

COUNTY OF MARIN



**DEPARTMENT OF HEALTH AND HUMAN SERVICES
MARIN BEHAVIORAL HEALTH AND RECOVERY SERVICES**

**CONTRACTOR RENEWAL MANUAL
FY 2022-23**

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Introduction

Dear Substance Use Services Contracted Providers,

Enclosed please find the Marin County Division of Behavioral Health and Recovery Services' (BHRS) FY 2022-23 Contractor Manual, which has been developed to serve as a guide to orient you to the Division's various contract renewal requirements. As this Manual only includes the instructions and forms for the FY 2022-23 contract renewal process, please be sure to visit the [Contractor Resources](#) section of our website for fillable templates, links to relevant regulations, standards and policies, and a variety of additional resources related to billing, documentation and reporting. Many of the applicable regulations, resources and guidance can also be found in the newly-developed [Clinical Practice and Administrative Guidelines](#) document. Please also provide these links and relevant information from the Manual to key managers and staff within your organization.

All FY 2022-23 contract renewal materials—including Exhibits, insurance and required forms—are due to BHRS Contract Manager. It is the expectation that the Exhibits will be correct and final, so please ensure that you work with your designated County staff person in advance of the due date to discuss and review Exhibits.

For those of you providing Residential, Outpatient, OTP, Case Management and/or Recovery Services, and Sober Living Environment services, we are again this year developing Master contract agreements, so your contract manager will be outreaching to you to communicate the fee-for-service rates, finalize allocations and due dates for required documents within the next two weeks.

We appreciate the hard work, collaboration and passion that you and your staff continue to offer the residents of Marin.

Sincerely,

Catherine Condon, MPH
BHRS DIVISION DIRECTOR

Contract Renewal Submission Checklist

Contract Renewal Required Forms

Contract Exhibits

- Exhibit A - Master Agreement Scope of Work (For SLE and DMC-ODS Residential, Withdrawal Management, Outpatient, OTP/NTP, Case Management and Recovery Services Providers). *All other services shall follow the Exhibit A – Logic Model instructions.*
- Exhibit A - Supplemental Form (For DMC-ODS Providers)
- Exhibit A - Logic Model (For Prevention and other non-ODS Providers)
- Exhibit B - Revenue and Expense Summary
- Exhibit B - Budget Detail
- Exhibit B - Overall Agency Budget
- Exhibit C - Evidence of General and/or Professional Liability, Workers Compensation and Auto Insurance (and separate page with an Endorsement naming the County of Marin as an additional insured)

Forms

All Providers:

- Signature Authorization Form
- Assurances Regarding the No Unlawful Use of Drugs or Alcohol
- Certification of Smoking Prohibitions
- Certification of Non-Acceptance of Tobacco Funds
- Marin County Living Wage Ordinance Declaration
- Contract Authorization

DMC-ODS Treatment Providers: (When Applicable)

- Electronic Health Record User Agreement Form
- Assurance of Qualified Health Information System (EHR Attestation)

Prevention Providers:

- Certification of Compliance with the Strategic Prevention Framework

Documents

All Providers:

- Staff Certification and Training Log (Template Provided)
- Board Member List
- Cultural Competency – Compliance with CLAS Standards
- Indirect Rate Calculation/Description

DMC-ODS Providers:

- Sliding Scale Fee Schedule
- Published Charges
- Program Admission, Re-Admission and Exclusion Criteria
- List of Insurance Company Agreements
- ASAM Assessment Tool(s) – *If not using the County-provided tool*
- Copies of five (5) CEUs in Addiction Medicine for LHPAs from FY 2021-22
- Medical Director: Code of Conduct and Roles & Responsibilities

Policies/Protocols

Please submit a copy of each policy that has not been submitted to the SUD Administrative Team during Self Audit. Please contact your contract manager for the list of missing P&Ps.

All Providers

- Accessibility of Services Requirements
- Charitable Choice Requirements
- Compliance with OMB Circular A-133
- Continuing Education for Employees
- Cultural Competency
- Nondiscrimination

Primary Prevention Excluded:

- Utilization Review Procedure
- HIV/Early Intervention Services

All Treatment Providers:

- Electronic Health Records Usage
- Interim Services
- Provision of TB Services
- Priority Populations
- Re-Assessment and Transitions between levels of care
- Notice of Adverse Beneficiary Determinations
- Interpreter and Translation Services & Forms
- CalOMS Treatment/WITS
- Provider Credentialing
- License/Certification Tracking – Verification of NPPES, etc., Excluded Provider Checks (Monthly), Background Check/Live Scan, Privacy and Security (Training, Oath of Confidentiality, etc.)
- Credentialing Attestations (not a policy but still need to be attached)
- Medication Assisted Treatment (MAT)
- Medication Practices
- Client Relapse
- Financial Assessment Procedure and Form
- EBP Fidelity
- No Unlawful Use Messaging Regarding Drugs
- Medical Policies & Standards – with evidence of Medical Director developing/implementing

All Sober Living Environment (SLE) Providers

- House Rulebook
 - Rules, Regulations, Expectations, Governance Procedures of the House
 - Standards of Operation
 - House Rules
- Policies and Procedures Addressing the
 - Admission and Discharge
 - Confidentiality
 - Sexual Harassment and Verbal use
 - Weapons, Alcohol, Illegal Drugs and Illegal Activity
 - Prescribed Medication Policy
 - Drug and Alcohol Testing Protocol
 - Management and Staff Responsibilities
 - Documentation/Record Keeping/Financial Agreements

- Incident Reporting
- Accessibility of Service Requirements
- Cultural Competency
- Nondiscrimination

Instructions: Exhibit A and B Submission

Instructions for Submission of Exhibit A

Develop your work plan according to the guidelines set forth below.

