RESOLUTION - ACTION REQUESTED 2021-426

MEETING: July 20, 2021

TO: The Board of Supervisors

FROM: Shannon Gadd, Health and Human Services Agency Director

RE: Agreement with Aegis Treatment Centers, LLC

RECOMMENDATION AND JUSTIFICATION:
Approve a Three-Year Agreement with Aegis Treatment Centers, LLC to Provide Outpatient Treatment Services in an Amount Not to Exceed $45,000 for Each Fiscal Year; and Authorize the Board of Supervisors Chair to Sign the Agreement.

Aegis Treatment Centers provides a Drug Medi-Cal (DMC) outpatient Narcotic Therapy Replacement Services to Mariposa County residents. Additional services include methadone treatment, individual and group counseling, and drug screening and testing as appropriate.

BACKGROUND AND HISTORY OF BOARD ACTIONS:
Board of Supervisors approved Health Insurance Portability and Accountability Act (HIPAA), Business Associate Agreement with Aegis Treatment Centers on November 13, 2018 through Resolution No. 2018-525

ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:
If this agreement is not approved, County of Mariposa will lose the services of a key DMC provider and risk being ill equipped in meeting a vital need of its residents.

FINANCIAL IMPACT:
The costs for this agreement will be paid within the Substance Use Disorder budget. There is no impact to the County General Fund.

ATTACHMENTS:
Aegis Pinnacle Mariposa County Treatment Center Agreement - June 24 2021 (PDF)

RESULT: ADOPTED BY CONSENT VOTE [UNANIMOUS]
MOVER: Miles Menetrey, District V Supervisor
SECONDER: Wayne Forsythe, District IV Supervisor
AYES: Smallcombe, Sweeney, Long, Forsythe, Menetrey

REF ID# 11952
NARCOTIC REPLACEMENT THERAPY SERVICES AGREEMENT BETWEEN

THE COUNTY OF MARIPOSA

AND

AEGIS TREATMENT CENTERS, LLC

Fiscal Years 2021-2024

LEGAL ENTITY:

AEGIS TREATMENT CENTERS, LLC

1317 Route 73 North, Suite 200, Mount Laurel, NJ 08054

Central Office Address

590 Rio Lindo Ave., Chico, CA  95926

Facility Address: (Provider)

Contract Number

Legal Entity Number

Provider number(s)
COUNTY OF MARIPOSA
NARCOTIC REPLACEMENT THERAPY SERVICES AGREEMENT
FYs 2021-2024

This NARCOTIC REPLACEMENT THERAPY SERVICES AGREEMENT ("Agreement") is made and entered into by and between the County of Mariposa, a political subdivision of the State of California, through its Mariposa County Health and Human Services Agency, hereinafter referred to as “County”, and

Provider | AEGIS TREATMENT CENTERS, LLC (hereafter “Provider”)
| 1317 Route 73 North, Suite 200
| Mount Laurel, NJ 08054

Facility | Aegis Merced
| 1343 W. Main Street
| Merced, CA 95340

| Aegis Fresno
| 3707 East Shields Ave
| Fresno, CA 93726

WHEREAS, County believes it is in the best interest of the people of the County of Mariposa to provide a structured program for those who have the need to receive Narcotic Replacement Therapy Services; and

WHEREAS, Provider is in the business of operating a certified and licensed program to perform Narcotic Replacement Therapy Services in Merced, Fresno, and other California Counties; and

WHEREAS, these services shall be provided by Provider in accordance with all applicable County, State and Federal statutes, laws, regulations and standards, required licenses, ordinances, rules, Regulations, manuals, guidelines, and directives, which may include, but are not necessarily limited to, the following: California Health and Safety Code (HSC), Division 10.5; Title 9; California Code of Regulations (CCR), Division 4, Section 9000 et seq; Title 9, CCR, Division 4, Chapter 2.5; California Government Code, Article 1.7, Federal Block Grants, Chapter 2, Part 2, Division 4, Title 2, commencing at Section 16366.1-16367.8; California Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130; Title 42, USC, Chapter 6A, Subchapter XVII – Part B, Subpart II, commencing at Section 300x-21 through 300x-35; Block Grant [Public Law 102-321 (Title 42, USC, commencing at Section 101)]; Single Audit Act of 1984 (31 USC section 7501 Public Law 98-502) and the Single Audit Act Amendments of 1996 (31 USC sections 7501-7507 Public Law) and corresponding most recently revised OMB Circular A-133; Title 21, CFR, Part 291 (Food and Drug Administration Requirements for Narcotic Treatment Programs); Title 42, Code of Federal Regulations, 42 U.S.C. § 290dd-2, and implementing regulations found at 42 C.F.R. Part 2, Sections 8.1 through 8.34, Title 21, CFR, Part 1301.01 through 1301.93 (Drug Enforcement Administration Requirements for Food and Drugs); State Administrative Manual, Chapter 7200, USC The Office of Management and Budget (OMB) Circular A-133 revised June 27, 2003; Title 45 Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137; State Administrative Manual (SAM); Title 45, CFR, Part 96 as applicable in the expenditure of the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds; Perinatal Services Network
WHEREAS, The provisions of this Agreement are not intended to abrogate any provisions of Laws or Regulations, or any standards existing or enacted during the term of this Agreement;

WHEREAS, the words and terms of this contact are intended to have their usual meanings:

A. “Alcohol and Drug Substance Abuse Recovery Services” means services provided by a Drug Treatment Program which is licensed and certified by the Department of Alcohol and Drug Programs pursuant to Chapter 10.5 (commencing with Section 11750) of the Health and Safety Code. Services under this definition may include but not be limited to: Support Services, Primary and Secondary Prevention Services, Nonresidential Outpatient Services (ODF Individual/Group), Day Care Habilitative-Day Treatment, Residential Treatment Services, Alcohol and Drug Free Housing, and/or Ancillary Services;

B. “Available Capacity” means the total number of units of service (bed days, hours, slots, etc.) that a Provider actually makes available in the current fiscal year;

C. “Beneficiary” means a person who has been determined eligible for Medi-Cal and is not prohibited from benefits under federal law by virtue of institutionalization. A beneficiary eligible for Drug Medi-Cal (DMC) services must have a substance-related disorder according to the Diagnostic and Statistical Manual of Mental Disorders” (hereafter referred to as DSM), DSM-III-R, and/or DSM-IV criteria, and meet the admission criteria for the Covered Services in this part; and could be a defendant, probationer, parolee, and any other individuals eligible to receive services pursuant to this Agreement.

