staff takes leave, the program is not changed since it's already been accrued. Our Positions are based on class/step, some might be less and some might be more, all according to the person's experience and education when they come to work for Turning Point. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1118	Mental Health Specialist	95,253	Mental Health Specialist will carry a caseload while also specializing in linking and providing services to those interested in engagement in employment and education services. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1119	Supervising Personal Services Coordinator	11,587	Provides supervision to all Mental Health Specialists to ensure client care, maintain compliance with Turning Point policies and procedures. Supervisor also assisting in training new staff and reporting to the Assistant Program Director. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or nonbillable related costs to be able to continue to provide continuity of care.
	1120	Peer Support	18,769	Serves as a client advocate and provides information and peer support to clients throughout their recovery process. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1121	Mental Health Professional	41,087	Provides mental health assessment, assessing for Medical Necessity, assists client in identifying treatment plan goals according to diagnosis. MHP also provides individual and group therapy as client requests, while also providing program support to assist clients in crisis. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
	1122	Nurse	17,139	Nurses work with the doctors for client care, maintaining compliance with Turning Point policies and procedures, providing training and ensuring accurate charting in accordance with Medi-cal. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1123	0	-	
	1124	0	-	
	1125	0	-	
	1126	0	-	
	1127	0	-	
	1128	0	-	
	1129	0	-	
	1130	0	-	
	1131	0	-	
	1132	0	-	
	1133	0	-	
	1134	0	-	
Direct Employee Benefits			**77,580**	
	1201	Retirement	8,173	10-5940 Retirement: Cost of Agency contribution to employee retirement plans. These are non-treatment related costs.
	1202	Worker's Compensation	2,907	10-5930 Workers Compensation Insurance: Cost of workers compensation insurance. These are non-treatment related costs.
	1203	Health Insurance	36,324	10-5950 Health Insurance: Agency cost for health insurance including Vision These are non-treatment related costs.
	1204	Other (Dental)	2,849	10-5960 Dental Insurance: Agency cost for dental insurance. These are non-treatment related costs.
	1205	Other (ACI)	81	10-5990 Other Benefits: Agency cost for other wage related employee benefits. These are non-treatment related costs.
	1206	Other (Accrued Paid Leave)	27,246	10-5980 Accrued Paid Leave: The monetary value of staff Paid Leave hours as they accrue on a monthly basis. These are non-treatment related costs.
Direct Payroll Taxes & Expenses:			**23,557**	
	1301	OASDI	4,013	10-5910 F.I.C.A. (Federal Insurance Contributions Act): Employer portion of F.I.C.A. taxes charged to the Agency by the Internal Revenue Service. F.I.C.A. is comprised of "Old-Age, Survivors, and Disability Insurance" (OASDI), plus "Hospital Insurance" (Medicare). These are non-treatment related costs.
	1302	FICA/MEDICARE	15,502	10-5910 F.I.C.A. (Federal Insurance Contributions Act): Employer portion of F.I.C.A. taxes charged to the Agency by the Internal Revenue Service. F.I.C.A. is comprised of "Old-Age, Survivors, and Disability Insurance" (OASDI), plus "Hospital Insurance" (Medicare). These are non-treatment related costs.
	1303	SUI	4,042	10-5920 S.U.I. (State Unemployment Insurance): Employer portion of S.U.I. taxes charged to the Agency by the various states in which wages are paid. These are non-treatment related costs.
	1304	Other (specify)	-	
	1305	Other (specify)	-	
	1306	Other (specify)	-	

2000: DIRECT CLIENT SUPPORT			**41,104**	
	2001	Child Care	-	
	2002	Client Housing Support	-	10-7060 Client Housing Assistance: Cost of rent, housing assistance and deposit paid on behalf of client. (Examples: first/last month deposit, late fees, monthly rent, hotel charges, room & board, board & care, etc.)
	2003	Client Transportation & Support	1,782	10-7015 Client Transportation: Cost for client transportation. (Examples: bus tokens/passes, taxi, other public transportation, bicycles, etc.)
	2004	Clothing & Hygiene	1,274	10-7021 Client Clothing & Hygiene: Cost of client hygiene supplies and non-work related clothing. (Examples: clothes, shoes, hats, beanies, scarves, soap, toothpaste, deodorant, grooming supplies, hair accessories, diapers, etc.)
	2005	Education Support	2,547	10-7150 Client Educational Material: Cost of course fees and educational materials distributed to clients and prospective clients. Including court ordered educational class.
	2006	Employment Support	816	10-7022 Client Employment Support: Cost of client pre-employment preparation and employment retention. (Examples: job search and interview attire, work boots and tools required for employment, etc.)
	2007	Household Items for Clients	-	
	2008	Medication Supports	21,897	10-7030 Client Medical Expense: Cost of medical supplies or treatment/medical expense for a specific client. (Examples: co-pays*, prescription/lab work not covered by insurance, over-the-counter medications*, first aid kit/supplies for client's use at home, etc.) *if allowable per contract

PROGRAM EXPENSE			
ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
2009	Program Supplies - Medical	561	10-6122 Program Supplies-Medical: Cost of medical supplies to be used by staff or clients at the program location to meet program objective. Such items are to remain at the program location and not sent home with the client. Such items include, but are not limited to first aid kits, blood pressure monitor, latex gloves, syringes, hazard disposal service, sunblock, insect repellent, *over-the-counter medication/vitamins-if allowable per contract*, etc.
2010	Utility Vouchers	4,888	10-7023 Client Utility/Rental Security Deposits: Cost of client utility bills and/or security deposits.
2011	Client Activities	2,547	10-7010 Client Activities/Recreation: Cost for client activities & recreation events. (Examples: cable bill, food/drinks/utensils/decorations needed for a specific client event, incentive rewards, cash reinforcer, admission fees to events, etc.)