EXHIBIT A – SCOPE OF WORK FOR TREATMENT AND DRUG/MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PROVIDERS

The Marin County Division of Behavioral Health and Recovery Services has developed a standardized Exhibit A - Scope of Work template for SLEs, Residential, Withdrawal Management, General Outpatient, Intensive Outpatient, OTP/NTP, Case Management and Recovery Services. For a copy of the Exhibit A – Scope of Work, visit: <https://www.marinbhhs.org/providers/substance-use-providers/contract-exhibits-and-templates>.

Contractors are required to complete a **Supplemental Exhibit A**, which includes information related to DMC-ODS provider requirements. One should be completed for each contract. BHRS can provide technical assistance related to any of the requirements.

EXHIBIT A - SCOPE OF WORK FOR NTP AND NON-DMC-ODS PROVIDERS

PLEASE TITLE ALL PAGES OF WORKPLAN “EXHIBIT A”

A. PROGRAM DESCRIPTION

Describe the types of services and activities provided by your agency. In your description, be sure to include the specific program design, as well as any methods and strategies that you feel are specific to the services of your agency.

B. LOGIC MODEL (OBJECTIVES, ACTIVITIES, OUTCOMES, DATA COLLECTION/CONTINUOUS QUALITY IMPROVEMENT)

Please use the following format for expressing your agency's/program's work plan. **Service Codes should be numerically identified either beside the objective and/or activity.** It is important that the service aligns with the correct service code as that is what will be used in the Cost Report to the State. A listing of service codes and Unit Definitions are included in the Resources section of the Contractor Manual.

In accordance with the Division's Standards and Practices, agencies shall strive to be tobacco-free and shall offer cessation services and support on site or by referral. Agencies will include steps they are taking toward becoming tobacco-free in their annual work scopes.

1. **Objective(s).** *Objectives are the specific, time limited, measurable, action oriented steps dedicated to achieving the outcome.*

Example: Eighty (80%) percent of clients admitted to treatment services will be engaged in treatment, as measured by receiving at least four treatment sessions within 30 days of admission.

Example: By June 30, 2020, Agency X will provide 200 units of outpatient individual sessions and 540 units to 15 clients. (Service Code 34)

2. **Activity(s).** *Activities are the specific processes, events and/or actions that are intentionally used to bring about the intended results.*

Examples:

- *Within 24 hours of admission, connect the client to a counselor or support staff.*
- *Provide each client with a welcoming orientation, establish clear two-way expectations, and assign a peer buddy.*
- *On an ongoing basis, identify clients at risk of leaving and barriers to continuation in treatment.*
- *Within 14 days of admission, establish an individual client-driven treatment plan*
- *Offer positive reinforcements for continuing in treatment.*

3. Expected Outcome(s). *Outcomes are the specific changes in a communities' or program participants' behavior, knowledge, skills, or level of functioning.*

Example: Fifty percent (50%) of clients admitted to services will successfully complete their treatment program.

4. Data Collection/Continuous Quality Improvement: *Include what **data collection instruments/tools** (e.g. WITS, Agency MIS, surveys) will be used to measure objectives and outcomes, as well as information on how the data will be used for **CQI**. For treatment providers – Include information about your agency's utilization review procedures in this section.*

For intervention providers, objectives **must reflect the unit of services** necessary to correlate with the State/County Contract process as follows:

- Staff hours for some Secondary Prevention and Ancillary Services;
- Early Intervention Sessions: Minimum of 50 minutes

EXHIBIT A – SCOPE OF WORK FOR PRIMARY PREVENTION PROVIDERS

Goals and Objectives should come directly from the 2020-2025 Continuum of Services Strategic Plan. The Strategic Planning documents can be found at <https://www.marinhhs.org/strategic-planning-2020-2025>.

FY 2022-23 Objectives, Outcomes and Activities should be created by contract providers and refer to specific, measurable and time-limited activities and their concrete and measurable outcomes that will take place between July 1, 2022 and June 30, 2023. These sections of the Exhibit A are referenced with the word “PROVIDER” in the requisite columns.

Technical assistance is available from the Prevention Coordinator at (415) 473-6756.

REQUESTING CONTRACT CHANGES TO EXHIBIT A

If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:

Scope of Work

- Proposing to re-distribute units of service between existing service codes by more than 20%
- Proposing to add or remove a service modality
- Proposing to transfer substantive programmatic work to a subcontractor
- Proposing to provide any services by telephone or field-based

Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures (www.MarinHHS.org/policies-procedures), including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

Instructions for Submission of Exhibit B

Excel Budget sheets have been provided in order that specific details of both your composite and program budgets are included. It is imperative that all contractors provide budget details which establish clear audit trails and are consistent and uniform throughout the delivery system. **Please use the enclosed templates, which already include the correct formulas, in developing your budget documents.**

Please identify each budget page as "Exhibit B".

BUDGET DETAIL EXPENDITURES - FOR ALL PROVIDERS (FORM PROVIDED)

Please make sure to insert the name of the service modality(ies) and service codes being provided under your contract with the Division. Replace the words "Service Modality" in each column with the Name and Service Code number assigned to or chosen by your organization. **It is important that the applicable State service code is listed as that it what will be used in completing and submitting the Cost Report to the State.** Please then fill-in Salary, Services & Supplies and Indirect costs that reflect actual projected expenses within each service code area. Please ensure that all budgeted expenditures are identified under each contracted service modality.

Items listed under Facilities, Services and Supplies are only a sample of what may or may not be included at your agency. Please identify all that are appropriate for your agency.

	A	B	C	D	E
1	EXHIBIT B				
2	BUDGET DETAIL				
3	July 1, 2007 - June 30, 2008				
4	Contractor:				
5					
6	Contract Services:				
7					
8		Service Modality	Service Modality	Service Modality	Total
9	Salaries, Wages & Bene				
10					\$0
11					\$0
12					\$0
13					\$0
14					\$0
15					\$0
16					\$0
17					\$0
18					\$0
19					\$0
20					\$0
21					\$0
22	Sub-Total				\$0
23	Employee Benefits				\$0
24	Total of Salaries & Benefits				\$0
25	Services & Supplies				
26					
27	Office Supplies				\$0
28	Printing/Copying				\$0
29	Postage				\$0

REVENUE AND EXPENSE SUMMARY (FORM PROVIDED)

This page includes, at a minimum, Total Expenses and Total Revenues (inclusive of alcohol/drug and all other funding streams, including client fees, private pay and insurance) that are applied to the various programs funded by the County office. This page also includes the total number of contracted units, the unit description (e.g., Staff hour, visit days, bed day, etc.) and both the Gross and Net Unit rates under each contracted service.