D. “Contract Maximum” shall mean the maximum financial obligation of the County to the Provider for services performed during each fiscal year of the term of the Agreement;

E. “County” means (a) Mariposa County (b) Mariposa County Health and Human Services Agency; authorized by the Mariposa County Board of Supervisors to administer narcotic treatment programs;

F. “Provider County” means Mariposa County authorized by their County Board of Supervisors to administer narcotic treatment programs; and the county where the Drug Medi-Cal certified Provider physically provides covered substance abuse treatment services;

G. “Covered Services” means DMC services authorized by Title XIX of the Social Security Act and specified in Title 22, CCR, Section 51341.1; HSC Section 11758.46; the W&IC; and California’s Medicaid State Plan. Covered Services are Naltrexone treatment, outpatient drug free treatment, narcotic treatment, day care rehabilitative (for pregnant or postpartum beneficiaries and those receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services), and perinatal residential substance abuse treatment (excluding room and board);
H. “Days” means calendar days unless noted otherwise;
I. “Director” means the Mariposa County Health and Human Services Agency Director/Mariposa County Alcohol and Drug Administrator;
J. “Drug Medi-Cal (DMC) Program” means the State system wherein eligible Beneficiaries receive Covered Services from DMC certified substance abuse treatment providers that are reimbursed for services with Local Revenue Fund of 2011 Drug Medi-Cal subaccount funds and federal Medicaid funds, also referred to as Federal Financial Participation (FFP);
K. “Drug Treatment Program” means a program licensed and certified by the State pursuant to Chapter 10.5 (commencing with Section 11750) of the Health and Safety Code;
L. “Drug Treatment Services” means services, which may include one or more of the following: outpatient treatment, half-way house treatment, narcotic replacement therapy, drug education or prevention courses and/or limited inpatient or residential drug treatment as needed to address special detoxification or relapse situations or severe dependence. The term "drug treatment program" or "drug treatment" does not include drug treatment programs offered in a prison or jail facility;
M. “Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program” means the federally mandated Medicaid benefit for full-scope Medi-Cal beneficiaries under 21 years of age that provides any Medicaid service necessary to correct or ameliorate a defect, or mental illness, or other condition, such as substance-related disorder, discovered during a health examination. Refer to also Title 22, CCR, Sections 51340 through 51340.1;
N. “Encumbered Amount” means the amount reflected as the Contract Maximum in this Agreement and supported by the Service Summary;
O. “Family counseling” means face-to-face counseling with individuals, couples, or groups which examines interpersonal and family relationships. Such counseling shall be provided by an individual licensed in accordance with Sections 4980 through 4981 of the California Business and Professions Code;
P. “Federal Financial Participation (FFP)” means the federal funds reimbursed for covered Medicaid services;
Q. “Final Settlement” for providers other than Narcotic Treatment Programs (NTPs) means permanent settlement of the Provider’s actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year end cost settlement report was accepted for interim settlement by the State. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement; “Final Settlement” for NTPs means the permanent settlement based on verification of approved Units of Service at the lower of per capita Uniform Statewide Daily Reimbursement rate or the Provider’s usual and customary charge to non-DMC patients for the same or similar services;
R. “Interim Settlement” means temporary settlement of actual allowable costs or expenditures reflected in the Provider’s year-end cost report settlement. For Narcotic Treatment Program Providers, “Interim Settlement” consists of determining the total allowable reimbursement using approved Units of Service at the lower of the Uniform Statewide Daily Reimbursement rate or the Provider’s usual and customary daily charge;
S. “Literacy Training” means instruction and information presented in an individual or group setting to increase literacy skills and reading comprehension;
T. “Medical Necessity” refers to the requirement that substance abuse treatment services are covered by DMC reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury as determined by a physician;

U. “Minor Consent Drug Medi-Cal (DMC) Services” means substance abuse treatment services and other services defined in Title 22, CCR, Section 50063.5, that may be provided to a person aged 12 through 20, without parental consent;

V. “Modality” means those necessary overall general service activities to provided alcohol and/or drug prevention or treatment that conform to the services described in Division 10.5 of the HSC;

W. “Narcotic Treatment Program” as defined in Title 22, CCR, Section 51341.1(b)(14), means an outpatient service licensed by the Department to provide replacement narcotic therapy using methadone, directed at stabilization and rehabilitation of persons who are opiate addicted and have a substance abuse diagnosis;

X. “Performance” means materially (a) providing the services in accordance with the Service Summary; (b) complying with the terms of the expenditures associated with allowable costs; and (c) abiding by the terms of this Agreement including all applicable County, State and federal statutes, regulations, and standards in expending funds for the provision of alcohol and drug treatment services;

Y. “Performance Report” means an annual year-end cost settlement based on billing activity;

Z. “Perinatal DMC Services” means Covered Services as well as mother/child habilitative services; service access, i.e., provision arrangement of transportation to and from medically necessary treatment; education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, CCR, Section 51341.1(c)(4));

AA. “Provider” means (a) the Provider identified in this Agreement who is authorized by the State and the Board of Supervisors to administer Narcotic Replacement Therapy Services Programs and/or Alcohol and Drug Prevention or Treatment Programs and who is certified by the State as meeting applicable standards for participation in the DMC Program set forth in the “DMC Certification Standards for Substance Abuse Clinics and Standards for Drug Treatment Programs;

BB. “Post-Service Post-Payment (PSPP) Utilization Review” means the review by the State or County for services of Medical Necessity and program coverage after service was rendered and the claim paid. The State or County may recover prior payments if such review determines that the services did not comply with the applicable statues, regulations, or standards.

