TULARE COUNTY AGREEMENT NO. _____

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of _____ between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **CALIFORNIA PSYCHIATRIC TRANSITIONS** ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to retain the services of CONTRACTOR for the purpose of providing mental health programs in Tulare County in conformance with the Welfare & Institutions Code: Division 5, Titles 9 and 22 of the California Code of Regulations, the Cost Reporting/Data Collection Manual of the State Department of Mental Health and the Tulare County Mental Health Annual Plan; and

B. CONTRACTOR has the experience and qualifications COUNTY requires to operate the service(s) applied for and deal with mentally ill persons with persistent needs; and

C. CONTRACTOR is willing to enter into this Agreement with COUNTY upon the terms and conditions set forth herein.

THE PARTIES AGREE AS FOLLOWS:

1. **TERM:** This Agreement becomes effective as of July 1, 2019 and expires at 11:59 PM on June 30, 2022 unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.

2. **SERVICES:** See attached **Exhibits A, A-1.**

3. **PAYMENT FOR SERVICES:** See attached **Exhibits B, B-1, B-2, B-3.**

4. **INSURANCE:** Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C.**

5. **GENERAL AGREEMENT TERMS AND CONDITIONS:** COUNTY'S "General Agreement Terms and Conditions" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

6. **ADDITIONAL EXHIBITS:** CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

☒	**Exhibit D**	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
☒	**Exhibit E**	Cultural Competence and Diversity
☒	**Exhibit F**	Information Confidentiality and Security Requirements
☐	**Exhibit G**	Contract Provider Disclosures (Must be completed by Contractor and submitted to County prior to approval of agreement.)
☐	**Exhibit G1**	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
☐	**Exhibit H**	Additional terms and conditions for federally-funded contracts
☐	**Exhibit ___**	

7. NOTICES: (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage prepaid and addressed as follows:

COUNTY:

CONTRACT UNIT
TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY
5957 S. Mooney Boulevard
Visalia, CA 93277
Phone No.: 559-624-8000
Fax No.: 559-737-4059

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

CONTRACTOR:
CALIFORNIA PSYCHIATRIC TRANSITIONS
PO BOX 339
Delhi, CA 95315
Phone No.: 209-667-9304
Fax No.: 209-669-3978

(b) Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

8. AUTHORITY: CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which is an original and all of which taken together form one single document.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

CALIFORNIA PSYCHIATRIC TRANSITIONS

Date: 7-11-19

By Dina Hackett
Print Name DINA HACKETT
Title VICE PRESIDENT

Date: 7.11.19

By Jack T Hackett
Print Name JOHN T. HACKETT
Title PRESIDENT

[Pursuant to Corporations Code section 313, County policy requires that contracts with a **Corporation** be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a **Limited Liability Company** be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date: _____

By _____
Chairman, Board of Supervisors

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board
of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form
County Counsel

By E. Scott
Deputy
Matter # 2019619

CALIFORNIA PSYCHIATRIC TRANSITIONS
EXHIBIT A
SCOPE OF SERVICES
FISCAL YEAR 2019/2022

A. DESCRIPTION OF SERVICES

In accordance with and pursuant to the terms and conditions of this Agreement, CONTRACTOR agrees to provide basic mental health rehabilitation program as described in Title 9, Chapter 3.5 of the California Code of Regulations to assist COUNTY in meeting the needs of their target population clients who require this level of care. These clients require continuous supervision and may be expected to benefit from an active rehabilitation program designed to improve their adaptive functioning or prevent any further deterioration of their adaptive functioning. Services are provided to individuals having special needs or deficits in one or more of the following areas: self-help skills, behavioral adjustment, interpersonal relationships, prevocational preparation, and alternative placement planning. CONTRACTOR will be funded to provide a program to County residents who have been determined by the Director of Mental Health, or his designee, as appropriate for CONTRACTOR's program.

B. ELIGIBILITY

a. CONTRACTOR shall admit clients with a Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) diagnosis who are in need of 24-hour skilled psychiatric nursing services, clients who, without prompt and adequate treatment, are evaluated as being at risk of displaying behavioral symptoms (such as combativeness, elopement, suicide threats, and excessive verbal abusiveness) which precluded them from being admitted to a lower level of care. The frequency, scope, and severity of these behaviors are determining factors for admission, which is negotiated between COUNTY and CONTRACTOR for each client admission. Individuals, whose mental illness is deemed by COUNTY to be appropriate for acute care, individuals suffering exclusively from developmental disability, mental retardation, or physical illness without a psychiatric component, shall not be considered for admission.

b. A client's eligibility for admission to CONTRACTOR's facility shall be certified by COUNTY prior to admission. Eligibility for Medi-Cal will be verified or confirmed by COUNTY. Any referral source that wishes to access funding for an individual client to enter CONTRACTOR's facility must petition the Director of Mental Health for authorization by submitting a referral packet. This packet shall include, but may not be limited to:

    1. A physician's order for admission with a current psychiatric evaluation that identifies why an Institution for Mental Disease (IMD) and/or Mental Health Rehabilitation Center (MHRC) is the least restrictive, most appropriate level of care where services can be safely and adequately delivered.

2. A current diagnosis of serious mental illness.

3. A list of client problems/behaviors that led to the referral.

4. A clear statement of what the referral source's expectations are for treatment at the facility.

c. If the Assistant Agency Director agrees that the presented information justifies admission to CONTRACTOR's facility, or if Director of Mental Health determines that a situation exists that requires waiving the preadmission packet submission requirement, Director of Mental Health will sign an Authorization for IMD and/or MHRC Admission form authorizing treatment. At a minimum, this form shall contain clear client identification, admission date, and County approval of the admission.

d. CONTRACTOR shall not obtain non-urgent services for any COUNTY patients without prior authorization from Director of Mental Health or those persons designated by Tulare County, said services may be provided by independent contractors. CONTRACTOR agrees that all subcontractors will perform per terms of this Agreement.

e. Where special non-authorized psychiatric services are deemed necessary, authorization by COUNTY shall be obtained as established.

f. Notification shall be given to COUNTY if patient requires emergency hospitalization or is the subject of or committed any unusual incident.

g. CONTRACTOR shall make available to COUNTY, on request, a list of the person who will provide services under this Agreement. This list shall state the name, title, professional degree, and job description.

h. CONTRACTOR shall provide sufficient staffing levels so that during the provision of services under this Agreement such levels shall be in compliance with applicable state and federal law.

i. CONTRACTOR warrants that all staff, including their subcontractors, who perform services under this Agreement, shall be fully licensed and qualified to perform such services, shall be competent in the performance of such services, and shall perform such services according to acceptable professional standards of the applicable professional community.

C. TRAINING PROGRAM CONTRACTOR

CONTRACTOR will maintain active in-service and other training programs as stipulated in Title 9, Chapter 3.5 of the California Code of Regulations, other appropriate regulations, and as otherwise required.

D. CONTRACTOR'S STAFF

During the term of this Agreement, CONTRACTOR shall provide and maintain sufficient qualified employees, agents, and personnel to perform its duties and obligations hereunder.

E. REFERRALS

Referrals to CONTRACTOR for provision of services may be made by any provider designated by the Director of Mental Health. COUNTY shall not be responsible for cost of any services, which are not made pursuant to a referral as set forth in this paragraph.

F. DISPUTES

Any dispute arising on admission of an individual patient shall be resolved between the Director of Mental Health and the Administrator of CONTRACTOR, or their respective designees, and with the safety of all patients taken into consideration.

G. CLIENT MONITORING

COUNTY and CONTRACTOR recognize that in order to maintain close coordination of services that frequent, in person contacts between the assigned case manager and CONTRACTOR's staff is vital.

a. The purpose of the contacts will be to:
    1. Assure that the treatment plan clearly addresses the reason why the client requires extended placement in CONTRACTOR's facility.
    2. Monitor the client's participation to assure the client is making the fullest use of the program provided.
    3. Monitor the client's progress to assure that appropriate discharge plans are made and completed on a timely basis.

b. To facilitate close coordination of services, COUNTY agrees to:
    1. Provide an assigned case manager to make visits to CONTRACTOR's facility to review the client's progress, assist in the treatment planning process, and to monitor the client's participation in the program.
    2. Assure that the case manager has access to necessary COUNTY resources to facilitate the client's care and to accomplish discharge plans.
    3. Move clients in a timely fashion when a written discharge request is delivered.
    4. Regularly contact CONTRACTOR's designee to receive information on progress between case manager visits.
    5. Contact CONTRACTOR's in take coordinator regarding any potential admission to the facility.

c. To facilitate close coordination of services, CONTRACTOR agrees to:
    1. Assure, to the extent possible, the availability of appropriate program staff to meet with the case manager during facility visits.
    2. Prepare written discharge requests that include a statement of the client's current condition, a statement of recommended level of care, a list of current medications, and a statement of the client's continuing treatment needs and deliver these to COUNTY promptly so discharge arrangements

can be made in a timely fashion.

d. In providing mental health services, CONTRACTOR further agrees:
    1. To furnish all personnel, facilities, insurance, equipment and administrative services as reasonably necessary to competently and professionally conduct the mental health services and programs provided for by this Agreement.
    2. To provide the COUNTY, in satisfaction of Section 621 of Title 9 of the California Code of Regulations, with the services of a psychiatrist with the qualifications set forth in Section 623of that Code, who shall have the duties and responsibilities set forth in Section 522of the Code.
    3. To comply with those provisions of Titles 9 and 22 of the California Code of Regulations, the Cost Reporting/Data Collection Manual of the State Department of Health policies and regulations, and interagency agreements to which COUNTY and CONTRACTOR are parties, all of which are hereby incorporated by this reference.