PROGRAM EXPENSE			
ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
2012	Client Personal Needs	561	10-7020 Client Personal Needs: Cost of supplying clients with necessary personal items not detailed in other accounts. (Examples: birth certificate, DMV fee for ID or license, clients household cleaning products/house supplies/kitchen supplies for their own home, pots/pans/dishes, linens, locker lock, paper towels and child related expenses such as car seat/stroller/play pin/toys, special food for allergies, reinforcers from P & I funds, laptop, tablet, etc.)
2013	Client Food	1,340	10-6150 Food: Cost of food and drink to be consumed by the residents/clients. (Examples: Groceries to prepare onsite, outside food brought onsite, food/drinks for clients)
2014	Client Physical Exams	2,483	10-7080 Client Physical Exams: Cost of client admission physical examinations and TB testing.
2015	Client Testing Materials	408	10-7140 Client Testing Material: Cost of U/A testing supplies, including breathalyzer, used to determine treatment required for clients.
2016	Other (specify)	-	
3000: DIRECT OPERATING EXPENSES		**11,983**	
3001	Telecommunications	1,776	10-6340 Communications: Cost of electronic communications. (Examples: internet, phone, fax, cell phones, etc.) These are non-treatment related costs.
3002	Printing/Postage	185	10-6400 Postage: Cost of Agency postage and delivery. Including delivery by the U.S. Post Office, U.P.S., FedEx or other courier services. These are non-treatment related costs.
3003	Office, Household & Program Supplies	1,704	10-6110 Office Supplies: Cost of items normally used in an office setting. 10-6130 House Supplies: Cost of supplies used by staff during their scheduled work hours. These items are normally used to operate the building at the program location. These items are to remain at program location and not sent home with client. 10-6120 Program Supplies: Cost of any items normally used by clients or to directly benefit the clients to meet program objectives while receiving services. These items are to remain at the program location and not sent home with the client. 10-6243 General Supplies: Cost of items generally used by all at program's location. 10-6244 Janitorial Supplies & Services: Cost of items or services to maintain the esthetics of the premises. These are non-treatment related costs.
3004	Advertising	-	
3005	Staff Development & Training	1,536	10-6440 Staff Educational Expense: Cost of employee training courses and materials. (Examples: certification, training, books, etc.) *May include cost of room rental. These are non-treatment related costs.
3006	Staff Mileage	201	10-6060 Staff Mileage: Cost of employee mileage reimbursement paid in accordance with FPM section 1005. These are non-treatment related costs.
3007	Subscriptions & Memberships	151	10-6360 Dues & Subscriptions: Cost of membership dues and subscriptions. (Examples: magazine, newspaper, memberships, etc.) These are non-treatment related costs.
3008	Vehicle Maintenance/Fuel/Insurance	5,187	10-6030 Vehicle Insurance: Cost for vehicle insurance. 10-6040 Vehicle Fuel: Cost of gas in vehicles. 10-6050 Vehicle Maintenance: Cost of vehicle maintenance. Including cost of parts, supplies and labor associated with maintenance and repair of vehicles used by Agency programs. (Examples: repairs, battery, carwash *Includes: impounds) These are non-treatment related costs.
3009	Recruitment	1,243	10-6470 Recruitment: Cost of advertising and other employee recruitment expenses. (Examples: newspaper ad, urine screening, background check, etc.) These are non-treatment related costs.
3010	Other (specify)	-	
3011	Other (specify)	-	
3012	Other (specify)	-	
4000: DIRECT FACILITIES & EQUIPMENT		**37,730**	
4001	Building Maintenance	160	10-6330 Building Maintenance: Cost of Agency building repairs and maintenance. (Examples: electrical work, A/C and heating, hood cleaning, plumbing, deadbolt, door knob/lock, keys, key tags, air/furnace filters, smoke alarm, co2 alarm, exit sign, blinds, etc.) This account should not be used if a specific outside labor contractor is doing an identifiable project, in this case use 6603, or projects over $2,000.00 that will require the procurement process and a WIP to be completed. These are non-treatment related costs. These are non-treatment related costs.
4002	Rent/Lease Building	26,424	10-6320 Building Rent (Other): Cost of rent/lease payments made for building leases from outside sources. These are non-treatment related costs.
4003	Rent/Lease Equipment	168	10-6220 Furniture & Equipment Rent/Lease (Other): Cost of rent/lease payments made for furniture and equipment leases from outside sources. (Examples: high capacity copier/printer/scanner, washer/dryer, vending machine, furniture, water cooler, postage meter, etc.) These are non-treatment related costs.
4004	Rent/Lease Vehicles	4,878	10-6020 Vehicle Rent/Lease (Other): Rental cost of non-Agency vehicles and lease of agency vehicles.