CC. “Projected Units of Service” means the number of reimbursable DMC Units of Service, based on historical data, the Provider expects to provide on an annual (fiscal year) basis;

DD. “Revenue” means income from sources other than this Agreement;

EE. “Satellite Site” has the same meaning as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics;

FF. “Services Element” is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service
elements codes is incorporated into this Agreement as Document 1Hb of the State Documents Reference Manual, “Program Codes Listing.” A description of service codes is incorporated into this Agreement as Document 1Ha of the State Documents Reference Manual, “Service Code Descriptions and Unit Information”;

GG. “State” means the State of California;

HH. “Statewide Maximum Allowances (USDR)” means the maximum amount authorized to be paid by DMC for each covered Unit of Service for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. The USDR’s are subject to change annually and are listed in the “Units of Service” table. While these rates are approved by the State, they are subject to change by the California Department of Health Care Services (DHCS) and/or in the regulation process;

II. “Uniform Statewide Daily Reimbursement (USDR)” rate for a Narcotic Treatment Program is a “unit of service” that is a daily treatment service provided pursuant to Title 22, Section 51341.1, and Chapter 4 commencing with Section 10000 of Title 9, CCR. See Title 22, CCR, Section 51516.1, for NTP-specific services. The rates covered under this Agreement include rates for group and individual counseling for ten minute increments. While these rates are approved by the State, they are subject to change by DHCS and/or in the regulation process; If services are necessary and appropriate, NTP providers may be reimbursed for a maximum of 200 minutes (20, 10 minute increments) of individual and/or group counseling per calendar month per Beneficiary. NTP providers may request additional Units of Service if medical necessity warrants more than 200 minutes per month;

JJ. “Unit of Service” means the type of unit used to quantify the service modalities/service elements. Outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services means face-to-face contact on a calendar day. Only one face-to-face service contact per day is covered by DMC except emergencies when additional face-to-face contact may be covered for intake crisis intervention or collateral service. To count as a Unit of Service, the second contact shall not duplicate the services provided on the first contact, and each contact shall be clearly documented in the Beneficiary’s record. The Units of Services are listed below:

<table>
<thead>
<tr>
<th>Description</th>
<th>Unit of Service (UOS)</th>
<th>FY 2020-24 UOS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotic Treatment Program (NTP) - Methadone</td>
<td>Daily</td>
<td>$14.20</td>
</tr>
<tr>
<td>NTP - Individual Counseling</td>
<td>One 10-minute</td>
<td>$16.65</td>
</tr>
<tr>
<td>NTP - Group Counseling</td>
<td>One 10-minute</td>
<td>$3.80</td>
</tr>
</tbody>
</table>

Department of Health Care Services Substance Use Disorders - Program, Prevention and Fiscal Division Drug Medi-Cal (DMC) Rates for Fiscal Year 2021-2024 (based on the most recent rates listed in IN20-028)
### Perinatal DMC

<table>
<thead>
<tr>
<th>Description</th>
<th>Unit of Service (UOS)</th>
<th>FY 2020-24 UOS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTP - Methadone</td>
<td>Daily</td>
<td>$15.29</td>
</tr>
<tr>
<td>NTP - Individual Counseling</td>
<td>One 10-minute</td>
<td>$23.84</td>
</tr>
<tr>
<td>NTP - Group Counseling</td>
<td>One 10-minute</td>
<td>$6.09</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>Face-to-Face Visit</td>
<td>$91.45</td>
</tr>
<tr>
<td>Perinatal Residential</td>
<td>Daily</td>
<td>$112.55</td>
</tr>
<tr>
<td>ODF Individual Counseling</td>
<td>Face-to-Face Visit (Per)</td>
<td>$119.23</td>
</tr>
<tr>
<td>ODF Group Counseling</td>
<td>Face-to-Face Visit (Per)</td>
<td>$54.25</td>
</tr>
</tbody>
</table>

KK. “Utilization” means the total actual Units of Service used by Beneficiaries; and

NOW, THEREFORE, in consideration of the foregoing recitals and in consideration of the covenants, conditions, and promises contained in this Agreement, the parties agree to the following:

The foregoing recitals are hereby incorporated into this Agreement, and are made a part of this Agreement by this reference.

1. **TERM:**
   
   A. The term of this Agreement shall commence on July 1, 2021, and shall continue in full force and effect through each fiscal year of July 1, 2022 – June 30, 2023 and July 1, 2023 – June 30, 2024, with an end term date of June 30, 2024.
   
   B. **Termination:**
      
      1) This Agreement may be terminated by either party at any time without cause by giving at least thirty days prior written notice to the other party.
      
      2) This Agreement may be terminated by County or Provider upon a minimum of fifteen (15) days prior written notice;
a) If County or Provider reasonably and in good faith determines that:

(i) By County if any Federal, State, and/or County funds are not available for this Agreement or any portion thereof; or

(ii) By either party if it determines that the other party has failed to fulfill its obligations hereunder, including but not limited to failure to timely pay amounts due, failure to initiate services within the time and manner provided upon the commencement of this Agreement; or

(iii) By either party if the other party has failed to materially comply with any of the provisions of this Agreement in accordance with County, State, and Federal regulations, laws and policy; or

b) In accordance with Paragraphs 27 (TERMINATION FOR INSOLVENCY), 28 (TERMINATION FOR DEFAULT), and/or 29 (TERMINATION FOR IMPROPER CONSIDERATION).