To complete this form, enter the total expenses, revenue and funding source breakdown applied to each service modality for the contract. Note that the total expenses must be equal to the total revenue (BHRS contract funds and other funds). Similarly, the totals of the funding source breakdown must also equal the total expenses and revenue.

REVENUE & EXPENSE SUMMARY

July 1, 2008 - June 30, 2009

Contractor:

Contract Services:

Total Budget	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	Total
Salaries & Wages							\$0.00
Services & Supplies							\$0.00
Indirect Expenses							\$0.00
Total Expenses	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Participant Fees							\$0.00
Other Revenue							\$0.00
Net Contract Amount	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Funding Source Breakdown:

<i>Enter the Funding Source Here</i>							
							\$0.00
							\$0.00
							\$0.00
Total Funds Required:	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Units of Service:

Unit Description						
<i>Enter Unit Description Here</i>						
<i>Enter Unit Description Here</i>						
<i>Enter Unit Description Here</i>						

Contract No. ADP-AD-08-09

Provider No.

Then enter the total units of service provided for each service modality.

Unit rates are standardized and should not be rounded. You may add partial units for contracting purposes. However, units must be billed as a whole number unless based on a staff hourly rate.

The gross and unit rates will automatically calculate as these forms contain pre-populated formulas. Please make sure to fill in the service modalities, service codes (e.g. individual counseling,

26	Units of Service:						
27	Unit Description						
28	<i>Enter Unit Description Here</i>						
29	<i>Enter Unit Description Here</i>						
30	<i>Enter Unit Description Here</i>						
31							
32							
33							
34							

education, group counseling, etc.) and unit descriptions (e.g. bed day, staff hour, etc.) on all of the forms.

Prevention Providers: Please note that if you do not report staff hours, you may leave page 2 blank.

OVERALL AGENCY BUDGET – FOR ALL PROVIDERS

Please provide an overall agency budget showing all sources of projected revenue and expenditures within your agency. Demonstrate how the alcohol and drug program revenue(s) fit into the overall agency budget.

INDIRECT COSTS – FOR ALL PROVIDERS

Provide your agency's indirect rate and a detailed description of what is included in calculating the indirect rate. Indirect rates cannot exceed 15% of personnel and direct costs. If your agency has a federally-approved indirect rate, use that rate in your Exhibit B documents and attach a copy of the documentation with your contract renewal materials.

PROPOSED CONTRACT BUDGET CHANGES – FOR ALL PROVIDERS

If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:

Budget

- Proposing to re-distribute more than 20% between budget categories
- Proposing to increase or decrease FTE
- Proposing to increase the contract maximum

Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures (www.MarinHHS.org/policies-procedures), including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

Templates: Exhibit A and B

Exhibit A Supplement– Substance Use DMC-ODS Providers

Overview of FY 2022-23 Service Capacity

ASAM Level of Care	Total Projected Units of Service <i>(Units =15- minutes)</i>	Unit Rate* <i>(Unit = 15- minutes)</i>	Total – Contract Maximum**
Total: Marin Drug/Medi-Cal			
Total: Marin Low Income Uninsured			
Total			

ASAM Level of Care	Total Projected Units of Service <i>(Units =15- minutes)</i>	Unit Rate* <i>(Unit = 15- minutes)</i>	Total – Contract Maximum**
Total: Marin Drug/Medi-Cal			
Total: Marin Low Income Uninsured			
Total			

****Should the demand for *Marin Medi-Cal beneficiaries* exceed contracted capacity, contact your contract manager to discuss a contract amendment.**

Source of funds for the contract may include Federal Drug/Medi-Cal, 2011 Realignment (Behavioral Health Subaccount), State General Funds, Probation funds, County General Funds

Evidence-Based Practices

Indicate which of the following evidence-based practices (EBPs) will be used to deliver contracted services and describe how you will assess implementing with fidelity (e.g. include a description of tools/methods used, frequency of assessing fidelity, etc.) to the EBPs? Note that DMC-ODS providers are required to implement at least two (2) of the below EBPs.

Evidence-Based Practice	Implementation Plan to Ensure Fidelity
<input type="checkbox"/> Motivational Interviewing	
<input type="checkbox"/> Cognitive Behavioral Therapy	
<input type="checkbox"/> Relapse Prevention	
<input type="checkbox"/> Trauma-Informed Treatment	
<input type="checkbox"/> Psycho-Education	

Provision and/or Linkage to Medication Assisted Treatment

1. What procedures does your organization use to: 1) identify whether a client is appropriate for a MAT assessment; and 2) link them to MAT? If your agency does not provide MAT, list the provider(s) you intend to refer clients to for a MAT assessment/treatment.

Medi-Cal Eligibility Verification

1. Describe your process—including position(s) responsible and method (e.g. POS device, Medi-Cal website, telephone, etc.)—used to check and verify Medi-Cal eligibility on a monthly basis.
2. If a client is uninsured, describe your process—including the position(s) responsible and timeframes—for linking the client to Medi-Cal, Covered California or other resources for obtaining health insurance.

Linkage to Care Coordination, Mental Health and Physical Health

	Mental Health	Physical Health
Explain your agencies procedure for providing beneficiaries the contact information for their assigned Care Coordinator (ex: form with contact info and business hours, included on tx plan, provide business card and document in progress note, etc.)		
List the screening tools used		
Is there a question at intake asking the client if they have a mental health/primary care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you request releases/consents to exchange information with identified mental health/primary care providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the process used for coordinating care, including the position(s) responsible.		
Describe the process, including the position(s) responsible, used for assisting the client access a mental health/primary care provider, as appropriate.		