PROGRAM EXPENSE			
ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
4005	Security	277	10-6390 Security: Cost of installation, maintenance and monthly service fees for building alarms and other security measures. (Examples: security/surveillance equipment, service and installation, safes, locks, padlocks, etc.) These are non-treatment related costs.
4006	Utilities	5,622	10-6350 Utilities: Cost of service for power, gas, water, sewer, garbage, etc. These are non-treatment related costs.
4007	Equipment Maintenance	201	10-6230 Equipment Maintenance: Cost of repair or maintenance of office/house equipment and furniture. (Examples: high capacity copier/printer/scanner, replacement parts such as hard drive, video card, adapter, laptop battery, monitor/printer/phone cord, cord covers, power strip, surge protector, extension cord, cable ties, drum, hose, filter, drawer slide set/rollers, keys for filing cabinet, etc.) These are non-treatment related costs.
4008	Other (specify)	-	
4009	Other (specify)	-	
4010	Other (specify)	-	

5000: DIRECT SPECIAL EXPENSES		24,572	
5001	Consultant (Network & Data Management)	100	10-6115 Software & Computer Support: Cost of computer software and computer support. (Examples: Microsoft Office, QuickBooks, PDF converter, Avatar, Vipre anti-virus, LogMeIn, web filter, etc.) This account should not be used for the purchase of computers and related accessories. Computer accessories such as a mouse, keyboard and speakers must be coded to 6190. These are non-treatment related costs.
5002	HMIS (Health Management Information System)	-	
5003	Contractual/Consulting Services (Specify)	-	
5004	Translation Services	764	Paid to outside vendors for translation / interpreter services. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
5005	O/S Labor Phychiatrist	23,708	These accounts are assigned to record various professional services provided by contracted Psychiatrist working as independent agents. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
5006	Other (specify)	-	
5007	Other (specify)	-	
5008	Other (specify)	-	

6000: INDIRECT EXPENSES		129,212	
6001	Administrative Overhead	-	
6002	Professional Liability Insurance	1,030	10-6370 Insurance: Cost of Agency liability and property insurance. These are non-treatment related costs.
6003	Accounting/Bookkeeping	-	
6004	External Audit	209	10-6460 Audit Expense: Cost of outside audit fees. These are non-treatment related costs.
6005	Insurance (Specify):	-	
6006	Payroll Services	1,175	10-6482 Payroll Software & Support. These are non-treatment related costs.
6007	Depreciation (Provider-Owned Equipment to be Used	-	
6008	Personnel (Indirect Salaries & Benefits)	-	
6009	Licenses	486	10-6380 Licenses: Cost in obtaining and renewing licenses and permits. (Examples: Electronic Medical Records (EMR) database, kitchen/restaurant permit, fire clearance, facility inspections, vehicle registration, etc.) These are non-treatment related costs.
6010	Indirect	126,312	10-9000's Indirect Allocated Costs. These are non-treatment related costs, amount includes indirect overhead cost for Fiscal, HR, IT, and Executive departments
6011	Other (specify)	-	
6012	Other (specify)	-	
6013	Other (specify)	-	

7000: DIRECT FIXED ASSETS		3,223	
7001	Computer Equipment & Software	-	
7002	Copiers, Cell Phones, Tablets, Devices to Contain HIPAA	-	
7003	Furniture & Fixtures	336	10-6240 Expendable Furniture: Cost of small, inexpensive Agency property with a normal useful life generally less than one year or a value that is minor or insignificant, typically items with a total cost of less than $5000 per item. (Examples: small desk, portable desk, chair, filing cabinet, mail slots, shelving unit, table, foldable tables/chairs, bed, mattress, nightstand, room divider, etc. *Includes assembly fee) (For additional information, see procedures section 0900) These are non-treatment related costs.
7004	Leasehold/Tenant/Building Improvements	-	
7005	Other Assets over $500 with Lifespan of 2 Years +	-	

PROGRAM EXPENSE			
ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
7006	Assets over $5,000/unit (Specify)	-	
7007	Expendable Equipment	2,887	10-6190 Expendable Equipment: Cost of purchasing office/house equipment that has a cost less than $5000 per item. (Examples: electronic stapler/calculator/hole puncher, computer, monitor, keyboard, mouse, speakers and other computer accessories including mousepad and wrist pad, desk printer, tablet, tablet cover, lamp, desk lamp, fan, radio, television, phone, coffee machine, popcorn maker, toaster, refrigerator, dishwasher, washer, dryer, portable a/c unit, hand soap/hand towel dispenser, fire extinguisher, dolly, canopy, shed, barbecue, drill, etc.) These are non-treatment related costs.
7008	Other (specify)	-	

TOTAL PROGRAM EXPENSE FROM BUDGET NARRATIVE: 594,199

Forensic Continuum of Care Outpatient
Turning Point Forensic Continuum of Care
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PROGRAM EXPENSES