3) In the event that this Agreement is terminated, or services would be reduced in any capacity then:

a) Contractor must notify MCBHRS within 3 business days of any termination of this Agreement, or material reduction in type or frequency of services.

b) Provider shall prepare and submit the Drug Medi-Cal Fiscal Detail Year End Expenditure Report pursuant to Paragraph 4 (FINANCIAL PROVISIONS) within 60 days of the date of termination. As per the terms of this Agreement, the permanent settlement shall be promptly tendered to Provider and shall be based on verification of approved Units of Service at the lower of per capita Uniform Statewide Daily Reimbursement rate or the Provider’s usual and customary charge; and

c) Upon receipt of any notice of termination, whether initiated by County or Provider, Provider shall use best efforts to make prompt and appropriate plans to transfer or refer all Beneficiaries receiving services under this Agreement to other agencies for continuing services in accordance with the Beneficiary’s needs. Such plans shall be subject to prior written approval of Director or Director’s designee (which shall not be unreasonably withheld), except that in specific cases, as determined by Provider, where an immediate Beneficiary transfer or referral is needed, Provider may make an immediate transfer or referral. If Provider terminates this Agreement, upon termination date, all costs related to such transfers or referrals shall not be a charge to this Agreement nor reimbursable in any way under this Agreement; and

d) In full accordance with applicable Laws or Regulations, upon receipt of any notice of termination, whether initiated by County or Provider, Provider shall forward copies of all County Beneficiary chart/record information necessary to transfer clients back to the County for services on a timely basis, but no later than seven (7) days following the effective contract termination date.

C. Suspension of Payments:

1) Upon a minimum of Fifteen (15) days prior written notice, upon good faith discretion of Director or the Director’s designee, payments to Provider under this Agreement may be suspended for good cause. Such 15 day notice of such suspension shall be provided to Provider, including a statement of reason(s) for such suspension. Following receipt of notice, Provider may, within 15 days, request reconsideration of the Director’s decision.
2. **OPERATION AND ADMINISTRATION:**

A. Director shall have the authority to administer this Agreement on behalf of County. Provider shall designate in writing a Contract Manager who shall function as liaison with County regarding Provider’s performance hereunder.

B. This Agreement shall be based on verification of approved Units of Service at the lower of per capita Uniform Statewide Daily Reimbursement (USDR) rate or the Provider’s usual and customary charge. The Projected Units of Service shall be based on historical data and Provider’s current capacity provided to the County by Provider. In order for the Director to administer and monitor Provider’s performance, Provider shall submit a quarterly report of Units of Service delivered throughout the term of this Agreement. All changes shall be made pursuant to Agreement, Paragraph 32 (ALTERATION OF TERMS).

1) In the event Provider’s referrals exceed the number of Beneficiaries, or Units of Service which can be reasonably served within the allocated financial provisions as reflected in the Service Summary(ies), the Provider shall notify the County in writing within ten (10) working days. Provider hereby certifies that Provider can provide services within the scope and limitation of this Agreement.

C. Provider agrees to furnish all space, facilities, equipment and supplies reasonably necessary for its proper operation and maintenance.

D. Any printed material or video media shall be reviewed and approved by the Director or the Director’s designee (which shall not be unreasonably withheld) prior to public distribution.

E. Provider agrees to collect proof of Mariposa County residency at the time of Beneficiary case opening and quarterly thereafter. Acceptable documents for proof of residency include one of the following forms of photo identification: (1) United States Passport, CA Driver’s License or ID Card, and one of the following proofs of residency: (1) current utility bill in client’s name listing residence address; (2) letter from current landlord listing client’s name and address; or (3) copy of current rental agreement signed by landlord listing client’s name and address.

F. Covered services provided by the Contractor shall be charged to Mariposa County only when the Beneficiary has Mariposa County Medi-cal.

G. Provider’s Board of Directors shall operate in material accordance with the provisions of its Articles of Incorporation and By-laws. To the extent in compliance with its governance standards, said documents and any amendments shall be maintained and retained by Provider and made available for review and/or inspection by Director at reasonable times during normal business hours.

3. **DESCRIPTION OF SERVICES/ACTIVITIES:**

A. County shall contract with Provider for the provision of Narcotic Replacement Therapy Services to eligible residents of County, in the form as detailed within this Agreement, and as identified on the Service Summary(ies), attached service exhibit(s) and attachment(s) including any addenda thereto. Services provided by Provider shall be the same regardless of the Beneficiary’s ability to pay or source of payment. This Agreement defines the rights and obligations of the parties regarding County payment to Provider.

B. If, during Provider’s provision of services under this Agreement, there is any need for substantial deviation from the services as described in the Service Exhibit(s) for this Agreement including any addenda thereto, then Provider shall submit a written request to the Director requesting approval in writing before any such substantial deviation may occur. Director shall provide written response to any such request within fifteen (15) days of receipt.
All changes shall be made in the form of an amendment pursuant to Paragraph 33 (ALTERATION OF TERMS).

4. FINANCIAL PROVISIONS:

A. General: This Agreement provides for reimbursement as provided in this Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph I (Payment) and as shown on the Service Summary(ies). The Provider shall materially comply with all requirements necessary for reimbursement as established by County, Federal, State, and local statutes, laws, ordinances, rules, regulations, manuals, policies, guidelines and directives. Under no circumstances can the total Maximum Contract Amount of this Agreement be increased or decreased without a properly executed Amendment.

1) Reimbursement: County agrees to reimburse Provider for State approved Units of Service during the term of this Agreement, resulting from services/activities, but not to exceed the Uniform Statewide Daily Reimbursement (USDR) rate per service rendered or Contract Maximum as shown on the Service Summary(ies) when Provider is providing Narcotic Replacement Therapy Services hereunder in accordance with CCR 22; SDMH Policy Letters; CR/DC Manual; RO/TCM Manual; DMH policies and procedures; and all other applicable Federal, State, and local laws, ordinances, rules, regulations manuals, guidelines, and directives.