Exhibit A – Substance Use Residential Treatment DMC-ODS Providers

Overview of FY 2022-23 Service Capacity

* The unit rate reflects the total rate – DMC will only be claimed for the treatment costs (not Room & Board)

Should the demand for **Marin Medi-Cal beneficiaries exceed contracted capacity, contact your

ASAM Level of Care	Contracted Capacity (Beds)	Total Projected Units of Service (Unit = Bed Day)	Unit Rate* (Unit = Bed Day)	Total – Contract Maximum**
Total: Marin Drug/Medi-Cal				
Total: Marin Low Income				
Uninsured				
Total ASAM Level of Care	Contracted Capacity (Beds)	Total Projected Units of Service (Unit = Bed Day)	Unit Rate* (Unit = Bed Day)	Total – Contract Maximum**
Total: Marin Drug/Medi-Cal				
Total: Marin Low Income				
Uninsured				
Total				

contract manager to discuss a contract amendment.

Source of funds for the contract may include Federal Drug/Medi-Cal, 2011 Realignment (Behavioral Health Subaccount), State General Funds, Probation funds, County General Funds

Evidence-Based Practices

Indicate which of the following evidence-based practices (EBPs) will be used to deliver contracted services and describe how you will assess implementing with fidelity (e.g. include a description of tools/methods used, frequency of assessing fidelity, etc.) to the EBPs? Note that DMC-ODS providers are required to implement at least two (2) of the below EBPs.

Evidence-Based Practice	Implementation Plan to Ensure Fidelity
<input type="checkbox"/> Motivational Interviewing	
<input type="checkbox"/> Cognitive Behavioral Therapy	
<input type="checkbox"/> Relapse Prevention	
<input type="checkbox"/> Trauma-Informed Treatment	
<input type="checkbox"/> Psycho-Education	

Provision and/or Linkage to Medication Assisted Treatment

2. What procedures does your organization use to: 1) identify whether a client is appropriate for a MAT assessment; and 2) link them to MAT? If your agency does not provide MAT, list the provider(s) you intend to refer clients to for a MAT assessment/treatment.

Medi-Cal Eligibility Verification

- 3. Describe your process—including position(s) responsible and method (e.g. POS device, Medi-Cal website, telephone, etc.)—used to check and verify Medi-Cal eligibility on a monthly basis.

- 4. If a client is uninsured, describe your process—including the position(s) responsible and timeframes—for linking the client to Medi-Cal, Covered California or other resources for obtaining health insurance.

Linkage to Mental Health and Physical Health

	Mental Health	Physical Health
List the screening tools used		
Is there a question at intake asking the client if they have a mental health/primary care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you request releases/consents to exchange information with identified mental health/primary care providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the process used for coordinating care, including the position(s) responsible.		
Describe the process, including the position(s) responsible, used for assisting the client access a mental health/primary care provider, as appropriate.		

Telehealth [To be completed by Providers utilizing telehealth]

- 1. Describe how your telehealth services will be structured and how confidentiality will be maintained.

SCOPE OF WORK
Agency/Coalition Name

Exhibit A
Scope of Work
July 1, 2022 – June 30, 2023

Objective #1: SMART FORMAT (Specific, Measurable, Achievable, Relevant and Timed)

Activities	Person(s) Responsible	Timeline	Deliverables/Metrics	Service Code (12, 14, 16, 17)
A.				
B.				
C.				

Objective #2:

Activities	Person(s) Responsible	Timeline	Deliverables/Metrics	Service Code (12, 14, 16, 17)
A.				
B.				
C.				

Objective #3:

Activities	Person(s) Responsible	Timeline	Deliverables/Metrics	Service Code (12, 14, 16, 17)
A.				
B.				
C.				

BUDGET DETAIL

July 1, 2022 - June 20, 2023

Contractor: _____

Program Name: _____

	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	Total
	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	
Salaries, Wages & Benefits							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
Sub-Total	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Employee Benefits							\$0
Total of Salaries & Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Services & Supplies							
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
Total Services & Supplies	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Indirect Costs							
Indirect Costs @ X %							\$0
TOTAL EXPENSE	\$0	\$0	\$0	\$0	\$0	\$0	\$0

**EXHIBIT B
REVENUE & EXPENSE SUMMARY**

July 1, 2022 - June 20, 2023

Contractor: _____
Contract Services: _____

Total Budget	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	Total
	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	
Salaries & Wages	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Services & Supplies	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Indirect Expenses	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total Expenses	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Participant Fees							\$0.00
Other Revenue							\$0.00
Net Contract Amount	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Funding Source Breakdown:

<i>Enter the Funding Source Here</i>							\$0.00
							\$0.00
							\$0.00
Total Funds Required:	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Units of Service:

Unit Description

<i>Enter Unit Description Here</i>						
<i>Enter Unit Description Here</i>						
<i>Enter Unit Description Here</i>						

Contract No. BHRS-SUS-____-22-23

Provider No. _____

EXHIBIT B

REVENUE & EXPENSE SUMMARY

July 1, 2022 - June 20, 2023

Contractor: _____

Contract Services: _____

Gross Unit Rates:

Unit Description	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>	<i>Enter Service Modality Here</i>
	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	<i>Enter Service Code</i>	
<i>Enter Unit Description Here</i>	#DIV/0!					
<i>Enter Unit Description Here</i>		#DIV/0!				
<i>Enter Unit Description Here</i>			#DIV/0!			
				#DIV/0!		
					#DIV/0!	
						#DIV/0!

Net Unit Rates:

<i>Enter Unit Description Here</i>	#DIV/0!					
<i>Enter Unit Description Here</i>		#DIV/0!				
<i>Enter Unit Description Here</i>			#DIV/0!			
				#DIV/0!		
					#DIV/0!	
						#DIV/0!