H. REPORTS

a. CONTRACTOR shall provide COUNTY, to the satisfaction of the Director of Mental Health, monthly reports of the units of service performed.
b. CONTRACTOR shall prepare a revenue collection report, which shall reflect all revenue collected by CONTRACTOR from COUNTY on a monthly basis, and such report shall be forwarded to COUNTY with the monthly billings.
c. CONTRACTOR shall provide client data information within specified time periods including, but not limited to, client identification, admission, and discharge data.
d. CONTRACTOR shall, without additional compensation, make further fiscal, program evaluation and progress reports as required by Director of Mental Health or by the State Department of Mental Health concerning CONTRACTOR's activities as they affect the contract duties and purposes herein. COUNTY shall provide and explain reporting instructions and formats.

EXHIBIT A-1

TRANSLATION SERVICES

CONTRACTOR agrees to provide translation services such as, but not limited to, interpreting and sign language to consumers for the provision of services under this Agreement at CONTRACTOR'S sole cost.

Services provided may include:

- AT&T Language Line
- American Sign Language Translation Services, including TTY/TDD California Relay Services
- Orchid Interpreting
- Other interpreting services as deemed necessary to provide the consumer with linguistically and culturally appropriate services

CONTRACTOR will not be allowed to use COUNTY'S language and translation services' providers' accounts. Separate accounts will need to be arranged at CONTRACTOR'S discretion.

If COUNTY at any given time receives charges for CONTRACTOR'S language and translation services, CONTRACTOR will receive an invoice for such charge(s).

Exhibit B
Compensation
Fiscal Year 2019/2022

1. COMPENSATION

a. COUNTY agrees to compensate CONTRACTOR for allowed cost incurred as detailed in **Exhibit A**, subject to any maximums and annual cost report reconciliation.
b. The maximum contract amount shall not exceed Five Million One Hundred Thousand ($5,100,000), $1,700,000 will be allocate for Fiscal Years 2019/2020, 2020/2021, and 2021/2022. Payment shall consist of County, State, and Federal funds. Notwithstanding any other provision of this Agreement, in no event shall COUNTY pay CONTRACTOR more than this Maximum Contract Amount for CONTRACTOR's performance hereunder without a properly executed amendment. Notwithstanding any other provisions of this Agreement, in no event may CONTRACTOR request a rate that exceeds the contracted rate or request a rate that exceeds CONTRACTOR'S published charge(s) to the general public except if the CONTRACTOR is a Nominal Charge Provider.
c. If the CONTRACTOR is going to exceed the Maximum contract amount due to additional expenses or services, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2022.
d. CONTRACTOR agrees to comply with Medi-Cal requirements and be approved to provide Medi-Cal services based on Medi-Cal site certification.
e. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps to reactivate or establish eligibility where none exists.
f. CONTRACTOR shall certify that all Units of Service (UOS) listed on the invoice submitted by the CONTRACTOR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.
g. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in the **Exhibit A** of this Agreement.
h. CONTRACTOR shall permit authorized COUNTY, State and/or Federal agency (ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed hereunder including subcontract support activities and the premises, which it is being performed. The CONTRACTOR shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.
i. In the event the state or federal government denies any or all claims submitted by COUNTY on behalf of the CONTRACTOR, COUNTY will not be responsible for any payment obligation and, accordingly, CONTRACTOR shall not seek payment from COUNTY and shall indemnify and hold harmless COUNTY from any and all liabilities for payment of any or all denied claims, including those claims that were submitted outside the period of time specified in this Agreement.

2. Contract Renewal

a. If applicable, should both parties exercise the right to renew this Contract, the maximum fund amount for this Contract/these Contracts in total per renewal term is identical to the maximum fund amount within the current executed contract unless the Parties agree otherwise.

b. This contract may be renewed if the CONTRACTOR continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The County may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract.

3. ACCOUNTING FOR REVENUES

a. CONTRACTOR shall comply with all County, State, and Federal requirements and procedures, as described in WIC Sections 5709, 5710 and 14710, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP) (2) the eligibility of patients/clients for Medi-Cal , Medicare, private insurance, or other third party revenue, and (3) the collection, reporting, and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. Grants and other revenue, interest, and return resulting from services/activities and/or funds paid by COUNTY to CONTRACTOR shall also be accounted for in the Operating Budget.
b. CONTRACTOR shall maintain internal financial controls, which adequately ensure proper billing and collection procedures. CONTRACTOR shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort. All fees paid by or on behalf of the consumer receiving services under this Agreement shall be utilized by CONTRACTOR only for the delivery of mental health service units as specified in this Agreement.

4. INVOICING

a. CONTRACTOR shall submit monthly invoices to Tulare County Mental Health Department, Managed Care, 5957 S. Mooney Blvd, Visalia, Ca 93277, no later than fifteen (15) days after the end of the month in which those expenditures were incurred. The invoice must be supported by a system generated a report that validates services indicated on the invoice.
b. Invoices shall be in the format approved by the Tulare County Health & Human Services Agency. All payments made under this Agreement shall be made within thirty (30) days of submission of all required documentation and in accordance with the COUNTY'S payment cycle.
c. 12-month billing limit: Unless otherwise determined by State or Federal regulations (e.g. medi-medi cross-over) all original (or initial) claims for eligible individual persons under this Agreement must be received by COUNTY within twelve (12) months from the month of service to avoid denial for late billing.

5. COST REPORT:

a. Within sixty (60) days after the close of the fiscal year covered by this Agreement, CONTRACTOR shall provide COUNTY with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the prior fiscal year. The Annual Cost Report shall be prepared by the CONTRACTOR in accordance with all applicable Federal, State, and County requirements and generally accepted accounting principles. CONTRACTOR shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by CONTRACTOR shall be reported in its Annual Cost Report and shall

be used to offset gross cost. CONTRACTOR shall maintain source documentation to support the claimed costs, revenues, and allocations, which shall be available at any time to Designee upon reasonable notice. CONTRACTOR shall be responsible for reimbursement to the County upon final settlement.

b. The Cost Report shall be the final financial and statistical report submitted by CONTRACTOR to COUNTY and shall serve as the basis for a final settlement to the CONTRACTOR. CONTRACTOR shall document that costs are reasonable, allowable, and directly or indirectly related to the services to be provided hereunder.
c. CONTRACTOR must keep records of services rendered to Medi-Cal beneficiaries for ten years from final date of contract, completion of audit, or date of service whichever is later, Per W&I Code 14124.1.

6. RECONCILIATION AND SETTLEMENT:

a. COUNTY will reconcile the Annual Cost Report and settlement based on the lower of cost or County Maximum Allowance (CMA). Upon initiation and instruction by the State, COUNTY will perform the Short-Doyle/Medi-Cal Reconciliation with CONTRACTOR.
b. COUNTY will perform settlement upon receipt of State Reconciliation Settlement to the COUNTY. Such reconciliation and settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or federal statutes, regulations, policies, procedures and/or other requirements pertaining to cost reporting and settlements for Title XIX Short-Doyle/Medi-Cal.

7. REPAYMENT OR REIMBURSEMENT TO STATE OR OTHERS:

a. CONTRACTOR agrees that any repayment or reimbursement that must be made by COUNTY to the State of California or others as a result of an audit or conduct by CONTRACTOR, its agents, officers or employees of the programs or services provided under this Agreement shall be paid by CONTRACTOR, out of its own funds, within thirty (30) days after the parties are notified that repayment or reimbursement is due. For purposes of this provision, it is agreed that offsets made by the state are included within the phrase "repayment or reimbursement."
b. It is understood that if the State Department of Health Care Services disallows Medi-Cal claims, CONTRACTOR shall reimburse COUNTY for any and all State and Federal Medi-Cal funds for those disallowed claims, regardless of the fiscal year of the disallowance within sixty (60) days of the State disallowing claims.

8. Overpayments and Prohibited Payments:

a. The County may offset the amount of any state disallowance, audit exception, or overpayment for any fiscal year against subsequent claims from the Contractor.
b. Offsets may be done at any time after the county has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the CONTRACTOR.
c. CONTRACTOR shall report to the County within sixty (60) calendar days of payments in excess of amounts specified by contract standards.
d. CONTRACTOR shall retain documentation, policies, and treatment of recoveries of overpayments due to fraud, waste, or abuse. Such documentation should include timeframes, processes, documentation, and reporting.
e. CONTRACTOR shall provide an annual report of such overpayments to the County.

f. The County shall not furnish any payments to the CONTRACTOR if that individual/entity is under investigation for any fraudulent activity. Payments of this manner will be prohibited until such investigations are complete by the County or State.