B. Compensation: The Maximum Contract Amount for each Fiscal Year during the term of this Agreement as described in Paragraph 1 (TERM) shall not exceed Forty-Five Thousand Dollars ($45,000) and shall consist of County, State, and/or Federal funds as shown on the Service Summary(ies). Notwithstanding any other provisions of this Agreement, in no event shall County pay Provider more than this Maximum Contract Amount for Provider’s performance hereunder for each Fiscal Year during the term of this Agreement.

C. Established Maximum Allowable Rates: Notwithstanding any other provision of this Agreement, County shall not be required to pay Provider more than the unit charge/rate as identified on the Service Summary(ies). In no event will County contract to pay Provider more than the USDR rate for State approved Units of Service provided to Mariposa County Beneficiaries.

D. Narcotic Replacement Therapy Services:

1) Except as otherwise provided in this Agreement, if Provider provides Narcotic Replacement Therapy Services, then Provider shall be reimbursed as described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph A (General), Section (1) (Reimbursement) and at the rate established in the Service Summary(ies) of this Agreement.

a) Provider may appeal a denied or modified request for payment with the County concerning the processing or payment of a Provider’s claim, by submitting a written appeal request. Written appeals shall be submitted within 60 days of the date of receipt of the non-approval of payment or within 30 calendar days of the County’s failure to act on the request in accordance with the time frames within the County’s Provider Appeal Process described in section (b) below. County shall respond with its decision to the appeal request within 30 days of receipt of Providers appeal.

b) County, in accordance with WIC 14680, and Title 9, CCR has established a Provider Appeal Process. County’s appeal process may be obtained by contacting the County at the address and/or phone number as shown in Introduction, Paragraph 61 (NOTICES), of this Agreement.
2) Notwithstanding any other provision of this Agreement, if Narcotic Replacement Therapy Services, are provided hereunder, such services shall comply with and be compensated in accordance with all applicable Federal and State reimbursement requirements.

3) Provider shall be solely liable and responsible for all data and information submitted by Provider to County and/or State in support of all claims for services that may be based on data and information submitted by Provider. Provider shall process all service data within the time frame prescribed by the County and/or State.

4) Provider shall be required to participate in electronic submission of data, including but not limited to CalOMS entry and electronic data submission for upload into State’s data systems as required by Director.

5) Provider shall report to County all program, Beneficiary, staff and other data and information about Provider’s services hereunder, within fifteen days after the end of each reporting month.

6) Notwithstanding any other provision of this Agreement, Provider shall be totally liable and responsible for: 1) the accuracy of all data and information on all claims for services which County or Provider uploads into the County’s data systems; 2) the accuracy of all data and information which Provider provides to State; and 3) ensuring that processes are in place to ensure all services are performed appropriately within the Federal, State, and County guidelines, regulations, code, statutes, and law, including but not limited to, administration, utilization review, documentation, and staffing.

7) County is the designated fiscal intermediary for services provided under this Agreement. Provider shall comply with all written instructions from County with regard to any such claiming and documentation. Claim(s) shall only include those services provided by Provider.

8) Provider shall maintain an audit file of all records, including, but not limited to, all time studies or service activity logs/rosters prepared by Provider, documenting services as instructed by County for a period of 10 years from the end of the Fiscal Year in which such services were provided or until final resolution of any audits, whichever occurs later.

9) County may modify the claiming systems for services, at any time in order to comply with changes in, or interpretations of, State or Federal laws, rules, regulations, manuals, guidelines, and directives. County shall notify Provider in writing of any modification(s) which would impact Provider and the reason for the modification(s) within thirty days of County’s receipt of State or Federal notification for the implementation of the modification(s).

10) Narcotic Replacement Therapy Services, Overpayment Recovery Procedures: Provider shall repay to County the amount, if any, paid by County to Provider for any services which are found by County, State, and/or Federal governments to be un-reimbursable.

   For Federal audit exceptions, Federal audit appeal processes shall be followed. County recovery of Federal overpayment shall be made in accordance with all applicable Federal laws, regulations, manuals, guidelines, and directives.

   For State audit exceptions, in full accordance with State written requirements and this Agreement, County shall immediately recover any overpayment from Provider as soon as the State notifies the County of the overpayment due from County.

   For County audit exceptions, within 30 days of completion of Audit the County shall notify Provider in writing of the Audit settlement. The Provider shall have 30 calendar days
from receipt of notification of Audit settlement to appeal the Audit settlement. If Provider intends to appeal said notice, either in whole or in part, the County’s Provider Appeal Process shall be followed. The County’s Provider Appeal Process may be obtained by contacting the County at the address and/or phone number as shown in Paragraph 64 (NOTICES) of this Agreement.

Overpayment Recovery shall be handled in accordance with County Policy. Provider shall pay County according to the method described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph O (Payments Due to County/Method of Payment).

E. Shift of Funds

1) County, State, and/or Federal funds shall be limited to and shall not exceed the respective amounts shown on the Service Summary(ies).

2) Control of funds shall be for each Service Element identified on the Service Summary(ies) within this Agreement and in the amounts shown in the Service Summary(ies). With Director’s prior written approval (which shall not be unreasonably withheld), Provider may shift funds, on a dollar for dollar basis, from one service element to another Service Element identified on the Service Summary(ies) within this Agreement and within the applicable Fiscal Year.

3) Provider shall make a written request in the applicable Fiscal Year for Director’s approval of a shift of funds between respective Service Elements identified in the Service Summary(ies). Director shall approve or deny in writing a request to shift funds after a program review within ten days of the receipt of Provider’s written request. As described in Paragraph 32 (ALTERATION OF TERMS), a formal amendment shall be executed to reflect any Service Element shifts approved by the Director.