Contract No. BHRS-SUS-____-22-23

Provider No. _____

Instructions: Submission of Other Contract Renewal Documents

Instructions for Submission of Other Materials Required For Contract Renewal

TO BE COMPLETED BY ALL PROVIDERS:

Staff Certification and Training List – For All Treatment Providers (Template Provided)

Provide a list of current staff affiliated with contracted services that includes, but not limited to:

- Last Name
- First Name
- Gender
- Ethnicity/Race
- National Provider ID (NPI) Number
- Language Spoken (other than English), please note fluency level: certified, fluent, good, fair or poor
- Position/Title
- FTE/Salary
- Start Date
- License/Registration/Certification Number
- Issue Date
- Expiration Date
- Licensing/Certification Body
- Excluded Provider Check Date (Most Recent)
- Cultural Competency Training (Required Annually, 4 hours)
- Oath of Confidentiality (Required at Hire and Annually Thereafter)
- Information Privacy & Security Training (42 CFR & HIPAA/Law & Ethics, Required Annually)
- ASAM E-Training 1 & 2 (Required Prior to Conducting Assessments)
- CPR & First Aid Training (Required for Withdrawal Management Only)
- HIV/AIDS Training
- CalOMS Treatment Training (Required at Hire and As Need Thereafter)
- Continuing Education to Addiction Medicine (Required for LPHA & Medical Director, 5 hours Annually)
- PPSDS Training (Required for Prevention Only)

Board Member List

Provide an updated roster of your Board of Directors and, if appropriate, your Advisory Board, that includes:

- Name
- Address
- Occupation
- Gender and Ethnicity
- Position held on Board
- Affiliations

Contract Authorization Form

Submit a certified copy of a resolution of the Board of Directors authorizing that the Executive Director (include name) of your agency, is duly authorized to execute and deliver the Contract Agreement on behalf of the agency, in accordance with the resolution or the bylaws of the

agency, and that the Contract Agreement is binding upon the agency in accordance with its terms. This resolution must be passed annually as previously passed resolutions cannot be interpreted as binding for the current year. Sample language is provided in this document under the forms labeled “Contract Authorization”.

Signature Authorization Form (Form Provided)

Complete the attached Signature Authorization Form. Include all names and signatures of persons who are authorized to sign documents, including invoices, for your agency. Monthly invoices that are signed by persons not listed on the Signature Authorization Form cannot be reimbursed.

Assurance of “No Unlawful Use of Drugs or Alcohol” (Form Provided)

The authorized signatory must read, complete and sign the assurance of No Unlawful Use of Drugs or Alcohol form.

Certification of Smoking Prohibitions (Form Provided)

The authorized signatory must read, complete and sign the certification of Smoking Prohibitions form.

Acknowledgement of Contract Compliance Policy (Form and Policy Provided)

The authorized signatory must read, complete and sign the acknowledgement of Contract Compliance Policy. Please note that **all billing invoices and reports that are not received by the prescribed due dates will result in a delay of payment until the following month.** A copy of the Policy can be found in with the Acknowledgement of Contract Compliance Form.

Insurance

All insurance policy(ies) must confirm to the limits outlined in the County contract and be valid for the duration of the contract period. Provide a copy of the following insurance documents for your agency:

- General Liability Insurance
 - A separate endorsement indicating the “County of Marin” as the “Additional Insured”
- Automobile Liability Insurance
- Workers Compensation
- **NEW:** In addition to the insurance requirements in the Professional Services Contract, substance use disorder recovery or treatment facilities licensed by DHCS shall also maintain professional liability and errors and omissions insurance that includes an endorsement for contractual liability, with minimum coverage amounts of one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) aggregate. If applicable, the contract shall include an endorsement for defense and indemnification of any government entity with which the licensee has contracted. [DHCS BHIN 22-023; HSC 11834.10]

Living Wage Ordinance (Form Provided)

The Marin County Living Wage Ordinance (LWO) incorporates an automatic Cost of Living Adjustment (COLA) component every January 1. All LWO-applicable contractors must sign and return the declaration with the completed contract renewal documents.

Certification of Non-Acceptance of Tobacco Funds (Form Provided)

All providers are required to certify they will not accept funding from nor have an affiliation or contractual relationship with a tobacco company, and of its subsidiaries or parent company during the term of the grant from the Marin County Behavioral Health and Recovery Services Division.

Cultural Competency

Provide a description of how your agency meets the CLAS standards and ensures access to and provision of culturally sensitive services. Also be sure to include your agency’s capabilities to provide oral interpreter and translation services (free of charge to the beneficiary) and offer services in languages other than English (specific which language).

Indirect Rate

Provide your agency’s indirect rate and a detailed description of what is included in calculating the indirect rate. Indirect rates cannot exceed 15% of personnel and direct costs. If your agency has a federally-approved indirect rate, use that rate in your Exhibit B documents and attach a copy of the documentation with your contract renewal materials.

To BE SUBMITTED BY PRIMARY PREVENTION PROVIDERS

Certification of Compliance with Strategic Prevention Framework (Form Provided)

The authorized signatory must read, complete and sign the certification of compliance with Strategic Prevention Framework.

To BE SUBMITTED BY TREATMENT PROVIDERS

Schedule of Published Charges and Proposed Sliding Scale Fee Schedule

Provide a copy of the agency’s Board-approved Published Charges for FY 2022-23 and the sliding scale fee schedule that your agency is proposing to use to determine a client’s fees. This must be reviewed and approved by Catherine Condon, County Alcohol and Drug Administrator, prior to contract approval.

Program Admission, Re-Admission and Exclusion Criteria

Provide a current description of each program(s) admission and re-admission criteria, as well as any exclusion criteria. Re-admission criteria should include, if applicable, any waiting period for participants who were discharged from your program(s).

Policy Regarding Use of Medication(s)

Provide a copy of the agency's current policy regarding the use of medication(s) by participants in your program(s).