9. Audit Requirements

a. The CONTRACTOR shall submit any documentation requested by the County or State in accordance to audit requirements and needs. Documentation can be requested any time and must be supplied within a reasonable amount of time.
b. The audit shall be conducted by utilizing generally accepted accounting principles and generally accepted auditing standards.
c. The County will involve the Contractor in developing responses to any draft federal or State audit reports that directly impact the county.

10. Beneficiary Liability

a. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the CONTRACTOR or an affiliate, vendor, or sub-subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments.
b. Consistent with 42 C.F.R. § 438.106, the CONTRACTOR or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

11. Contractor's Exemption from Audit and Reporting Requirements.

a. Notwithstanding any other provision contained herein, County and Contractors agree that Contractor does not meet the definition of a Non-Federal Entity under 2 CFR 200 and, hence, is exempt from the audit provisions applicable to such entities. The Parties further agree that any review of contracts, books, accounts, records, accounting and administrative documents, statistics, program procedures or any other information (collectively "Documentation") in Contractor's possession shall be limited solely to that Documentation that relates to the specific services provided by Contractor under this Contract. Nothing contained herein shall be deemed to allow inspection of the financial statements or any other Documentation relating to the operation of California Psychiatric Transitions.

CALIFORNIA PSYCHIATRIC TRANSITIONS
EXHIBIT B1
RATES
FISCAL YEAR 2019/2022

I. DAILY RATES

a. All admissions to CONTRACTOR facility will require the Admission Agreement Part I in **Exhibit B-2** and Part II in **Exhibit B-3** to signed by COUNTY Director and/or Designee.

b. The 2019/2022 rates will be as follows:

MHRC	
Level 1	$400/Day
1:1 Monitoring	$40.00/Hour
DBU	
Level 1	$850/Day
1:1 Monitoring	$40.00/Hour
DIVERSION	
Level 1 (IST)	$575/Day
Level 2	$475/Day
1:1 Monitoring	$40.00/Hour

c. The 2019/2022 rates will be as follows:

MHRC	
Level 1	$400/Day
1:1 Monitoring	$40.00/Hour
DBU	
Level 1	$850/Day
1:1 Monitoring	$40.00/Hour
DIVERSION	
Level 1 (IST)	$575/Day
Level 2	$475/Day
1:1 Monitoring	$40.00/Hour

d. The daily rate for CPT Diversion program will be eligible for review.

e. There are no automatic rate reductions.

f. At no time will a rate be decreased according to an automatic schedule. Request for a rate decrease must be submitted in writing to the CPT Director, according to the terms set forth by the Admission Agreement in **Exhibit B-2.**
g. A rate decrease must be reviewed by the treatment team and authorized in writing by the facility director. Criteria for a daily rate reduction may be based on but not limited to; change in legal status, overall progress in the CPT level system, program participation, behavior(s), medication/treatment compliance and the necessary support required to adequately maintain said individual.
h. The bed hold day rate is the same as the agreed daily rate.
i. COUNTY will be responsible for any additional cost necessary to employ additional services in order to maintain the safety and security of the resident.
j. All discharges must have a two-week written notice. Unless waived by the director; COUNTY is responsible for payment of any day short of two weeks.

II. PAYMENT

a. The payment of the above rate is based upon the referred client having a higher or lower level of impairment. The payment criteria will be four tiered, with each step indicating a need for more or less intensive services and so a higher or lower patch rate. The services will be based on identified needs in five areas:
    1. Behavior
        - Suicide
        - Assaultive
        - AWOLRisk
        - Self-Injury Behavior
        - Fire Hazard
        - Sexually Intrusive
        - Property Destruction
        - Verbal Abuse
        - Low Impulse Control
        - Low Med Compliance
        - History of Violence
        - Manipulative Behavior
        - Substance Abuse

    2. Psychotic Symptoms
        - Behaviorally Responds to: Hallucinations or Delusions

    3. Living Skills
        - Poor Socialization Skills
        - Poor ADL Skills
        - Dependent for ADL's
        - Disorientation
        - Wanders
        - Money Management Skills

4. Community Re-entry Skills
    - Poor Motivation
    - Poor Work Skills
    - Poor Independent Living Skills
    - Poor Community Resources
    - Low Level of Responsibility
    - Poor Insight & Acknowledgement of Problems
    - Poor Medication Knowledge &Compliance
    - Unrealistic Plan for Life

5. Physical Medical Issues
    - Wheelchair (can transfer independently)
    - Diabetes
    - Congestive Heart Failure
    - Chronic Obstructive Pulmonary Disease
    - Hypertension
    - Medication Intolerance
    - Incontinence

III. ONE ON ONE SUPERVISION

a. One-on-one supervision is occasionally indicated. The purpose of this service is to maintain placement and reduce the probability of injury to self or others.
b. The COUNTY shall reimburse CONTRACTOR at the rate of Forty Dollars ($40.00) per HOUR for 1:1(one-on-one) supervision services on an "as-needed" basis as determined by medical order of the CONTRACTOR's staff psychiatrist, and with approval within 24 hours of an appointed designee of COUNTY and this service is limited to a maximum of 60 hours, while transport services are arranged by the COUNTY.

IV. SERVICES PROVIDED

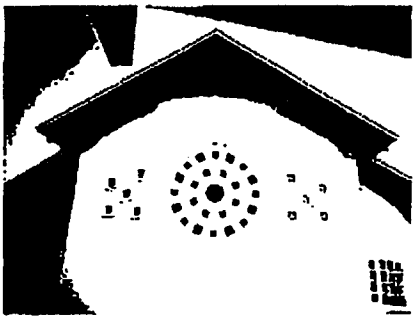
a. Medication, medical and psychiatric services, if not covered by insurance, shall be paid by COUNTY.
b. Expenses for other services or materials not herein listed are neither authorized nor reimbursable.

EXHIBIT B-2

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

CPT MENTAL HEALTH REHABILITATION CENTER

P.O. BOX 339, DELHI, CA 95315
PH (209) 667-9304 FAX (209) 669-3978



MAIN / DBU / DIVERSION PROGRAM ADMISSION AGREEMENT

Part I

Regional Center / County Mental Health Agency

Date: MM/DD/YYYY

THIS ADMISSION AGREEMENT AND THE ACCOMPANYING ADMISSION DOCUMENTATION IS A LEGALLY BINDING CONTRACT. PLEASE READ ALL OF IT AND BE SURE YOU UNDERSTAND ITS TERMS BEFORE SIGNING.

RESIDENT NAME----SOCIAL SECURITY NUMBER----DATE OF BIRTH	CPT #
Last, First----000-00-0000-----MM-DD-YYYY	PENDING

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

PAYMENT AGREEMENT

DAILY RATE

With respect to payment responsibilities,

Placement cost of;

Last, First----000-00-0000-----MM-DD-YYYY shall be reimbursed as follows.
RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH

FUNDING SOURCE (PRIMARY)

FUNDING SOURCE (SECONDARY) if applicable

Shall reimburse CPT at a rate of $000.00 ( ) per day.

RATE DECREASE
At no time will a rate be decreased according to an automatic schedule. Requests for a rate decrease must be submitted in writing to the CPT Director. The Treatment Team will then review the request and must support the rate decrease based on but not limited to: the current level status of the resident, medication/treatment compliance, behavior and program progress. The Medical Director and Facility Director must approve the rate decrease. The Facility Director will then contact your agency with a decision. No rate change will be final until the Facility Director authorizes this change in writing. Effective date of reduction will be the 1st of the next month following request approval. If a Resident leaves temporarily, the holding rate for his/her room is the same as the agreed daily rate.

The signature below is of a person(s) who is authorized to enter into for this Payment Agreement.

√	√	√
PRIMARY AUTHORIZED PERSON, TITLE (PRINTED)	SIGNATURE	DATE
√	√	√
SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable	SIGNATURE	DATE

RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH	CPT #
Last, First----000-00-0000-----MM-DD-YYYY	PENDING

FILE NAME: ADMISSION MHRC NEW

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

PAYMENT AGREEMENT

ONE ON ONE

In order to maintain some residents at this level of care one-on-one supervision is occasionally indicated. The purpose of this service is to maintain placement and reduce the probability of injury to self or others. In this facility, one-on-one supervision has to be medically indicated and approved by the staff psychiatrist. Unfortunately, such supervision cannot be provided at the basic admission rate for services. An agreement for reimbursement for one-on-one services must be established in order for this facility to be able to provide this service. CPT would explain the resident's current behavior and why one-on-one services would be indicated. One-on-one services will be provided until the need no longer exists.

With respect to payment responsibilities,

One on One supervision cost of;

Last, First----000-00-0000-----MM-DD-YYYY shall be reimbursed as follows.
RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH

FUNDING SOURCE (PRIMARY)

FUNDING SOURCE (SECONDARY) if applicable

Shall reimburse CPT at a rate of $ (DOLLARS) per HOUR, for 1:1 (one on one) supervision services on an "as needed" basis as determined by medical order of the CPT staff psychiatrist.

The signature below is of a person(s) who is authorized to enter into for this Payment Agreement.

√

PRIMARY AUTHORIZED PERSON, TITLE (PRINTED) SIGNATURE DATE

√ √ √

SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable SIGNATURE DATE

RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH	CPT #
Last, First----000-00-0000-----MM-DD-YYYY	PENDING

FILE NAME: ADMISSION MHRC NEW

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

PAYMENT AGREEMENT

PHARMACY & LABORATORY SERVICES

This page MUST be completed and signed by authorized person(s) prior to admission.
A copy of this page will be sent to the vendors to establish services.