4) During the Final Settlement Process, Upon a minimum of fifteen days prior written notice to Provider, County may shift funds between respective Service Elements identified in the Service Summary(ies) at the Director’s good faith reasonable discretion, without requiring an Amendment to the Agreement.

5) Under no circumstances can the total Maximum Contract Amount of this Agreement be increased or decreased without a properly executed Amendment.

F. Provider Requested Changes:

1) If Provider desires any change in the terms and conditions of this Agreement, including adjustments between Service Elements within the Service Summary(ies), Provider shall request such change in writing. Notification to County of Provider’s requested changes shall include a revised Service Summary(ies), and a statement of the reason and basis for the proposed changes. All changes shall be made in the form of an amendment pursuant to Agreement Paragraph 32 (ALTERATION OF TERMS). Upon receipt of Provider’s request for change, Director shall respond with the determination within thirty (30) days.

2) If Provider requests to increase or decrease any Maximum Contract Amount, such request and all reports, data, and other information requested by County, shall be received by County’s Director for review prior to April 1 of the Fiscal Year in which the increase or decrease has been requested by Provider.

G. Government Funding Restrictions:

1) This Agreement shall be subject to any restrictions, limitations, or conditions imposed by
State, including but not limited to, those contained in the State’s Budget Act, which may in any way affect the provisions or funding of this Agreement. This Agreement shall also be subject to any additional restrictions, limitations, or conditions imposed by the Federal government that may in any way affect the provisions or funding of this Agreement.

2) This Agreement is valid and enforceable, subject to sufficient funds being made available to the County by the State and/or Grant sources funded by the United States Government, and subject to authorization and appropriation of sufficient funds pursuant to the State’s Budget Act and County’s Budget adoption process.

3) In the event the United States Government and/or the State Government and/or the County do not authorize and appropriate sufficient funds to allocate amounts pursuant to the Financial Provisions of this Agreement, it is mutually agreed that the Agreement shall be amended to reflect any reduction in the Financial Provisions and Performance Provisions for services rendered subsequent to any such amendment.

4) Notwithstanding any other provision of this Agreement, this Agreement shall not be effective and binding upon the parties unless and until County’s Board of Supervisors appropriates funds for purposes hereof in County’s Budget for County’s each current fiscal year during the term hereof.

H. Patient/Client Fees, Third Party Revenue:

1) Pursuant to Section 9532(b)(1), Title 9, of the CCR, Beneficiaries placed in Narcotic Treatment Programs shall be assessed by Provider to determine their ability to pay in accordance with Section 11991.5 of the HSC.

2) Except where share of cost is applicable, Providers shall accept proof of Drug Medi-Cal eligibility as full payment for treatment. Providers are not allowed to charge fees to a Beneficiary of Drug Medi-Cal to access substance use disorder services or for admission.

3) Provider retains contractual responsibility for determination of patient/client fees, and for the billing and collection of such fees.

I. Payment:

1) For each calendar month throughout the term of this Agreement, Provider shall submit to County a monthly report and/or document for each applicable Service Element delivered, in the form and content specified by County in writing. Data and documentation shall be submitted within 15 days from the end of the month for which the services were provided, in order to meet claiming timelines. A DHCS 100186 form must be included with the data and documentation of the services provided to County Medi-Cal Beneficiaries monthly (Attachment 10). If, after the close of the monthly submission time-frame, Provider desires to submit to County claim(s) and/or data and information documenting Units of Services for a particular month then Provider shall submit a request in writing setting forth the good cause reasons which prevented Provider from timely submission of such particular claim(s) data and information. Director or Director’s designee shall use good faith efforts in review and may, in writing Provider's request for submission beyond the County’s monthly time-frame. County shall assume no liability for payment of claim(s) not received within this time period.

a) Provider agrees to certify via signed invoice that DMC claims submitted represent legitimate and eligible expenditures and were reviewed for accuracy and legitimacy. The Provider will not knowingly submit claims for services rendered to any Beneficiary after that client has died, or has been unenrolled.
b) **Claims Reimbursement:** The County shall make provisional reimbursement to Provider based on the rate as reflected on the Service Summary(ies) less all other revenue, interest and return collected by Provider from services/activities delivered under this Agreement, as described in Paragraph 4 (FINANCIAL PROVISIONS), for the State approved Narcotic Replacement Therapy Services. Provisional reimbursement shall be based upon services actually provided as shown by Provider. By submission of claim, Provider certifies that all Units of Service claimed by Provider on a provisional reimbursement basis are to the best of Provider’s knowledge true and accurate claims for reimbursement.

(i) Final reimbursement/settlement to Provider shall be based upon State approved Units of Service, the Drug Medi-Cal Fiscal Detail Year End Expenditure Report for those approved units and/or USDR as described in Paragraph 4 (FINANCIAL PROVISIONS).

(ii) Further, Provider agrees to hold harmless the Beneficiary in the event County cannot or will not pay for services performed by Provider pursuant to this Agreement.

2) On the basis of this monthly claim and after GCBH and County Auditor review and approve the monthly claim, Provider shall receive from County provisional reimbursement of Provider's claimed amount, resulting from services/activities provided hereunder, including, but not limited to any other revenue, interest, and return as described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph H (Patient/Client Fees, Third Party Revenue).

The monthly claim and subsequent payment shall be made in accordance with County policies and procedures and terms of this Agreement. If a claim is not submitted as required by County and this Agreement, then payment shall be withheld until County is in receipt of a complete and correct claim and such claim has been reviewed and approved by Director or Director’s designee.

3) All monthly claims shall be subject to adjustment based upon the Audits or Disallowances, and/or Provider’s Drug Medi-Cal Fiscal Detail Year End Expenditure Report, which shall supersede and take precedence over all claims.

4) All monthly claims shall be based on narcotic replacement therapy services actually provided as shown on Provider’s invoice. By submission of claim, Provider certifies that all Units of Services reported by Provider are to the best of its knowledge true and accurate claims for reimbursement.