Policy Regarding Client Relapse

Provide a copy of the agency's current policy, procedures, and dispositions for clients who relapse during treatment.

Recovery Support Services

Procedures and/or protocols to access and/or provide ancillary and peer support services. Procedures should also include how all clients are linked to Recovery Support Services upon discharge from treatment.

Financial Assessment

Provide a copy of the agency's procedures (and the forms utilized) to assess whether a client may be eligible for Medi-Cal or other insurance, and if so, a copy of the procedures your agency takes to link a client with Eligibility.

Utilization Review Protocol and Template(s)

Provide a copy of the agency's protocol—including timeframes and percentage of charts reviewed—and forms for performing chart reviews.

Medical Necessity

Provide a copy of the agency's protocol, criteria and template(s) for documentation for determining medical necessity. The criteria must align with ASAM criteria for determining medical necessity.

Insurance Company Agreements

Provide a list of the insurance companies and the term of agreement (length of agreement) that the agency has a formal MOU or contract with for billing for substance use and/or mental health treatment services.

Linking Clients to MAT

Provide a copy of the agency's protocol on how clients are being identified and when appropriate linked to Medicated Assisted Treatment (MAT).

Transitioning Clients Between Levels of Care

Provide a copy of the agency's protocol on re-assessing clients (which should be at least every 30-45 days for Residential treatment and at least every 90 days for Outpatient) and when appropriate, transitioning between different Levels of Care, including staff roles and timeframes.

Oral Interpretation and Translation Services

Provide a description of how the agency is meeting the requirement of providing access to Oral Interpretation and Translation Services free of charge to clients when necessary. Also include a copy of the Agreement with the entity providing oral interpreter services.

Electronic Health Record User Agreement Form

This Agreement governs the rights, duties, and responsibilities of County of Marin- Health & Human Services staff and contract providers in the use of an electronic signature in Marin WITS. Ensure that a current form is on file for any authorized WITS user.

Assurance of Qualified Health Information System (EHR Attestation)

The attestation ensures agency understand that all client health information that is stored or transmitted electronically must be within a qualified Health Information System (HIS).

ASAM Tool

Provide a copy of the agency’s ASAM Assessment tool(s). If your agency uses the County-provided tool, then indicate that and do not attach a copy.

Client Coordination for Mental Health and Physical Health

Provide a copy of the agency’s current policy/protocol describing how care is coordinated and documented with Mental Health and Physical Health providers, as appropriate.

Notifying County of Marin of NOABDs

Provide a copy of the agency’s policy/protocol for notifying the County of Marin of any issue that may require the County to issue a Notice of Adverse Benefit Determination (NOABD).

Copies of Continuing Education Units in Addiction Medicine for LPHAs for FY 2022-23

Submit copies of the minimum of five (5) CEUs annually for all LPHAs providing services as part of the DMC-ODS program.

Medical Director Code of Conduct and Medical Director Roles & Responsibilities

Refer to the Practice Guidelines for specific information on what should be in the documents. The Code of Conduct and Roles & Responsibilities documents shall be signed and dated by the physician and a provider representative.

Copies of Policies and Standards Developed by the Medical Director

Submit any policies and standards developed and implemented by the Medical Director. Include evidence that the Medical Director developed and implemented a medical policy and standard, which can include the policies being signed and dated by the Medical Director and a program representative.

To BE SUBMITTED BY SOBER LIVING ENVIRONMENT PROVIDERS

House Rulebook

Policies and Procedures that address the following:

(Please include, unless the documents were already submitted with the Self-Audit Report.)

1. Confidentiality
2. Sexual Harassment & Verbal Abuse
3. Weapons, Alcohol, Illegal Drugs and Illegal Activity
4. Prescribed Medication Policy
5. Drug and Alcohol Testing Protocol
6. Management and Staff Responsibilities
7. Documentation/Record Keeping/Financial Agreements
8. Incident Report Policy

Forms/Templates: Submission of Other Contract Renewal Documents

For your reference we have attached copies of the below forms:

- Contract Authorization
 - Sample Contract Authorization Language Contract Compliance Policy
- Signature Authorization Form
- Assurances Regarding No Unlawful Use of Drugs or Alcohol
- Certification of Smoking Prohibitions
- Compliance with the Living Wage Ordinance
- Certification of Non-Acceptance of Tobacco Funds
- Electronic Health Record User Agreement Form
- Assurance of Qualified Health Information System
- Certification of Compliance with the Strategic Prevention Framework
- Staff Certification and Training Log

{AGENCY NAME}

BOARD OF DIRECTORS

RESOLUTION-

Contract Authorization

This resolution of the Board of Directors of {Agency} certifies and authorizes the Executive Director, _____ to execute and deliver any and all contract agreements on behalf of {Agency} including any County of Marin contracts. The Board recognizes the contract agreement is binding upon the agency in accordance with its terms for FY 2022-2023.

President

Date

SAMPLE

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

**Signature Authorization Form
FISCAL YEAR FY 2022-23**

AGENCY NAME: _____

EXECUTIVE DIRECTOR: _____

(Print or Type)

(Signature)

CHAIRPERSON,

BOARD OF DIRECTORS: _____

(Print or Type)

(Signature)

NAME: (Print or Type)

SIGNATURE

This form supersedes and voids all other authorization forms for the agency identified above. The Executive Director or the Chairperson of the Board of Directors are the only individuals authorized to sign contracts between the identified agency and the County of Marin. Other individuals designated above are authorized to sign agency invoices on behalf of the Executive Director.