1000: DIRECT SALARIES & BENEFITS

Direct Employee Salaries

Acct #	Administrative Position	FTE	Admin	Program	Total
1101	Records Technician	0.12	$ 4,810		$ 4,810
1102	Secretary	0.26	10,182		10,182
1103	Bookkeeper	0.26	11,804		11,804
1104	-		-		-
1105	-		-		-
1106	-		-		-
1107	-		-		-
1108	-		-		-
1109	-		-		-
1110	-		-		-
1111	-		-		-
1112	-		-		-
1113	-		-		-
1114	-		-		-
1115	-		-		-
	Direct Personnel Admin Salaries Subtotal	**0.64**	**$ 26,796**		**$ 26,796**
Acct #	**Program Position**	**FTE**	**Admin**	**Program**	**Total**
1116	Intake Assistant	0.26		$ 26,082	$ 26,082
1117	Program Director	0.26		23,695	23,695
1118	Case Manager	0.28		26,972	26,972
1119	Supervising Personal Services Coordinator	0.28		18,180	18,180
1120	Substance Abuse Counselor	0.28		67,080	67,080
1121	Mental Health Professional	0.27		67,041	67,041
1122	Nurse	0.06		7,025	7,025
1123	-			-	-
1124	-			-	-
1125	-			-	-
1126	-			-	-
1127	-			-	-
1128	-			-	-
1129	-			-	-
1130	-			-	-
1131	-			-	-
1132	-			-	-
1133	-			-	-
1134	-			-	-
	Direct Personnel Program Salaries Subtotal	**1.69**		**$ 236,075**	**$ 236,075**
			Admin	**Program**	**Total**
	Direct Personnel Salaries Subtotal	**2.33**	**$ 26,796**	**$ 236,075**	**$ 262,871**

Direct Employee Benefits

Acct #	Description	Admin	Program	Total
1201	Retirement	$ 1,164	$ 7,507	$ 8,671
1202	Worker's Compensation	414	2,671	3,085
1203	Health Insurance	4,846	31,264	36,110
1204	Dental Insurance	380	2,453	2,833
1205	ACI	12	75	87
1206	Accrued Paid Leave	3,879	25,023	28,902
	Direct Employee Benefits Subtotal:	**$ 10,695**	**$ 68,993**	**$ 79,688**

Direct Payroll Taxes & Expenses:

Acct #	Description	Admin	Program	Total
1301	OASDI	$ 562	$ 3,628	$ 4,190
1302	FICA/MEDICARE	2,424	15,640	18,064

1303	SUI	566	3,653	4,219
1304	Other (specify)	-	-	-
1305	Other (specify)	-	-	-
1306	Other (specify)	-	-	-
	Direct Payroll Taxes & Expenses Subtotal:	**$ 3,552**	**$ 22,921**	**$ 26,473**
	DIRECT EMPLOYEE SALARIES & BENEFITS TOTAL:	**Admin**	**Program**	**Total**
		$ 41,043	**$ 327,989**	**$ 369,032**

DIRECT EMPLOYEE SALARIES & BENEFITS PERCENTAGE:	Admin	Program
	11%	89%

2000: DIRECT CLIENT SUPPORT		
Acct #	**Line Item Description**	**Amount**
2001	Child Care	$ -
2002	Client Housing Support	120,000
2003	Client Transportation & Support	500
2004	Clothing, Food, & Hygiene	1,000
2005	Education Support	-
2006	Employment Support	-
2007	Household Items for Clients	-
2008	Medication Supports	4,300
2009	Program Supplies - Medical	-
2010	Utility Vouchers	-
2011	Client Activities/Recreation	1,000
2012	Client Testing Material	9,850
2013	Client Food	300
2014	Other (specify)	-
2015	Other (specify)	-
2016	Other (specify)	-
	DIRECT CLIENT CARE TOTAL	**$ 136,950**

3000: DIRECT OPERATING EXPENSES		
Acct #	**Line Item Description**	**Amount**
3001	Telecommunications	$ 2,204
3002	Printing/Postage	706
3003	Office, Household & Program Supplies	3,888
3004	Advertising	-
3005	Staff Development & Training	1,957
3006	Staff Mileage	372
3007	Subscriptions & Memberships	106
3008	Vehicle Maintenance	936
3009	Recruitment	692
3010	Outreach & Engagement	147
3011	Other (specify)	-
3012	Other (specify)	-
	DIRECT OPERATING EXPENSES TOTAL:	**$ 11,008**

4000: DIRECT FACILITIES & EQUIPMENT		
Acct #	**Line Item Description**	**Amount**
4001	Building Maintenance	$ 80
4002	Rent/Lease Building	20,846
4003	Rent/Lease Equipment	519
4004	Rent/Lease Vehicles	-
4005	Security	453
4006	Utilities	5,819
4007	Equipment Maintenance	626
4008	Depreciation	159
4009	Other (specify)	-
4010	Other (specify)	-
	DIRECT FACILITIES/EQUIPMENT TOTAL:	**$ 28,502**

5000: DIRECT SPECIAL EXPENSES		
Acct #	**Line Item Description**	**Amount**
5001	Consultant (Network & Data Management)	$ 26
5002	HMIS (Health Management Information System)	-
5003	Contractual/Consulting Services (Specify)	-
5004	Translation Services	-
5005	OS Labor Psychiatrist	17,604
5006	OS Labor Physician	3,304
5007	Other (specify)	-
5008	Other (specify)	-
	DIRECT SPECIAL EXPENSES TOTAL:	**$ 20,934**