5) Claims for Narcotic Replacement Therapy Services, provided to clients, will be paid to Provider, only for the period of time Provider is licensed and/or certified by ADP as an Narcotic Treatment Program Provider, and only to the extent consistent with Federal laws and regulations.

6) Provider shall submit all claims for services delivered as per this Agreement within 60 days of termination of this Agreement. County shall not pay claims received after 60 days of termination of this Agreement unless claims are approved by the Director or Director’s designee, which shall not be unreasonably withheld.

J. **Withholding Submission of Monthly Claim For Non-submission of County Data System Documentation and Other Information:** County may withhold payment of any monthly claim, if any County data systems data, State data, Service Summary(ies) or other information to a material degree is not submitted by Provider to County and/or State in accordance with the
requirements of this Agreement. County shall give Provider written notice of its intention to withhold payment hereunder, including the reason(s) for its intended action. Thereafter, Provider shall have 30 days either to correct deficiencies, or to request reconsideration of the decision to withhold payment; said reconsideration shall not be unreasonably withheld. In circumstances under which Provider fails to comply with this Agreement and Laws and Regulations, County shall have no liability for Provider’s failure to comply with County, State, and Federal time frames for claiming and data submission.

K. Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report:

1) For each Fiscal Year or portion thereof that this Agreement is in effect, Provider shall provide County with one copy of an accurate and complete Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report, with a statement of expenses and revenue. The Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report will be submitted in accordance with the written instructions from County and shall be broken out into the respective Service Elements identified on the Service Summary(ies) within each legal entity. Such report shall be due within 90 days following the end of such Fiscal Year. In the event Provider ceases to do business, the final Drug Medi-Cal Fiscal Detail Year End Expenditure Report will be due no later than 90 days following the effective date of business closure. The Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report shall be prepared by Provider in accordance with the requirements set forth in the State’s Fiscal Reporting System requirements. Written guidelines shall be provided to Provider by the Director or Director’s designee, by July 31 following the Fiscal Year for which the Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report is to be prepared.

2) In the event that Provider is unable to complete the Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report by the date specified within this section, then Provider shall submit to the Director a written extension request giving good cause justification and a revised completion date. The Director or Director’s designee will review each request and prepare a written response within 15 days of receipt of said request.

3) If Provider fails to submit accurate and complete Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report by such due date, then County may, at the good faith and reasonable discretion of Director or Director’s designee and fifteen (15) days prior written notice, cease to make any further payments to Provider under this Agreement or at the County’s option, other current or subsequent Agreements with the County, until the accurate and complete Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report is submitted.

4) In the event that Provider does not submit accurate and complete Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report by the one-hundred and eightieth day, then all overpaid amounts covered by the outstanding Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report and paid by County to Provider in the Fiscal Year for which the Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report is outstanding shall be due by Provider to County.

   Provider shall pay County according to the method described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph O (Payments Due to County/Method of Payment).

L. Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report Adjustment and Final Settlement: Based on the Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report submitted pursuant to Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph K (Annual
Drug Medi-Cal Fiscal Detail Year End Expenditure Report), at the end of each Fiscal Year or portion thereof that this Agreement is in effect the final settlement shall be adjusted as follows:

1) Reimbursement - based on verification of State approved Units of Service at the lower of Uniform Statewide Daily Reimbursement (USDR) rate or the Provider’s usual and customary charge not to exceed the applicable Maximum Contract Amount for each Fiscal Year during the term hereof as shown in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation), as reflected in the Service Summary(ies), provided that reimbursement for services shall be consistent with the amounts authorized by State law and State’s Medicaid Plan not to exceed the Uniform Statewide Daily Reimbursement (USDR) rate in effect at the time of service delivery.

2) Once submitted with signed Letter of Certification the Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report shall be considered “provider certified” as to expenses and Units of Service. County shall review Provider’s Report before submission to the State and may modify certain aspects of the report as required by the State and Federal law, the State’s Drug and Alcohol Fiscal Reporting System requirements or the Contractual agreement. These modifications may include Units of Service, funding sources, and usual and customary charges. County shall not change expenses or total Units of Service unless instructed in writing to do so by Provider.

3) Upon County approval Provider’s Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report shall be deemed as final and not subject to change except by audit exception. Provider shall notify County promptly in writing if any time Provider becomes aware of errors in the submitted Annual Drug Medi-Cal Fiscal Detail Year End Expenditure Report.

4) Provider shall have 60 calendar days from receipt of notification of final settlement to appeal the settlement. All Drug Medi-Cal Fiscal Detail Year End Expenditure Report appeals shall be handled in accordance with County’s Provider Appeal Process. The County’s Provider Appeal Process may be obtained by Contacting the County at the address and/or phone number as shown in Paragraph 61 (NOTICES), of this Agreement.

M. Cost Settlement:

a. All DHCS required cost settlement documents, including but not limited to the Contractor’s Cost Report, the Narcotic Treatment Program Report of Expenditures and Revenues, the performance report, and any other forms required for the completion of the County’s Cost Reporting Responsibilities to DHCS:
   i. Are to be submitted to the County annually by September 30th, shall include all services delivered through June 30th of that fiscal year.
   ii. Settlement to cost will be made through the submission and acceptance of this Cost Report in accordance with Federal Medicaid requirements and the approved Medicaid state plan and waivers.

b. The Cost Report shall be in the format and completed within the guidelines provided in writing by September 30 2021.

c. Failure to complete cost report may result in termination of this Agreement at the discretion of MCBHRS.

N. Post Contract Audit Settlement:

1) In the event that a post-contract audit conducted by County, State, and/or Federal
personnel, determines that the amounts paid by County to Provider for any Narcotic Replacement Therapy Services furnished hereunder are more than the amounts allowable pursuant to this Agreement, upon receipt of detailed documentation and reconciliation confirming any such overpayment, then the difference shall be due by Provider within 90 days to County.