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Assurances Regarding the No Unlawful Use of Drugs or Alcohol

Consistent with the requirements of California Health and Safety Code, Division 10.5, Sections 11999 through 11999.3 (SB 1377), Statutes of 1989, Chapter 1429, and on behalf of _____ (official program name) the undersigned person does hereby assure that:

1. He or she understands the requirements of Section 11 999.2 which states:

(a) Notwithstanding any other provision of law, commencing July 1, 1990, no state funds shall be encumbered by a state agency for allocation to any entity, whether public or private, for a drug or alcohol-related program, unless the drug- or alcohol-related program contains a component that clearly explains in written materials that there shall be no unlawful use of drugs or alcohol. No aspect of a drug- or alcohol-related program shall include any message on the responsible use, if the use is unlawful of drugs or alcohol.

(b) All aspects of a drug- or alcohol-related program shall be consistent with the "no unlawful use" message, including, but not limited to, program standards, curricula, materials, and teachings. These materials and programs may include information regarding the health hazards of use of illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive concepts consistent with the "no unlawful use" of drugs and alcohol message.

(c) The "no unlawful use" of drugs and alcohol message contained in drug- or alcohol-related programs shall apply to the use of drugs and alcohol prohibited by law.

(d) This section does not apply to any programs funded by the state that provides education and prevention outreach to intravenous drug users with AIDS or AIDS-related conditions, or persons at risk of HIV-infection through intravenous drug use.

2. He or she has reviewed those aspects of the program to which Section 11999.2 applies, and

3. Those aspects of the program to which Section 11999.2 applies meet the requirements of Section 11999.2

Printed Name:

Original Signature*

Title

Date

* Note: This form must be signed by the person responsible for operating a drug- or alcohol-related program.

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Certification of Smoking Prohibitions

Company/Organization Name

The grantee named above hereby agrees to comply, and require that any subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18 if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee.

CERTIFICATION

I, the official named below, hereby swear that I am duly authorized legally to bind the contractor or grant recipient to the above described certification. I am fully aware that this certification, executed on the date below, is made under penalty of perjury under the laws of the State of California.

Director of Agency or Authorized Signatory:

Signature

Date

Print Name and Title

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Certification of Non-Acceptance of Tobacco Funds

Company/Organization Name

The applicant named above hereby certifies that it will not accept funding from nor have an affiliation or contractual relationship with a tobacco company, and of its subsidiaries or parent company during the term of the grant from the Marin County Behavioral Health and Recovery Services Division.

CERTIFICATION

I, the official named below, hereby swear that I am duly authorized legally to bind the contractor or grant recipient to the above described certification. I am fully aware that this certification, executed on the date below, is made under penalty of perjury under the laws of the State of California.

Director of Agency or Authorized Signatory:

Signature

Date

Print Name and Title



Marin County Living Wage Ordinance Declaration

What the Ordinance does. For new, continued, extended or otherwise amended contracts beginning January 1, 2021, the Living Wage Ordinance (LWO) requires County contractors and subcontractors to provide the following to their employees covered by the Ordinance on County contracts and subcontracts for direct services: (1) wages of at least **\$14.10** per hour with health benefits; or (2) the payment of at least **\$16.00** per hour if no health benefits are provided.

These rates may be adjusted annually, effective the 1st of each January, to reflect the increase during the preceding year in the Consumer Price Index for all urban consumers in the San Francisco-Oakland-San Jose area, as published in October by the U.S. Department of Labor, Bureau of Labor Statistics. New, continued, extended or otherwise amended contracts are required to incorporate the living wage in effect at the time of the contract change.

The LWO applies only if you have in excess of \$25,000 in cumulative annual business with a County department or departments. The County may require contractors to submit reports on the number of employees affected by the LWO, and may require at any time that contractors furnish to the County for services rendered a certification(s), under penalty of perjury, that the contractor and any subcontractor is in full compliance with the provisions of the LWO.

Effect on County of Marin contracting. For contracts and amendments signed on or after **January 1, 2022**, the LWO has the following effect:

- In each contract, the contractor will agree to abide by the LWO and to provide its employees the minimum benefits the LWO requires, and to require its subcontractors subject to LWO to do the same.
- If a contractor does not provide the LWO's minimum benefits, the County can award a contract to that contractor **only if** the contract is exempt under the LWO, or if the contract has received an approved waiver. The contract will not contain the agreement to abide by the LWO if there is an exemption or waiver on file.

What this form does. If you can assure the County that, beginning with the first County contract or amendment you receive after **January 1, 2022**, and until further notice, you will provide the minimum benefit levels specified in the LWO to your covered employees, and will ensure that your subcontractors also subject to the LWO do the same, this will help the County's contracting process.

For more information, (1) see our Website, including the complete text of the ordinance: www.marincounty.org/lwo, (2) e-mail us at: tsmith@marincounty.org , or (3) phone us at (415)473-6358.

Routing. Return this form to the County department that sent it to you.

DECLARATION

In order to be a certified vendor with the County of Marin, this company will provide, if applicable, the minimum benefit levels specified in the LWO to our Covered Employees, and will ensure that our subcontractors also subject to the LWO do the same, until further notice. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Signature

Company

Federal Employer ID
Number

Print Name

County Vendor Number
(if known)

Date

Phone Number

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Electronic Health Record User Agreement Form

MARIN WITS ELECTRONIC SIGNATURE AGREEMENT

This Agreement governs the rights, duties, and responsibilities of County of Marin- Health & Human Services staff and contract providers in the use of an electronic signature in Marin WITS. A Marin Wits is comprised of user's unique user name, password and pin. The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is stolen, lost, compromised, unaccounted for, or destroyed. I agree to the following terms and conditions:

I will use my electronic signature to establish my identity and sign electronic documents and forms. I am solely responsible for protecting my electronic signature. If I suspect or discover that my electronic signature has been stolen, lost, used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Behavioral Health and Recovery Services Director or his/her designee and request that my electronic signature be revoked. I will then immediately cease all use of my electronic signature. I agree to keep my electronic signature secret and secure by taking reasonable security measures to prevent it from being lost, modified or otherwise compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored.

I will immediately request that my electronic signature be revoked if I discover or suspect that it has been or is in danger of being lost, disclosed, compromised or subjected to unauthorized use in any way. I understand that I may also request revocation at any time for any other reason.