6000: INDIRECT EXPENSES		
Acct #	**Line Item Description**	**Amount**
	Administrative Overhead	
6001	Use this line and only this line for approved indirect cost rate	$ -
	Administrative Overhead	
6002	Professional Liability Insurance	2,277
6003	Accounting/Bookkeeping	-
6004	External Audit	346
6005	Insurance (Specify):	-
6006	Payroll Services	1,928
6007	Depreciation *(Provider-Owned Equipment to be Used for Program Purposes)*	-
6008	Personnel (Indirect Salaries & Benefits)	-
6009	Licenses	5,384
6010	Indirect	75,924
6011	Other (specify)	-
6012	Other (specify)	-
6013	Other (specify)	-
	INDIRECT EXPENSES TOTAL	**$ 85,859**

INDIRECT COST RATE	**15.00%**

7000: DIRECT FIXED ASSETS		
Acct #	**Line Item Description**	**Amount**
7001	Computer Equipment & Software	$ -
7002	Copiers, Cell Phones, Tablets, Devices to Contain HIPAA Data	-
7003	Furniture & Fixtures	2,583
7004	Leasehold/Tenant/Building Improvements	-
7005	Other Assets over $500 with Lifespan of 2 Years +	-
7006	Assets over $5,000/unit (Specify)	-
7007	Expendable Equipment	3,382
7008	Other (specify)	-
	FIXED ASSETS EXPENSES TOTAL	**$ 5,965**

TOTAL PROGRAM EXPENSES	**$ 658,250**

PROGRAM FUNDING SOURCES

8000: TOTAL PROGRAM REVENUES		
Acct #	**Line Item Description**	**Amount**
8001	Revenue Allocated by DBH	-
8002	Client Fees	-
8003	Client Insurance	-
8004	Grants (Specify) - CCP AB109	658,250
8005	Other (Specify)	-
8006	Other (Specify)	-
	TOTAL PROGRAM REVENUES	**$ 658,250**

TOTAL PROGRAM ESTIMATED REVENUES:	**$ 658,250**

NET PROGRAM COST:	**$ -**

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PARTIAL FTE DETAIL

For all positions with FTE's split among multiple programs/contracts the below must be filled out

Position	Contract #/Name/Department/County	FTE %
Records Technician	Allocation to FSC OP MH FFP	0.08
	Allocation to FSC OP MH CCP	0.02
	Allocation to FSC OP SUD FFP	0.25
	Allocation to FSC OP SUD CCP	0.10
	Allocation to FSC FSP CCP & DSH	0.38
	Allocation to FSC FSP FFP	0.17
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Secretary	Allocation to FSC OP MH FFP	0.17
	Allocation to FSC OP MH CCP	0.05
	Allocation to FSC OP SUD FFP	0.56
	Allocation to FSC OP SUD CCP	0.21
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Bookkeeper	Allocation to FSC OP MH FFP	0.17
	Allocation to FSC OP MH CCP	0.05
	Allocation to FSC OP SUD FFP	0.56
	Allocation to FSC OP SUD CCP	0.21
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Intake Assistant	Allocation to FSC OP MH FFP	0.17
	Allocation to FSC OP MH CCP	0.05
	Allocation to FSC OP SUD FFP	0.57
	Allocation to FSC OP SUD CCP	0.21
	Total	**1.00**

Position	Contract #/Name/Department/County	FTE %
Program Director	Allocation to FSC OP MH FFP	0.17
	Allocation to FSC OP MH CCP	0.05
	Allocation to FSC OP SUD FFP	0.56
	Allocation to FSC OP SUD CCP	0.21

	Total	1.00

Position	Contract #/Name/Department/County	FTE %
Case Manager	Allocation to FSC OP SUD FFP	0.72
	Allocation to FSC OP SUD CCP	0.28
	Total	1.00

Position	Contract #/Name/Department/County	FTE %
Supervising Personal Services Coordinator	Allocation to FSC OP SUD FFP	0.72
	Allocation to FSC OP SUD CCP	0.28
	Total	1.00

Position	Contract #/Name/Department/County	FTE %
Substance Abuse Counselor	Allocation to FSC OP SUD FFP	0.72
	Allocation to FSC OP SUD CCP	0.28
	Total	1.00

Position	Contract #/Name/Department/County	FTE %
Mental Health Professional	Allocation to FSC OP MH FFP	0.17
	Allocation to FSC OP MH CCP	0.05
	Allocation to FSC OP SUD FFP	0.56
	Allocation to FSC OP SUD CCP	0.22
	Total	1.00

Position	Contract #/Name/Department/County	FTE %
Nurse	Allocation to FSC OP MH FFP	0.04
	Allocation to FSC OP MH CCP	0.01
	Allocation to FSC OP SUD FFP	0.14
	Allocation to FSC OP SUD CCP	0.05
	Allocation to FSC FSP CCP & DSH	0.52
	Allocation to FSC FSP FFP	0.23

	Total	1.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Position	Contract #/Name/Department/County	FTE %
	Total	0.00

Forensic Continuum of Care Outpatient
Turning Point Forensic Continuum of Care
Fiscal Year (FY) 2026-27 Budget Narrative