COUNTY MENTAL HEALTH AGENCY / REGIONAL CENTER ensures that all medical insurance information (i.e., Medi-Cal or Medicare) for Last, First---###-##-####-MM/DD/YY is current /active and will be provided to California Psychiatric Transitions prior to admission.

If the information for Last, First---###-##-####-MM/DD/YY is not active or not available prior to admission,

COUNTY MENTAL HEALTH AGENCY / REGIONAL CENTER
FUNDING SOURCE (PRIMARY

N/A
FUNDING SOURCE (SECONDARY) if applicable

Will guarantee reimbursement of expenses incurred by:

- MID-VALLEY PHARMACY *#PV0912*
  602 SCENIC DRIVE, MODESTO, CA 95350 PH (209) 552-7600 FAX (209) 552-7638
- CENTRAL VALLEY DIAGNOSTIC LAB *#HC0163*
  31 Alexander Ave. Merced, CA 95348 PH (209)726-3846
- BIO-REFERENCE LABORATORIES #HS0709
  487 Edward H Ross Dr. Elmwood Park NJ 07407 PH (800)229-5227

BILLING INFORMATION (Please Print)

PLACEMENT AGENCY (Responsible Funding Source)		
MAILING ADDRESS (#/Street/Ste City, State, Zip)		
BILLING CONTACT NAME	PHONE (EXT)	FAX

ADDITIONAL CONTACT INFORMATION

CASE MANAGER NAME	PHONE (EXT)	FAX
CONSERVATOR NAME	PHONE (EXT)	FAX

The signature below is of a person(s) who is authorized to enter into this Payment Agreement.

√ PRIMARY AUTHORIZED PERSON, TITLE (PRINTED)	√ SIGNATURE	√ DATE
√ SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable	√ SIGNATURE	√ DATE

RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH	CPT #
Last, First----000-00-0000-----MM-DD-YYYY	PENDING

FILE NAME: ADMISSION MHRC NEW

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

PAYMENT AGREEMENT

RESPONSIBILITY FOR DAMAGES

This page MUST be completed and signed by authorized person(s) prior to admission.

The resident and/or representative will be billed for any damages to the facility and/or property, caused by the resident, which are not due to normal "wear and tear". Nonpayment of billed damages will be reason for discharge from this facility.

With respect to payment responsibilities regarding any damages to the facility and/or property caused by:

Last, First---###-##-####-MM/DD/YY
RESIDENT NAME—SOCIAL SECURITY NUMBER—DATE OF BIRTH

COUNTY MENTAL HEALTH / REGIONAL CENTER
FUNDING SOURCE (PRIMARY

N/A
FUNDING SOURCE (SECONDARY) if applicable

Will reimburse California Psychiatric Transitions for any damages to the facility and/or property caused by Last, First---###-##-####-MM/DD/YY

The placement agency will be provided with receipts and/or itemized list of damages, labor and cost of repairs. Supportive documentation may be provided upon request.

The signature below is of a person(s) who is authorized to enter into this Payment Agreement.

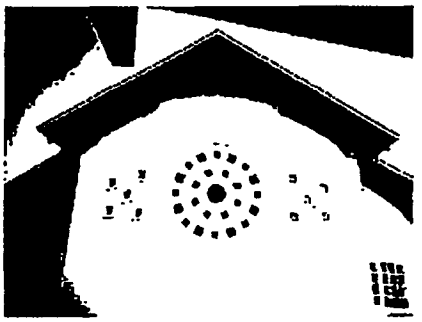
√	√	√
PRIMARY AUTHORIZED PERSON, TITLE (PRINTED)	SIGNATURE	DATE
√	√	√
SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable	SIGNATURE	DATE

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

CPT MENTAL HEALTH REHABILITATION CENTER

P.O. BOX 339, DELHI, CA 95315
PH (209) 667-9304 FAX (209) 669-3978



MAIN / DBU / DIVERSION PROGRAM ADMISSION AGREEMENT

Part II

Regional Center / County Mental Health Agency

Date: MM/DD/YYYY

THIS ADMISSION AGREEMENT AND THE ACCOMPANYING ADMISSION DOCUMENTATION IS A LEGALLY BINDING CONTRACT. PLEASE READ ALL OF IT AND BE SURE YOU UNDERSTAND ITS TERMS BEFORE SIGNING.

RESIDENT NAME----SOCIAL SECURITY NUMBER---DATE OF BIRTH	CPT #
Last, First----000-00-0000-----MM-DD-YYYY	PENDING

RESIDENT INITIALS: _____

MAIN / DBU / DIVERSION PROGRAM ADMISSION AGREEMENT

PLEASE NOTE: PLACEMENT IN THIS FACILITY DOES NOT CONSTITUTE A CHANGE OF RESIDENCE FOR THE CONSUMER. THE PLACING COUNTY RETAINS RESIDENCY INCLUDING PSYCHIATRIC MEDI-CAL RESPONSIBILITIES.

Last, First----000-00-0000-----MM-DD-YYYY	√	√
RESIDENT NAME—SOCIAL SECURITY NUMBER—DATE OF BIRTH	SIGNATURE	DATE
Aaron Stocking Director, CPT	√	√
CALIFORNIA PSYCHIATRIC TRANSITIONS	SIGNATURE	DATE
√	√	√
CONSERVATOR OR AUTHORIZED REPRESENTATIVE, TITLE	SIGNATURE	DATE
√	√	√
PLACEMENT AGENCY(S), TITLE	SIGNATURE	DATE

Basic Services—**General**

(a) CPT shall provide, at a minimum, the following basic services; physician, nursing, pharmaceutical, and dietary services. (In accordance to Title 9, chapter 3.5 and submitted Plan of Operations for the Forensic Diversion Program).

(b) If a service cannot be brought into CPT with regard to the health and welfare of the resident, CPT shall make necessary arrangements for transportation to and from a service location. (Examples; Non-emergency Medical Appointment, Labs or similar services with direct benefit to the resident).

(1) Due to legal status/hold it may be necessary for CPT to employ additional services in order to maintain the safety and security of the resident in question, this cost may be in addition to the daily contractual rate.

(2) In the event emergency services are necessary (911), CPT shall employ additional resources to insure the safety and wellbeing of the resident and staff while in the care of other healthcare providers. This cost may be in addition to the daily contractual rate.

(c) CPT shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated.

(d) Each resident shall be encouraged and assisted to achieve and maintain the highest level of self–care and independence. Every effort shall be made to keep residents active, and out of bed for reasonable periods of time, except when contraindicated by physician's orders.

(e) Each resident shall be provided with good nutrition and with necessary fluids for hydration.

(f) The weight and height of each resident shall be taken and recorded in the resident record upon admission, and the weight shall be taken and recorded once a month thereafter.

(g) Each resident shall be provided visual privacy during treatment and personal care.

(h) Each resident shall be screened for tuberculosis upon admission, unless a tuberculosis screening has been completed within 90 days prior to the date of admission to CPT.

(i) Prior to admission the following labs/tests are required; CBC with differential, VDRL, Lipid Panel with fasting (8) hours, CMP and TSH [all within 6 months and any test deemed necessary based on the safety and welfare of CPT staff and residents].

(j) This facility honors "full code" consisting of first aid, CPR, and 911 notification for every resident.

Basic and any additional services are paid in arrears, and due upon receipt. **Medication, Medical and Psychiatric services, if not covered by insurance shall be paid by the placement agency. All discharges must have a two-week written notice to director**, unless waived by director; placement agency shall be responsible for payment of all days short of two weeks.

RESIDENT INITIALS: _____

DISCHARGE

Residents discharged from this facility shall (in a planned/scheduled discharge) have all belongings, monies and appropriate medications given to responsible parties (or their representatives) at the time of discharge. In the event that the discharge is not scheduled/not planned, arrangements shall be made to return belongings to the resident's responsible party.

This facility cannot provide any services that can only be provided by law in higher levels of care such as State Psychiatric Hospitals, Health hospitals, Acute Care Psychiatric Health Facilities, serious medical conditions, etc. In addition the following will apply:

- In acute situations (as determined by the MHRC) the county shall make reasonable and timely arrangements for the transfer of the resident to an appropriate level of care.
- The discharge/transfer is necessary for the welfare of the resident and his/her needs cannot be met at this facility
- Based upon a reassessment of the Resident's needs, conducted pursuant to applicable regulations, *California Psychiatric Transitions* shall determine that the facility is not appropriate for the Resident
- The discharge/transfer is appropriate because the resident's health has improved sufficiently so that they no longer need the services of this facility
- The safety of individuals in the facility is endangered by Resident's presence
- The health of individuals in the facility is endangered by Resident's presence
- Payment for services have not been received within (10) days of due date
- The facility is ceasing to operate or its use is being changed
- Reassignment of case managers or placement agencies without prior written approval from this facility
- Failure of the Resident to comply with state or local laws
- Failure of the Resident to comply with written general polices of the facility which are for the purpose of making it possible for Residents to live together.