If I have requested that my electronic signature be revoked, or I am notified that someone has requested that my electronic signature be suspended or revoked, and I suspect or discover that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Requestor Signature _____	NPI _____
Requestor Printed Name _____	
Approver Signature _____	Date _____
Title _____	_____
County Signature _____	Date _____
Title _____	

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Assurance of Qualified Health Information System

Agency/Organization Name

As the duly authorized representative of the agency/organization named above, I understand that all client health information that is stored or transmitted electronically must be within a qualified Health Information System (HIS). I certify that my agency uses:

_____ MarinWITS as our only HIS system. We do not collect, store or transmit e-PHI (i.e. diagnosis, treatment notes or plans, or services rendered) in any other system.

_____ MarinWITS and _____ (name of HIS) a product of _____ (vendor) which meets the following criteria:

- a. Has a unique log-in and password as well as specific permissions set for each user.. Ref: HIPAA Requirement: Access Control. A covered entity must implement technical policies and procedures that allow only authorized persons to access electronic protected health information (e-PHI).²⁴
- b. Has a protected access log that records any access to the system and an audit log for access to client information for clinical or billing purposes. Ref: HIPAA Requirement: Audit Controls. A covered entity must implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI.²⁵
- c. Has safeguards to ensure information cannot be erased, altered or destroyed ref: HIPAA Requirement: Technical Safeguards Integrity Controls. A covered entity must implement policies and procedures to ensure that e-PHI is not improperly altered or destroyed. Electronic measures must be put in place to confirm that e-PHI has not been improperly altered or destroyed.²⁶
- d. Meets the Transmission Security HIPAA requirement: Transmission Security. A covered entity must implement technical security measures that guard against unauthorized access to e-PHI that is being transmitted over an electronic network.²⁷
- e. Meaningful Use/ 42 CFR Requirements: handles client amendments to a record.
- f. Logs users off after a specified period of inactivity.
- g. Permits an identified set of users to access electronic health information during an emergency.
- h. Tracks disclosures of PHI.
- i. Can generate an electronic copy of a client's record.

Director of Agency or Authorized Signatory:

Signature

Date

Print Name and Title

**MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION**

Certification of Compliance with Strategic Prevention Framework

Company/Organization Name

The grantee named above hereby agrees to comply, and require that any subcontractors comply, with Prevention Business Practices, as outlined in the California Department of Alcohol and Drug Program's Net Negotiated Amount Contract with the County of Marin and set forth below.

Prevention is defined as strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic alcohol, tobacco, and other drug (ATOD) availability, manufacture, distribution, promotion, sales, and use. The desired result is to promote safe and healthy behaviors and environments for individuals, families, and communities.

Not less than 20 percent of the Substance Abuse Prevention and Treatment (SAPT) Block Grant must be spent on "primary prevention" for individuals who do not require treatment for substance abuse as described in the SAPT Block Grant requirements. Inappropriate use of these funds for non-primary prevention services will require repayment of SAPT Block Grant funds.

Contracts will meet data reporting requirements for capacity, process, and outcome as required by federal grant requirements. The data will use the Institute of Medicine prevention categories of universal, selective, and indicated.

1. Universal prevention strategies address an entire population (national, local community, school, workplace, neighborhood), to prevention or delay ATOD use and/or abuse.
2. Selective prevention strategies address an entire subset of the total population that is at higher risk for ATOD use and/or abuse.
3. Indicated prevention strategies are designed to prevent/delay the onset of and/or reduce severity of substance abuse in individuals who are exhibiting early signs of substance abuse and associated problem behaviors.

Contractor agrees to comply with the following prevention business practices in its prevention activities funded under this Contract, and provide evidence of compliance with these practices if requested by State:

1. **Assessment of Needs with Data:** Through the use of data relevant to specific communities, identify at risk and under-served populations and their environmental

risks related to alcohol and other drugs.

2. **Prioritize and Commit to Purpose:** Through local or regional advisory bodies (coalitions), establish prevention priorities for the assessed needs. Provide a sound validation for the selection of priorities; identify the benefits. Provide evidence that identified priorities and desired outcomes are culturally relevant to priority populations.
3. **Determine Outcome Objectives and Measurements:** Establish the desired goal/desired outcome, objectives, and actions using well-defined terms. Determine the “who, what, where, when and how” that will attain these. Specify how prevention actions will be measured to monitor interim and final results.
4. **Proven Prevention Strategies:** Select prevention activities/services based on identified theories or practices supported by evaluation/research evidence that substantiates these actions are, or promise to be, effective for attaining the desired outcome. Select or adapt actions to assure they are culturally relevant to the intended populations and communities.
5. **Evaluate Measured Results and Improve:** Use goal and objective measurements to assess steps toward achieving the desired outcome as well as the final results. Apply this data to continuously refine, strengthen, and sustain the prevention effects.

CERTIFICATION

I, the official named below, hereby swear that I am duly authorized legally to bind the contractor or grant recipient to the above described certification. I am fully aware that this certification, executed on the date below, is made under penalty of perjury under the laws of the State of California.

Director of Agency or Authorized Signatory:

Signature

Date

Print Name and Title

Resources

For additional information and resources, please visit the following:

Policies and Procedures: www.marinhhs.org/policies-procedures

- Policies and Procedures

Contractor Resources: <https://www.marinbhrs.org/providers/substance-use-providers>

- Section 1: Contractor Renewal Manual
- Section 2: Contract Renewal Instructions and Forms
- Section 3: Reporting Instructions and Forms
- Section 4: Marin WITS Resources
- Section 5: Claiming
- Section 6: Standards and Practices
- Section 7: Other Resources

Drug/Medi-Cal Waiver: www.marinhhs.org/DMCWaiver

- DMC-ODS Implementation Plan
- DMC-ODS Standard Terms and Conditions
- DMC-ODS Intergovernmental Agreement
- DMC-ODS Beneficiary Informing Materials