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
1000: DIRECT SALARIES & BENEFITS			**369,032**	
Administrative Positions			**26,796**	
	1101	Records Technician	4,810	The Records Technician will keep track of the Medical Records and will do the billing for the program. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1102	Secretary	10,182	Provides direct services to the program by data entry, phone calls, checking in clients, etc. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1103	Bookkeeper	11,804	The Program Bookkeeper will be assisting the clients with their client fees for their portion of rent if necessary and keeping track of all the incoming and outgoing of petty cash as needed. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1104	-	-	
	1105	-	-	
	1106	-	-	
	1107	-	-	
	1108	-	-	
	1109	-	-	
	1110	-	-	
	1111	-	-	
	1112	-	-	
	1113	-	-	
	1114	-	-	
	1115	-	-	
Program Positions			**236,075**	
	1116	Intake Assistant	26,082	The Intake Assistant processes all referrals related to this program. These services include completeing all new admissions in a timely manner with the goal of opening the client. Any additional funds outside of Medi-Cal are used for this/these positions for non treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1117	Program Director	23,695	The Program Director oversees the program and the hiring, training and supervising of staff. When a staff takes leave, the program is not changed since it's already been accrued. Our Positions are based on class/step, some might be less and some might be more, all according to the person's experience and education when they come to work for Turning Point. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1118	Case Manager	26,972	The Case Managers provide services which will assist individuals in gaining access to needed medical, social, housing, economic, educational and other services as directed by the Program Director and Supervising PSC. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1119	Supervising Personal Services Coordinator	18,180	Provides supervision to all Substance Abuse Conselors, Case Managers and Intake Assistant to ensure client care, maintain compliance with Turning Point policies and procedures. Supervisor also assisting in training new staff and reporting to the Program Director. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1120	Substance Abuse Counselor	67,080	The Substance Abuse Counslor is responsible for the Substance Abuse Treatment services in accordance with program requirements and ADP licensing. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1121	Mental Health Professional	67,041	Provides mental health assessment, assessing for Medical Necessity, assists client in identifying treatment plan goals according to diagnosis. MHP also provides individual and group therapy as client requests, while also providing program support to assist clients in crisis. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
	1122	Nurse	7,025	Nurses work with the doctors for client care, maintaining compliance with Turning Point policies and procedures, providing training and ensuring accurate charting in accordance with Medi-cal. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	1123	-	-	
	1124	-	-	
	1125	-	-	
	1126	-	-	
	1127	-	-	
	1128	-	-	
	1129	-	-	
	1130	-	-	
	1131	-	-	
	1132	-	-	
	1133	-	-	
	1134	-	-	
Direct Employee Benefits			**79,688**	
	1201	Retirement	8,671	10-5940 Retirement: Cost of Agency contribution to employee retirement plans. These are non-treatment related costs.
	1202	Worker's Compensation	3,085	10-5930 Workers Compensation Insurance: Cost of workers compensation insurance. These are non-treatment related costs.
	1203	Health Insurance	36,110	10-5950 Health Insurance: Agency cost for health insurance including Vision. These are non-treatment related costs.
	1204	Dental Insurance	2,833	10-5960 Dental Insurance: Agency cost for dental insurance.
	1205	ACI	87	10-5990 Other Benefits: Agency cost for other wage related employee benefits. Theseare non-treatment related costs.
	1206	Accrued Paid Leave	28,902	10-5980 Accrued Paid Leave: The monetary value of staff Paid Leave hours as they accrue on a monthly basis. These are non-treatment related costs.
Direct Payroll Taxes & Expenses:			**26,473**	
	1301	OASDI	4,190	10-5910 F.I.C.A. (Federal Insurance Contributions Act): Employer portion of F.I.C.A. taxes charged to the Agency by the Internal Revenue Service. F.I.C.A. is comprised of "Old-Age, Survivors, and Disability Insurance" (OASDI), plus "Hospital Insurance" (Medicare). These are non-treatment related costs.
	1302	FICA/MEDICARE	18,064	10-5910 F.I.C.A. (Federal Insurance Contributions Act): Employer portion of F.I.C.A. taxes charged to the Agency by the Internal Revenue Service. F.I.C.A. is comprised of "Old-Age, Survivors, and Disability Insurance" (OASDI), plus "Hospital Insurance" (Medicare). These are non-treatment related costs.
	1303	SUI	4,219	10-5920 S.U.I. (State Unemployment Insurance): Employer portion of S.U.I. taxes charged to the Agency by the various states in which wages are paid. These are non-treatment related costs.
	1304	Other (specify)	-	
	1305	Other (specify)	-	
	1306	Other (specify)	-	

2000: DIRECT CLIENT SUPPORT			**136,950**	
	2001	Child Care	-	
	2002	Client Housing Support	120,000	10-7060 Client Housing Assistance: Cost of rent, housing assistance and deposit paid on behalf of client. (Examples: first/last month deposit, late fees, monthly rent, hotel charges, room & board, board & care, etc.)
	2003	Client Transportation & Support	500	10-7015 Client Transportation: Cost for client transportation. (Examples: bus tokens/passes, taxi, other public transportation, bicycles, etc.)
	2004	Clothing, Food, & Hygiene	1,000	10-7021 Client Clothing & Hygiene: Cost of client hygiene supplies and non-work related clothing. (Examples: clothes, shoes, hats, beanies, scarves, soap, toothpaste, deodorant, grooming supplies, hair accessories, diapers, etc.)
	2005	Education Support	-	
	2006	Employment Support	-	
	2007	Household Items for Clients	-	
	2008	Medication Supports	4,300	10-6122 Program Supplies-Medical: Cost of medical supplies to be used by staff or clients at the program location to meet program objective. Such items are to remain at the program location and not sent home with the client. Such items include, but are not limited to first aid kits, blood pressure monitor, latex gloves, syringes, hazard disposal service, sunblock, insect repellent, *over-the-counter medication/vitamins-if allowable per contract*, etc.
	2009	Program Supplies - Medical	-	
	2010	Utility Vouchers	-	