Residents admitted to California Psychiatric Transitions – MHRC, shall maintain their respective; LPS, conservatorship, 6500 or any other legal document, status or hold that has met the admissions criteria outlined in the Plan of Operations pursuant to (Title 9 Chapter 3.5). Any change, lapse, alteration, or discontinued condition of the resident's legal status without reasonable prior notification to California Psychiatric Transitions may be grounds for immediate discharge. It is the sole responsibility of the placing agency, county or governing body to notify and update California Psychiatric Transitions, of any changes as to the legal status of the resident. Failure to do so may result in immediate discharge of the resident.

VISITING POLICY

Visiting hours are between 11:30am and 2:00pm daily. If any of the Resident's guests fail to abide by the Facility's rules for visitors, the Resident and Responsible Party or Agent agree, upon the Facility's request, to arrange for the prompt removal of such visitors from the Facility.

NOTICE OF RATE CHANGE

If rates are increased, the Resident or LEGAL REPRESENTATIVE will be given at least 30 days written notice of the change.

CALIFORNIA PSYCHIATRIC TRANSITIONS is not responsible for any cash resources, valuables or personal property brought into the facility unless these items are delivered to the Director for safeguarding. **CPT shall not be financially responsible for any artificial or prosthetic devise. (Dentures, contact lenses, hearing aids etc.) [See P&P Artificial & Prosthetic Devise].**

RESIDENT INITIALS: _____

HOUSE RULES

1	Residents of California Psychiatric Transitions (CPT) shall not carry, keep or store any medication while at CPT. All medications, prescribed and over the counter medications (i.e. cough suppressants, nasal inhalers, pain medications, etc.), will be kept and dispensed by designated facility personnel. All medications must be taken as prescribed by the method prescribed (i.e. as a pill, as a liquid, crushed & mixed with applesauce, by mouth, by intra muscular injection, etc).
2	Residents are not permitted to smoke inside the center and where "No Smoking" signs are posted. Residents are permitted to smoke only at designated times in the designated areas that are under the periodic observation of CPT staff. Staff will show you where the designated smoking areas are located. NOTE Article 7. Physical Plant TITLE 9. DIVISION 1 — DEPARTMENT OF MENTAL HEALTH § 787.00 Fire Safety. Authority cited Sections 5675 and 5768, Welfare and Institutions Code, Section 3 of Chapter 678 of the Statutes of 1994 Reference Sections 5675 and 5768, Welfare and Institutions Code
3	Any alcohol, stimulants, illicit substances, or "drug related paraphernalia" are prohibited on facility property. The use of alcohol, stimulants or illicit substances is prohibited.
4	No resident may be in the possession of property belonging to another resident without first obtaining permission from both the owner of the property and the treatment team.
5	This facility discourages sexual activity among residents in order to protect residents from sexual exploitation. No resident may be in any other resident's room. Resident's cannot have visitors in their assigned rooms without the express permission of the facility director. The director or staff may enter resident's room with or without previous notice. Toilet and shower/bath rooms are limited to one resident at a time. All residents are only allowed to sleep in their assigned beds.
6	All residents are expected to maintain proper grooming and hygiene. Assistance with routine ADL skills will be provided for those residents requiring such assistance. Shoes or sandals must be worn when outside facility buildings. Eligibility for non-essential service outings shall be partially dependent upon satisfactory completion of ADL's.
7	All residents and staff are expected to use language and behavior that is neither abusive, threatening nor inappropriate to others.
8	All visits are to be scheduled. Visiting hours are between the hours of 11:30 AM and 2:00 PM daily. All visitors must sign in our guest book.
9	Between the hours of dusk to dawn, for protection and safety, all residents must be inside or within a 30 foot perimeter of the residential buildings unless accompanied by staff or if previous arrangements have been made with facility director. All residents on Standing Passes (unsupervised outings into the community) are to sign out prior to leaving on standing passes and sign in upon returning. Destination and duration of the standing pass outings must be clearly stated on the sign out sheet. Residents on standing passes must have met their daily group and ADL requirements prior to being allowed to go on standing passes. Standing passes (unsupervised outings into the community) must be approved by the facility director (or designee).

RESIDENT INITIALS: _____

10	All residents are expected to willingly, with minimal prompts, participate in their rehabilitation by active contribution to the development of their treatment plans and in scheduled program activities.
11	Telephone calls should be limited to reasonable hours and duration. A pay telephone is available to residents.
12	Mail will be delivered to residents on the day it arrives, after it has been sorted and not during group times. Mail is not delivered on Saturdays, Sundays, and holidays. CPT may cover the postage cost of regular class mail at a rate not to exceed one letter per resident per day.
13	Residents and staff may not make any purchases for other residents without the prior consent of treatment team.
14	Residents and staff may not trade, give or sell any items to other residents or staff without prior administrative approval. No perishable food items may be stored in any of the bedrooms. Facility refrigerators may not be used to store resident's personal food or drink items.
15	All residents funds are to be kept in the resident trust account. Funds can be signed out to residents as appropriate needs arise.
16	The resident (or representative) shall be billed for any damages to the facility or property, caused by the resident, that is not due to normal "wear and tear". Non payment of billed damages shall be reason for discharge from this facility.
17	The facility attempts to provide a secure environment by reducing potential stressors such as violent television/video programs, poster, pictures or magazines that promote violence, pornography, military or survivalist items, clothing that promotes the use of illicit drugs or alcohol, etc.

RESIDENT SIGNATURE & DATE	CPT STAFF SIGNATURE & DATE.
PLACEMENT AGENCY SIGNATURE & DATE	**CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE**

Rules subject to change as deemed appropriate by the facility director.

*653x. (a) Any person who telephones the 911 emergency line with the intent to annoy or harass another person is guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000), by imprisonment in a county jail for not more than six months, or by both the fine and imprisonment. Nothing in this section shall apply to telephone calls made in good faith.

(b) An intent to annoy or harass is established by proof of repeated calls over a period of time, however short, that are unreasonable under the circumstances.

(c) Upon conviction of a violation of this section, a person also shall be liable for all reasonable costs incurred by any unnecessary emergency response.

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

ACKNOWLEDGEMENT OF AUTHORIZED COMMUNICATION(S)

California Psychiatric Transitions is frequently contacted by outside sources regarding the residents; i.e. relatives, friends, previous placements, etc. In an effort to provide therapeutic support as well as absolute confidentiality regarding, Last, First----000-00-0000-----MM-DD-YYYY, please assist us by providing us the name(s), relationship and any pertinent information of individuals/agencies that CPT has permission to speak with regarding this resident. We also ask that you provide any names of individuals/agencies who are NOT okay to speak with.

RE: Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME—SOCIAL SECURITY NUMBER—DATE OF BIRTH

FROM: County/Regional Center
RESPONSIBLE PLACING AGENCY

APPROVED CONTACTS FOR, Last, First----000-00-0000-----MM-DD-YYYY:

Name (Please Print)	Relationship to CPT Resident	*Comment(s)

Please DO NOT share information with the following contact(s) without further consent:

Name (Please Print)	Relationship to CPT Resident	*Comment(s)

The signature(s) below is of a person(s) who can legally authorize contacts.

√ _____ √ _____ √ _____
CONSERVATOR OR AUTHORIZED REPRESENTATIVE, TITLE (PRINTED) SIGNATURE DATE

√ _____ √ _____ √ _____
CASE MANAGEMENT, TITLE (PRINTED) SIGNATURE DATE

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

TRUST FUND AUTHORIZATION

This page authorizes CPT to deposit resident funds into a CPT resident trust account.

1.

_____ _____
RESIDENT SIGNATURE DATE

2.

_____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3.

_____ _____
CPT STAFF SIGNATURE DATE

4.

_____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

INFORMED CONSENT

This document is to provide information to the resident regarding medications and treatment. The resident shall be advised of the expected benefits and potential side effects of any new or added or discontinued medication or treatment. These medications are intended to assist the resident in regaining thought processing abilities and lower acute anxiety and/or agitation. Some medications may require several doses to attain maximum benefits, other medications are immediately effective. Most often, side effects of psychotropic drugs fade during continued treatment. Side effects may or may not include; indigestion, nausea, vomiting, diarrhea, constipation, unsteadiness, dizziness, alteration in blood counts, liver function alteration or skin rash. Some medications affect body weight, can initiate tremors, headache, depression, unusual excitement, or irritability. Every effort is made to gain maximum benefit at the lowest dose possible while minimizing discomfort and side effects to improve the likelihood of long term compliance. All psychotropic, with the exception of Clozaril may cause tardive dyskinesia. As with all medications, there are numerous side effects other than those listed here. In specific cases the doctor will indicate the drug and side effects and counsel the resident and/or authorized legal representative directly.

In the event a change in medication or treatment is necessary an Informed Consent for Medication/Treatment form shall be processed, authorized and signed for each and every event as it occurs.

The undersigned hereby acknowledges and authorizes California Psychiatric Transitions Informed Consent procedures.