PROGRAM EXPENSE			
ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
2011	Client Activities/Recreation	1,000	10-7010 Client Activities/Recreation: Cost for client activities & recreation events. (Examples: cable bill, food/drinks/utensils/decorations needed for a specific client event, incentive rewards, cash reinforcer, admission fees to events, etc.)
2012	Client Testing Material	9,850	10-7140 Client Testing Material: Cost of U/A testing supplies, including breathalyzer, used to determine treatment required for clients.
2013	Client Food	300	10-6150 Food: Cost of food and drink to be consumed by the residents/clients. (Examples: Groceries to prepare onsite, outside food brought onsite, food/drinks for clients)
2014	Other (specify)	-	
2015	Other (specify)	-	
2016	Other (specify)	-	
3000: DIRECT OPERATING EXPENSES		**11,008**	
3001	Telecommunications	2,204	10-6340 Communications: Cost of electronic communications. (Examples: internet, phone, fax, cell phones, etc.) These are non-treatment related costs.
3002	Printing/Postage	706	10-6400 Postage: Cost of Agency postage and delivery. Including delivery by the U.S. Post Office, U.P.S., FedEx or other courier services. These are non-treatment related costs.
3003	Office, Household & Program Supplies	3,888	10-6110 Office Supplies: Cost of items normally used in an office setting. 10-6130 House Supplies: Cost of supplies used by staff during their scheduled work hours. These items are normally used to operate the building at the program location. These items are to remain at program location and not sent home with client. 10-6120 Program Supplies: Cost of any items normally used by clients or to directly benefit the clients to meet program objectives while receiving services. These items are to remain at the program location and not sent home with the client. 10-6243 General Supplies: Cost of items generally used by all at program's location. 10-6244 Janitorial Supplies & Services: Cost of items or services to maintain the esthetics of the premises. These are non-treatment related costs.
3004	Advertising	-	
3005	Staff Development & Training	1,957	10-6440 Staff Educational Expense: Cost of employee training courses and materials. (Examples: certification, training, books, etc.) *May include cost of room rental. These are non-treatment related costs.
3006	Staff Mileage	372	10-6060 Staff Mileage: Cost of employee mileage reimbursement paid in accordance with FPM section 1005. These are non-treatment related costs.
3007	Subscriptions & Memberships	106	10-6360 Dues & Subscriptions: Cost of membership dues and subscriptions. (Examples: magazine, newspaper, memberships, etc.) These are non-treatment related costs.
3008	Vehicle Maintenance	936	10-6030 Vehicle Insurance: Cost for vehicle insurance. 10-6040 Vehicle Fuel: Cost of gas in vehicles. 10-6050 Vehicle Maintenance: Cost of vehicle maintenance. Including cost of parts, supplies and labor associated with maintenance and repair of vehicles used by Agency programs. (Examples: repairs, battery, carwash *Includes: impounds) These are non-treatment related costs.
3009	Recruitment	692	10-6470 Recruitment: Cost of advertising and other employee recruitment expenses. (Examples: newspaper ad, urine screening, background check, etc.)
3010	Outreach & Engagement	147	10-6693 O & E Client Needs: Cost related to services and supplies used during outreach and engagement events/activities. These are non-treatment related costs.
3011	Other (specify)	-	
3012	Other (specify)	-	
4000: DIRECT FACILITIES & EQUIPMENT		**28,502**	
4001	Building Maintenance	80	10-6330 Building Maintenance: Cost of Agency building repairs and maintenance. (Examples: electrical work, A/C and heating, hood cleaning, plumbing, deadbolt, door knob/lock, keys, key tags, air/furnace filters, smoke alarm, co2 alarm, exit sign, blinds, etc.) This account should not be used if a specific outside labor contractor is doing an identifiable project, in this case use 6603, or projects over $2,000.00 that will require the procurement process and a WIP to be completed. These are non-treatment related costs.
4002	Rent/Lease Building	20,846	10-6320 Building Rent (Other): Cost of rent/lease payments made for building leases from outside sources. These are non-treatment related costs.
4003	Rent/Lease Equipment	519	10-6220 Furniture & Equipment Rent/Lease (Other): Cost of rent/lease payments made for furniture and equipment leases from outside sources. (Examples: high capacity copier/printer/scanner, washer/dryer, vending machine, furniture, water cooler, postage meter, etc.) These are non-treatment related costs.
4004	Rent/Lease Vehicles	-	
4005	Security	453	10-6390 Security: Cost of installation, maintenance and monthly service fees for building alarms and other security measures. (Examples: security/surveillance equipment, service and installation, safes, locks, padlocks, etc.) These are non-treatment related costs.

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
	4006	Utilities	5,819	10-6350 Utilities: Cost of service for power, gas, water, sewer, garbage, etc. These are non-treatment related costs.
	4007	Equipment Maintenance	626	10-6230 Equipment Maintenance: Cost of repair or maintenance of office/house equipment and furniture. (Examples: high capacity copier/printer/scanner, replacement parts such as hard drive, video card, adapter, laptop battery, monitor/printer/phone cord, cord covers, power strip, surge protector, extension cord, cable ties, drum, hose, filter, drawer slide set/rollers, keys for filing cabinet, etc.) These are non-treatment related costs.
	4008	Depreciation	159	10-8050 Depreciation: This account should be charged for the depreciation expense of the Agency's tangible assets. These are non-treatment related costs.
	4009	Other (specify)	-	
	4010	Other (specify)	-	

5000: DIRECT SPECIAL EXPENSES			20,934	
	5001	Consultant (Network & Data Management)	26	10-6115 Software & Computer Support: Cost of computer software and computer support. (Examples: Microsoft Office, QuickBooks, PDF converter, Avatar, Vipre anti-virus, LogMeIn, web filter, etc.) This account should not be used for the purchase of computers and related accessories. Computer accessories such as a mouse, keyboard and speakers must be coded to 6190. These are non-treatment related costs.
	5002	HMIS (Health Management Information System)	-	
	5003	Contractual/Consulting Services (Specify)	-	
	5004	Translation Services	-	
	5005	OS Labor Psychiatrist	17,604	These accounts are assigned to record various professional services provided by contracted Psychiatrist working as independent agents. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	5006	OS Labor Physician	3,304	These accounts are assigned to record various professional services provided by contracted Physician working as independent agents. Any additional funds outside of Medi-Cal are used for this/these positions for non-treatment and/or non-billable related costs to be able to continue to provide continuity of care.
	5007	Other (specify)	-	
	5008	Other (specify)	-	

6000: INDIRECT EXPENSES			85,859	
	6001	Administrative Overhead	-	
	6002	Professional Liability Insurance	2,277	10-6370 Insurance: Cost of Agency liability and property insurance. These are non-treatment related costs.
	6003	Accounting/Bookkeeping	-	
	6004	External Audit	346	10-6460 Audit Expense: Cost of outside audit fees. These are non-treatment related costs.
	6005	Insurance (Specify):	-	
	6006	Payroll Services	1,928	10-6482 Payroll Software & Support These are non-treatment related costs.
	6007	Depreciation (Provider-Owned Equipment to be Used	-	
	6008	Personnel (Indirect Salaries & Benefits)	-	
	6009	Licenses	5,384	10-6380 Licenses: Cost in obtaining and renewing licenses and permits. (Examples: Electronic Medical Records (EMR) database, kitchen/restaurant permit, fire clearance, facility inspections, vehicle registration, etc.) These are non-treatment related costs.
	6010	Indirect	75,924	10-9000's Indirect Allocated Costs. These are non-treatment related costs, amount includes indirect overhead cost for Fiscal, HR, IT, and Executive departments
	6011	Other (specify)	-	
	6012	Other (specify)	-	
	6013	Other (specify)	-	

7000: DIRECT FIXED ASSETS			5,965	
	7001	Computer Equipment & Software	$	-
	7002	Copiers, Cell Phones, Tablets, Devices to Contain HIPAA	-	
	7003	Furniture & Fixtures	2,583	10-6240 Expendable Furniture: Cost of small, inexpensive Agency property with a normal useful life generally less than one year or a value that is minor or insignificant, typically items with a total cost of less than $5000 per item. (Examples: small desk, portable desk, chair, filing cabinet, mail slots, shelving unit, table, foldable tables/chairs, bed, mattress, nightstand, room divider, etc. *Includes assembly fee) (For additional information, see procedures section 0900) These are non-reatment related costs.
	7004	Leasehold/Tenant/Building Improvements	-	
	7005	Other Assets over $500 with Lifespan of 2 Years +	-	
	7006	Assets over $5,000/unit (Specify)	-	

PROGRAM EXPENSE				
	ACCT #	LINE ITEM	AMT	DETAILED DESCRIPTION OF ITEMS BUDGETED IN EACH ACCOUNT LINE
	7007	Expendable Equipment	3,382	10-6190 Expendable Equipment: Cost of purchasing office/house equipment that has a cost less than $5000 per item. (Examples: electronic stapler/calculator/hole puncher, computer, monitor, keyboard, mouse, speakers and other computer accessories including mousepad and wrist pad, desk printer, tablet, tablet cover, lamp, desk lamp, fan, radio, television, phone, coffee machine, popcorn maker, toaster, refrigerator, dishwasher, washer, dryer, portable a/c unit, hand soap/hand towel dispenser, fire extinguisher, dolly, canopy, shed, barbecue, drill, etc.) These are non-treatment related costs.
	7008	Other (specify)	-	

TOTAL PROGRAM EXPENSE FROM BUDGET NARRATIVE:	**658,250**
TOTAL PROGRAM EXPENSES FROM BUDGET TEMPLATE:	658,250
BUDGET CHECK:	-