1. _____ _____
RESIDENT SIGNATURE DATE

2. _____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3. _____ _____
CPT STAFF SIGNATURE DATE

4. _____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

CONSENT/AUTHORIZATION FOR MEDICAL TREATMENT

With Respect To: Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME—SOCIAL SECURITY NUMBER—DATE OF BIRTH

As the Resident, Conservator, Agency Representative or Legal Guardian, I hereby give consent to *California Psychiatric Transitions* to provide medical and dental care as prescribed by a duly licensed physician (MD) or dentist (DDS). I authorize California Psychiatric Transitions to monitor medications and treatments including reviewing lab results and medical progress notes.

Prior to final admission the following Medical/Labs and Testing assessment will be required;

Tuberculosis Screening	CBC with differential
VDRL	Lipid Panel with fasting (8) hours
CMP	TSH

[All within 6 months and any test deemed necessary based on the safety and welfare of CPT staff and residents].

Financial responsibility and agreement information and/or Letter of Guarantee of payment or Purchase of Services (POS) shall also be required.

THANK YOU

1. _____ _____
RESIDENT SIGNATURE — DATE

2. _____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE — DATE

3. _____ _____
CPT STAFF SIGNATURE — DATE

4. _____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE — DATE

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

AUTHORIZATION FOR PHOTOGRAPH / VIDEO TAPE

I, GIVE PERMISSION FOR *CALIFORNIA PSYCHIATRIC TRANSITIONS* TO TAKE AND HAVE IN THEIR FILE, PHOTOGRAPHS, AND/OR VIDEO TAPE OF THIS RESIDENT TO BE USED FOR ADMINISTRATIVE IDENTIFICATION PURPOSES.

THANK YOU

1. _____ RESIDENT SIGNATURE _____ DATE

2. _____ CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE _____ DATE

3. _____ CPT STAFF SIGNATURE _____ DATE

4. _____ PLACEMENT AGENCY SIGNATURE AND TITLE _____ DATE

RESIDENT INITIALS: _____

AUTHORIZATION FOR MEDI-CAL / MEDICARE INFORMATION

DATE: _____

PERMISSION IS HEREBY GRANTED FOR *CALIFORNIA PSYCHIATRIC TRANSITIONS* TO COLLECT ALL INFORMATION PERTAINING TO THE MEDI-CAL COVERAGE REGARDING

Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME—SOCIAL SECURITY NUMBER—DATE OF BIRTH

THANK YOU

1.

_____ _____
RESIDENT SIGNATURE DATE

2.

_____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3.

_____ _____
CPT STAFF SIGNATURE DATE

4.

_____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

RESIDENT INITIALS: _____

CONSENT/AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As the Resident, Conservator, Agency Representative or Legal Guardian, I hereby give consent to ***California Psychiatric Transitions*** to obtain medical information from any health or psychiatric care agency providing service to this person during their residency at ***California Psychiatric Transitions.***

1.

RESIDENT SIGNATURE _____ DATE _____

2.

CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE _____ DATE _____

3.

CPT STAFF SIGNATURE _____ DATE _____

4.

PLACEMENT AGENCY SIGNATURE AND TITLE _____ DATE _____

THE FOLLOWING INFORMATION IS COPIED WORD FOR WORD FROM THE HANDBOOK OF RIGHTS FOR INDIVIDUALS IN MENTAL HEALTH FACILITIES FROM CALIFORNIA OFFICE OF PATIENTS'S RIGHTS APRIL 2004 REVISION

RESIDENT INITIALS: _____

RIGHTS FOR INDIVIDUALS IN MENTAL HEALTH FACILITIES HANDBOOK
Admitted Under the Lanterman-Petris-Short Act

HOW TO REACH YOUR PATIENTS' RIGHTS ADVOCATE

If you have any questions or would like to make a complaint about a possible violation of your rights, please call the advocacy office listed on the back cover of this handbook.

Patients' rights law is composed of a complex and evolving system of statutes, regulations, and court decisions This handbook should be considered a guide, but it may not accurately reflect all the rights available to persons at all times.

The person in charge of the facility in which you are receiving treatment is responsible for ensuring that all your rights in this handbook are protected. You should be informed of your rights in a language and a manner that you can understand

- On admission to the facility
- When there is a change in your legal status
- When you are transferred to another unit or facility
- At least once a year

If you believe that your rights may have been denied or violated, please contact your patients' rights advocate, even if your situation is not specifically covered in this handbook

INTRODUCTION

If you are receiving, either voluntarily or involuntarily, mental health services in one of the facilities listed below, you have the rights outlined in this handbook. Your rights may vary depending on your legal status or the type of facility you reside in. *Your rights may not be waived by your parent, guardian, or conservator.*

State Hospital
Acute Psychiatric Hospital
Psychiatric Unit of General Acute Care Hospital
Skilled Nursing Facility/IMD
Licensed Group Home
Adult Residential Facility
Licensed Family Home
Adult Day Care Facility
Psychiatric Health Facility
Mental Health Rehabilitation Center
Community Treatment Facility
23-Hour Treatment Facility

You cannot be asked to give up any of your rights or threatened into giving them up as a condition of admission or for receiving treatment; however, you may not choose not to exercise a specific right.

ACCESS TO THE PATIENTS' RIGHTS ADVOCATE

You have the right to see a patients' rights advocate who has no clinical or administrative responsibility for your mental health treatment and to receive his or her services. Your advocate's name and telephone number are located on the back cover of this handbook.

You have the right to contact the patients' rights advocate at any time. The facility where you are staying will provide you with assistance to ensure that you can exercise the right. You have the right to communicate with and to receive visits privately from your patients' right advocate or attorney.

WHAT IF YOU HAVE A COMPLAINT

You have the right to complain about your living conditions, any physical or verbal abuse, any threats or acts of cruelty, or your treatment in the facility without being punished for voicing such complaints

The patients' right advocate is responsible for investigating and trying to resolve complaints about your rights. If the advocate is unable to help you with your concern, your complaint may be referred, with your permission, to another agency that can assist you

If you are dissatisfied with the advocate's response to your complaint about your rights, your complaint may be referred to the facility director or to your local mental health director on your request

RIGHTS WHILE YOU ARE INVOLUNTARILY DETAINED

The following text provides information about being involuntarily detained.

72-Hour Hold of "5150"

When a person, as a result of a mental disorder, is a danger to himself/herself or others or is gravely disabled, a peace officer, a member of the attending staff, or another professional person designated by the county may with probable cause take the person into custody and place him or her in a facility for a 72-hour treatment and evaluation.

The facility shall require a written application stating the circumstances under which there is a probable cause to believe that a person is, as a result of a mental disorder, a danger to himself/herself or others or is gravely disabled If the probable cause is based on the statement of a person other than a police officer, a member of the attending staff, or a professional person, this person shall be liable in a civil action for intentionally giving a statement that he or she knows to be false.

If you were brought into a mental health facility against your will because you were considered to be a danger to yourself, a danger to others, or gravely disabled because of a mental disorder, you may be held up to 72 hours for treatment and evaluation unless the person in charge can establish that you need an additional 14 days of mental health treatment (*Welfare and Institutions Code Sections 5150 and 5250*).

14-Day Certification for Intensive Treatment or "5250"
If a person is detained for 72 hours under the provisions of Section 5150 of the *Welfare and Institutions Code* and has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to a mental disorder or an impairment by chronic alcoholism under the following conditions

- The professional staff of the facility that provides evaluation services has analyzed the person's condition and has found that the person is a danger to himself/herself or others or is gravely disabled.
- The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

If you are held beyond 72 hours, you have the right to remain in the hospital for voluntary treatment. If you do not wish to stay voluntarily treatment. If you do not wish to stay voluntarily, you will automatically be scheduled for a certification review hearing, which will occur at the facility where you are staying within four days of the end of your 72-hour hold. You may be represented at this hearing by a patients' rights advocate or another person of your choice. You can also request to have family members or someone of your choice at the hearing to help explain your circumstances (*Welfare and Institutions Code 5250*). If you want your advocate or facility staff member to telephone someone for you, make this request before the hearing.
*Helpful Hint
If you request a writ of habeas corpus, you give up your right to have a certification hearing. Talk to your advocate for more details about how the writ process works.

Re-certification for Intensive Treatment of "5260"
If during the 14-day certification you attempted or threatened to take your own life and if you remain an imminent threat of taking your life, your doctor may place you on an additional 14-day hold, which is known as a re-certification. You have the right to request a writ of habeas corpus. **Please note that no hearing will take place for this hold** (*Welfare and Institutions Code Section 5260*).

Additional 30-Day Hold or "5270.1"
In some counties, after you have completed a 14-day period of treatment, you may be held for an additional 30 days if your doctor determines that you remain gravely disabled and you are unwilling to accept voluntary treatment Another certification hearing will automatically be held You have the right to have a patients' rights advocate assist you at the hearing. You also have the right to request a writ of habeas corpus at any time during this period and to have a patients' rights advocate or attorney assist you at the hearing (*Welfare and Institutions Code Section 5270.1*).

Post Certification for Dangerousness or "5300 et. al."
If sufficient reason exists at the end of the 14-day certification to believe that you are a danger to others because of a mental disorder, the person who is in charge of the facility may petition the court to require you to remain in the facility for further treatment. This treatment is not to exceed 180 days. You have the right to representation by an attorney and to a jury trial (*Welfare and Institutions Code Section 5300 et. al.*).

Temporary Conservatorship
If the person in charge of the facility where you are staying believes that you may benefit from the services of a conservator because you remain *gravely disabled*, you may be placed on a temporary conservatorship (T-con) for up to 30 days. At the end of 30 days, a hearing will be held to determine whether you remain gravely disable and whether and whether a one-year conservatorship will be necessary. Your advocate or attorney can assist you with the conservatorship hearing process (*Welfare and Institutions Code Section 5352.1*).

CONFIDENTIALITY
Your record is confidential and can be released only to you or people who are involved in providing you with medical or psychiatric services, except under court order, or as provided by law. However, other specific people may be given access to your records whenever you, your guardian, or your conservator gives express consent by signing a form that authorizes the release of information
You must also be informed of your right to have or to not have other persons notified if you are hospitalized.

MEDICAL TREATMENT
While you are staying in a facility, you have the right to prompt medical care and treatment
*Helpful Hints

- If you don't feel well or are in pain, let your doctor or a treatment staff member know right away.
- If you have any question about your treatment, talk to your doctor or a treatment staff member or ask your advocate to help you.

RIGHT TO REFUSE TREATMENT
Voluntary Patients
You can refuse any type of medical or mental health treatment, including medications, unless the situation is an emergency (see the "Definitions" section of this handbook for *emergency treatment*).

Involuntary Patients
You have the right to refuse medical treatment or treatment with medications (except in an emergency) unless a capacity hearing is held and a hearing officer or a judge finds that you do not have the capacity to consent to or refuse treatment. The advocate or public defender can assist you with this matter.

RESIDENT INITIALS: _____

Conservatees
If you are on conservatorship and the judge has granted your conservator power to make mental health treatment decisions, you no longer have the right to consent to or refuse treatment. You should talk with your advocate or attorney for more information. In addition, in some cases, a judge may allow a patient on conservatorship to retain the right to consent to or refuse medical treatment.

All Patients
You have the right to refuses to take part in any research project or medical experiment You also have the right to refuse electroconvulsive treatment (ECT) or any form of convulsive therapy. However, if a court has determined that you lack the capacity to make this decision, then ECT may be given *without* your consent An advocate or a public defender can assist you with the hearing process (*Welfare and Institutions Code Section 5326.7*)

MEDICATIONS AND THE INFORMED CONSENT PROCESS
Voluntary Patients
If you are a voluntary adult patient, you have the right to consent to or refuse taking antipsychotic medications (except in an emergency). You may be treated with antipsychotic medications only after the hospital has completed the *informed consent* process.

Involuntary Patients
If you are being detained against your will, you have the right to refuse treatment with antipsychotic medications *unless the situation is an emergency or a hearing officer or a judge has determined that you are incapable of making this decision.*
*Helpful Hint
If your medication interferes with your ability to participate in daily activities or has other unpleasant side effects, let your doctor know

The Informed Consent Process
Before you give your consent to take any antipsychotic medication, your doctor must first explain to you the following:

1. The reasons for your taking this medication and the benefits that you can expect
2. Your right to withdraw your consent at any time
3. The type and the amount of medication and how often you must take it
4. The common side effects from taking the medication, the effects that you are most likely to experience, and for how long the doctor believes you will need to take the medication
5. Alternative treatments that are available (if any)
6. The potential long-term side effects of taking the medication

*Helpful Hint
If you are asked to consent to taking medications without being given a full explanation, talk to your advocate.

CAPACITY HEARING FOR MEDICATIONS
A capacity hearing, which is also called a Riese Hearing, may be held to determine whether you may or may not refuse treatment with medications. The capacity hearing will be conducted by a hearing officer at the facility where you are receiving treatment or by a judge in court. The hearing officer will determine whether you have the capacity to consent to or refuse medication as a form of treatment.
You have the right to be represented at the capacity hearing by an advocate or by an attorney Your representative will help you prepare for the hearing and will answer your questions or discuss concerns that you may have about the hearing process.
If you disagree with the capacity hearing decision, you may appeal the decision to a superior court or to a court of appeal. Your patients' rights advocate or attorney can assist you with filing an appeal
*Helpful Hint
If you have any questions about your right to consent to or refuse medications or about the capacity hearing process, talk to your patients' rights advocate or the public defender.

RIGHTS THAT CANNOT BE DENIED
Persons with mental illness have the same legal rights and responsibilities that are guaranteed all other persons by the federal and state constitution and laws unless specifically limited by federal or state laws and regulations (*Welfare and Institutions Code Section 5325.1*).

The Right to Humane Care
You have the right to dignity, privacy, and human care. You also have the right to treatment services that promote your potential to function independently. Treatment must be provided in ways that are least restrictive to you.
*Helpful Hints

- If you feel that your treatment is too restrictive, talk to your doctor and find out how your treatment can be changed.
- You can also talk to the patients' rights advocate or file a complaint

The Right to Be Free from Abuse or Neglect
You have the right to be free from abuse, neglect or harm, including unnecessary or excessive physical restraint, isolation, or medication. Medication shall not be used as punishment, for the convenience of staff, as a substitute for treatment, or in quantities that interfere with the treatment program. You also have the right to be free from hazardous procedures.
*Helpful Hint

RESIDENT INITIALS: _____

If you believe that you have suffered abuse or neglect in the facility or feel that your treatment is more restrictive than necessary, talk to your advocate or let a staff member know.

The Right to Social Activities and Recreation
You have the right to social interaction and participation in activities within the community or within the facility if you are hospitalized.
You have the right to physical exercise and recreational opportunities.

The Right to Education
You have the right to participate in appropriate programs of publically supported education.

The Right to Religious Freedom and Practice
You have the right to religious freedom and practice
*Helpful Hint
Your right to practice your religion cannot be denied by anyone. You may not be pressured in any way to participate in religious practices, and you do not have to accept a visit from a clergyman of any religion unless you want to. As soon as possible after you are admitted to a facility, you should let the staff know whether you have any special religious needs.

The Right to Be Free from Discrimination
You have the right to receive mental health services without discrimination on the basis of race, color, religious, sex, national origin, ancestry, age, marital status, physical or mental disability, medical condition, or sexual orientation.
*Helpful Hint
Talk with a staff member or your advocate if you have any concerns about discrimination.

RIGHTS THAT MAY BE DENIED WITH GOOD CAUSE
Unless the facility's staff and the doctor have good cause to do so, you cannot be denied any of the following rights:

Clothing
You have the right to wear your own clothes (except as prohibited by law in some state hospitals).

Money
You have the right to keep and be allowed to spend a reasonable sum or your own money or personal funds for canteen expenses and small purchases.

Visitors
You have the right to see visitors each day.
*Helpful Hint
Please check with the facility where you are staying for more details on visiting times and policies.

Storage Space
You have the right to have access to storage space for your personal belongings

Personal Possessions
You have the right to keep and use your own personal possessions, including your own toilet articles.

Telephone
You have the right to have reasonable access to a telephone both to make and receive confidential calls or to have such calls made for you.
*Helpful Hint
If telephones are not place where you can make private phone calls, ask a facility staff member whether you can have privacy when making your call.

Mail
You have the right to receive mail and unopened correspondence.

Writing Materials
You have the right to have letter-writing materials, including stamps, made available to you.

GOOD CAUSE
Good cause for denying any of the rights means that the professional person in charge has a good reason to believe that allowing a specific right would cause:

1. Injury to that person or others; or
2. A serious infringement on the rights of others; or
3. Serious damage to the facility;
   And there is no less restrictive way to protect against those occurrences

Your rights cannot be denied as a condition of admission, a privilege to be earned, a punishment, a convenience to staff, or a part of a treatment program A denial of a right can be made only by the person authorized by law or regulation to do so, and this denial must be noted in your treatment record. If one of your

RESIDENT INITIALS: _____

rights is going to be denied, a staff member must inform you. Any denial of a right must be reviewed on a regular and ongoing basis. Once good cause no longer exists, your right(s) must be restored.

*Helpful Hint

If you feel that you have had a right unfairly denied or you would like a right restored, you can talk to your advocate or a staff member or file a complaint.

DEFINITIONS

Advocate. The person mandated by state law to ensure that mental health patients maintain their statutory and constitutional rights.

Antipsychotic Medication. Any medication that is customarily prescribe for the treatment of mental disorders, emotional disorders, or both

Capacity. A determination of whether a person is:

- Aware of his or her situation,
- Able to understand the risks, benefits, and alternatives to the proposed treatment; and,
- Able to understand and knowingly and intelligently evaluate information as it concerns giving consent and to otherwise use rational thought processes to participate in treatment decisions.

Conservator. A person who is appointed by a court to take care of a patient, his or her property, or both when the patient is considered to be gravely disabled as a result of a mental disorder or an impairment by chronic alcoholism. A conservator may be a public agency representative or a private person. A conservator may make decisions about a patient's treatment, placement, and finances.

Emergency Treatment. A situation in which action to impose treatment over a person's objection is immediately necessary for the preservation of life or the preservation of serious bodily harm to the patient or to others and it is impractical to first gain consent from the patient.

Gravely Disabled. A person who is unable, by reason of a mental disorder, to provide for his or her own food, clothing, or shelter. A person is not gravely disabled is someone else is 3willing and able to provide these basic necessities.

Hearing Officer. A superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer who makes decisions in mental health certification review and capacity hearings.

Imminent. About to happen or ready to take place.

Informed Consent. A process by which a patient is informed of any antipsychotic medications that have been prescribed to him or her and the patient's consent is obtained. The informed consent form states that the patient was informed about the prescribed medication(s), including the type of medication, the quantity, the benefits or side effects of the medication, and the other forms of treatment that are available. The mental health facility is also require to keep the signed consent form in the patient's record.

Petition for Writ of Habeas Corpus. A legal request for release from a facility or an institution that a patient can file himself or herself or with the help of an attorney, an advocate, or a facility staff member. If accepted, the writ will entitle a patient to a hearing in a superior court.

Probable Cause. The amount of evidence that justifies issuing a 14-day certification. The mental health facility must establish specific facts that would reasonably lead someone to believe that a person is dangerous to himself, herself, or others or is gravely disabled.

Merced County Patients' Rights Advocate Address and Telephone Number
300 E. 15th Street
Merced, CA 95340
(209) 381-6876
(800) 736-5809

If you are unable to reach your patients' rights advocate you may contact:
Office of Patients' Rights (916) 575-1610
Office of Human Rights (916) 654-2327

RESIDENT INITIALS: _____

CPT CONTRABAND LIST

The following is a list of items that are not allowed in the facility, along with items that will be secured with client accessibility during designated times. This safety protocol will be implemented facility wide.

Restricted Items:
Illicit Drugs
Glass Products
Pepper Spray
Matches/Lighters
Solid Red or Blue Clothing (Forensic Program)
Compact Glass Mirrors
Loose Tobacco
Electronic Devices with recording capabilities
Cell phones
Alcohol/Alcohol based Products
Knives
Explosives
Weapons
Televisions (Smart type w/ Internet capabilities)
Metal Nail Files
Loose weights/dumb bell style
Fingernail/Toenail Clippers

Accessible Items that will be secured:
Nail Polish/Remover
Needles (Arts/Crafts Type)
Hair Curlers
Hair Dryers
Curling Irons/Flat Irons
Access to cash in the amount of $ 25.00
Televisions
Razors

*The accessible items that will be secured may not be restricted absent a showing of good cause, documented in the resident's record and approved by Dr. Hackett and/or Dr. Turpin or their designee.

DISTRIBUTION OF AGREEMENT

COMPLETE THE APPROPRIATE SECTION, EITHER SECTION 1 & 2 OR SECTION 3 & 4, DO NOT COMPLETE BOTH

SECTION 1 & 2

Last, First----000-00-0000-----MM-DD-YYYY

Has received a copy of this completed admission agreement as indicated by signature below.

1.

RESIDENT SIGNATURE _____ DATE _____

2.

CPT STAFF SIGNATURE _____ DATE _____

SECTION 3 & 4

Last, First----000-00-0000-----MM-DD-YYYY

Has chosen not to sign for a copy of this admissions agreement as evidenced by the staff signature and witness signature below.

3.

CPT STAFF SIGNATURE AND TITLE _____ DATE _____

4.

WITNESS _____ DATE _____

RESIDENT INITIALS: _____

California Psychiatric Transitions

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at a time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations, and you may give us written authorization to use or disclose your health information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or anther person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with and opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

RESIDENT INITIALS: _____

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials; health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You complete a medical records release form to obtain access to your health information. You may obtain a form by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you a minimum of $30.00 or $2.50 for each page after (12) twelve pages for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have a right to receive a list of instances in which our business associates or we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 15, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Aaron Stocking, Director
California Psychiatric Transitions
P.O. Box 339
Delhi, CA 95315
Phone: (209) 667-9304
Fax: (209) 669-3978

RESIDENT INITIALS: _____

CALIFORNIA PSYCHIATRIC TRANSITIONS
MENTAL HEALTH REHABILITATION CENTER
P.O. Box 339, Delhi, CA 95315

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, California Psychiatric Transitions has created this Notice of Privacy Practices. This Notice describes California Psychiatric Transitions' privacy practices and the rights to you, the individual; have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that California Psychiatric Transitions protect the privacy of your PHI that we have received or created.

Acknowledgement of Receipt of Notice of Privacy Practices

California Psychiatric Transitions
P.O. Box 339
Delhi, CA 95315

I hereby acknowledge that I received a copy of California Psychiatric Transitions' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of the Notice of Privacy Practices should there be any amendments.

_____ _____
SIGNATURE DATE

If not signed by the person receiving services, please indicate:

Relationship:

- ☐ Parent or Guardian of Minor.
- ☐ Legal Authorized Representative or Conservator of an adult receiving services.
- ☐ Beneficiary or personal representative of a person having received services.

Name of person receiving services: **Last, First----000-00-0000-----MM-DD-YYYY**

☐ **REFUSED TO SIGN** **Date:** _____

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

RESIDENT INITIALS: _____

ADDENDUM TO THE
CALIFORNIA PSYCHIATRIC TRANSITIONS
MENTAL HEALTH REHABILITATION CENTER (MHRC)
ADMISSION AGREEMENT

RE: Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME---SOCIAL SECURITY NUMBER---DATE OF BIRTH

FROM: County/Regional Center
RESPONSIBLE PLACING AGENCY

WHEREAS, California Psychiatric Transitions Mental Health Rehabilitation Center ("CPT") and _____ ("Placement Agency") entered into that certain written Admission Agreement, dated _____ ("Admission Agreement") for purposes of providing mental health rehabilitation services, including medical monitoring and routine health care, to the aforementioned Resident. The undersigned, being all of the parties to the foregoing Admission Agreement, by their respective signatures hereby acknowledge and agree as follows:

1. Placement Agency Representations and Warranty: The Placement Agency hereby represents and warrants to CPT the following:

1.1 Placement Agency has shared with CPT all available information about Resident, including relevant social, medical and educational history, behavior problems, court involvement and other specific characteristics of Resident before placement with CPT and shall promptly share additional information to CPT when obtained.

1.2 Placement Agency has conducted a background check of Resident and has provided written notice to CPT if the Resident has been convicted of a crime other than a minor traffic violation. Placement Agency has provided written notice to CPT if examination of arrest records has determined that there is a possible danger to CPT employees and personnel, CPT patients and/or any third parties located on or surrounding CPT's location.

1.3 Placement Agency represents and warrants that Resident:

1.3.1. Has not been registered as a sex offender, as defined by California Penal Code Section 290 et seq;

1.3.2. Has not been convicted for violating California rape laws as defined under California Penal Code 261 et seq.,

1.3.3. Has not been convicted for sexual battery under California Penal Code 243.3;

1.3.4. Has not been convicted for engaging in lewd acts with or involving minors, as defined under California Penal Code 288, California Penal Code 311 and Penal Code 314.

2. Indemnification. COUNTY/PLACEMENT AGENCY agrees to indemnify and hold harmless CPA and CPA's employees or agents from and against any damages including costs and attorney's fees arising out of negligent or intentional acts or omissions of COUNTY/PLACEMENT AGENCY, its employees or agents caused by the COUNTY/PLACEMENT AGENCY'S breach of any of its representations and warranties set forth in this Addendum.

RESIDENT INITIALS: _____

CPT agrees to indemnify and hold harmless COUNTY/PLACEMENT AGENCY, its employees, agents and elective and
appointive boards from and against any damages including costs and attorney's fees arising out of negligent or intentional acts or omissions of CONTRACTOR, its employees or agents for actions relating to this Addendum.
This indemnification shall extend to claims, losses, damages, injury, and liability for injuries occurring after completion of CPT'S services, as well as during the progress of rendering such services. Acceptance of insurance required by this Agreement does not relieve CPT from liability under this indemnification clause. This indemnification clause shall apply to all damages or claims for damages suffered by CONTRACTOR'S operations regardless if any insurance is applicable or not. This indemnification applies only to this Addendum.

3. Confirmation of Terms. All of the terms, covenants and conditions of the Admission Agreement, including all addendums, attachments and exhibits, except as are herein specifically modified and amended, shall remain in full force and effect, and are hereby adopted and reaffirmed by the parties hereto.

1. _____ _____
RESIDENT SIGNATURE DATE

2. _____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3. _____ _____
CPT STAFF SIGNATURE DATE

4. _____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

Exhibit C

PROFESSIONAL SERVICES CONTRACTS
INSURANCE REQUIREMENTS

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than $1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of $1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than $2,000,000.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.

2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:

   a. *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*

   b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.*

   c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTOR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

d. Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled, except after written notice has been provided to the COUNTY.

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Deductibles and Self-insured retentions must be declared and any deductible or self-insured retention that exceeds $100,000 will be reviewed by the COUNTY Risk Manager for approval.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.

WAIVERS:

I represent and attest that I am a person authorized to make representations on behalf of the CONTRACTOR, and represent the following:

(mark X if applicable)

☐ Automobile Exemption: I certify that _____ does not own nor use vehicles in the performance of the agreement for which this insurance requirement is attached.

☐ Workers' Compensation Exemption: I certify that _____ is not required to carry workers' compensation coverage or has filed an exemption with the State of California as required by law.

I acknowledge and represent that we have met the insurance requirements listed above.

Print Name Aaron J Stocking Date: 2.27.19

Contractor Name California Psychiatric Transitions

Signature _____