2) For Cost Reimbursed services, if the post-contract audit conducted by County, State, and/or Federal personnel determines that the amounts paid by County to Provider for any Cost Reimbursed State approved Units of Service furnished hereunder are less than the allowable pursuant to this Agreement, then the difference shall be paid by County within 30 days to Provider, provided that in no event shall County's Maximum Contract Amount for the applicable Fiscal Year, as shown in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation) be exceeded.

O. Audit Appeals After Post-Contract Audit Settlement: For County audit exceptions, County shall notify Provider in writing of the Audit Settlement. The Provider shall have 30 calendar days from receipt of notification of the Audit Settlement to appeal Audit Settlement. All appeals for County audit exceptions shall be handled in accordance with County's Provider Appeal Process. The County's Provider Appeal Process may be obtained by Contacting the County at the address and/or phone number as shown in Paragraph 61 (NOTICES), of this Agreement. If Provider appeals any audit report, the appeal shall not prevent the post-contract audit settlement pursuant to Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph M (Post-Contract Audit Settlement).

P. Payments Due to County/Method of Payment: Within 30 calendar days after written notification by County to Provider of any amount due by Provider to County, Provider shall notify County as to which of the following six payment options Provider determines to be used as the method by which such amount shall be recovered by County. Any payments due to the County shall be: (1) paid in one cash, check, or ACH payment by Provider to County, (2) offset against prior year(s) liability(ies), (3) deducted from future claims over a period not to exceed six months, (4) deducted from any amounts due from County to Provider under this Agreement, (5) paid by cash, check, or ACH payment(s) by Provider to County over a period not to exceed six months, or (6) a combination of any or all of the above. Interest Charges on Delinquent Payments: If Provider, without good cause as determined in the good faith reasonable judgment of Director or Director's designee, fails to pay County any amount due to County under this Agreement within 90 days after the due date, then Director or Director's designee, in their good faith reasonable discretion and after written notice to Provider, may assess interest charges at a rate equal to County's General Fund Rate, as determined by County's Auditor, per day on the delinquent amount due commencing on the 91st day after the due date. Provider shall have an opportunity to present to Director information bearing on the issue of whether there is a good cause justification for Provider's failure to pay County within 90 days after the due date. The interest charges shall be: (1) paid by Provider to County by cash payment upon demand and/or (2) at the sole discretion of Director, upon a minimum of 30 days prior written notice deducted from any amounts due by County to Provider whether under this Agreement or otherwise.

Q. Accrual of Interest: Providers are not allowed to retain more than $100 in interest earned on federal funds per year per Title 45 CFR, 92.21(i). Interest earned in excess of this amount is to be returned to the County. Any interest retained by Provider must be used for administrative expenses.

R. Revenue Collection: Provider shall conform to the revenue collection requirements in
Division 10.5 of the HSC, Section 11841.

S. **Financial Solvency:** Provider shall maintain reasonably adequate provisions against the risk of insolvency.

T. **Limitation of County's Obligation Due to Non-appropriation of Funds:** Should County, during this or any subsequent fiscal year impose budgetary restrictions, which appropriate less than the amount provided for in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph B (Compensation) of this Agreement, upon a minimum of 30 days prior written notice to Provider, County shall reduce services under this Agreement consistent with such imposed budgetary reductions. County shall notify Provider of any such changes in allocation of funds immediately.

5. **STAFFING:**

Provider shall operate throughout the term of this Agreement with staff, including but not limited to materially similar levels of professional staff, that approximates the type and number as indicated in Provider's Service Summary(ies), including any addenda thereto as approved in writing by Director, and as required by the County, State, and/or Federal Government. All staff providing services under this Agreement shall be qualified and shall possess all appropriate license(s) and/or certification(s) in accordance with County, State, and/or Federal Law and all other applicable requirements, and function within the scope of practice as dictated by licensing and certification boards/bodies. (1) if vacancies occur in any of Provider’s staff that would materially reduce Provider’s ability to perform any services under the Agreement, Provider shall promptly notify Director of such vacancies. (2) During the term of this Agreement, Provider shall have available and shall provide upon request to authorized representatives of County, a list of all persons by name, title, professional degree, and experience, who are providing any services under this Agreement.

a. **Medical Director Responsibilities**

All contractors providing outpatient drug free, day care habilitative, perinatal residential and naltrexone treatment services will ensure:

1. The medical director’s responsibilities will ensure provider’s physicians are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries and perform other physician duties.

2. The substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

3. For outpatient drug free, day care habilitative, perinatal residential and naltrexone treatment services the following shall apply:

4. The substance use disorder medical director’s responsibilities shall at a minimum include all of the following:

   (i) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.

   (ii) Ensure that physicians do not delegate their physician duties to non-physician personnel.
(iii) Develop and implement medical policies and standards for the Provider.

(iv) Ensure that physicians, registered nurse practitioners, and physician assistants follow the Provider's medical policies and standards.

(v) Ensure that the medical decisions made by physicians are not determined solely on fiscal considerations.

(vi) Ensure that Provider's physicians are adequately trained to perform diagnosis of substance use disorders for Beneficiaries, determine the Medical Necessity of treatment for Beneficiaries and perform other physician duties, as outlined in this section.

b. **Approved Providers**
Contractor will require all providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable Laws and Regulations.

c. **Personnel Policies**
Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

1. Use of drugs and/or alcohol;
2. Prohibition of social/business relationship with beneficiaries or their family members for personal gain;
3. Prohibition of sexual contact with Beneficiaries;
4. Conflict of interest;
5. Providing services beyond scope of practice;
6. Unlawful discrimination against Beneficiaries or staff;
7. Verbally, physically, or sexually harassing, threatening, or abusing Beneficiaries, family members or other staff;
8. Protection of Beneficiary confidentiality;
9. The elements found in the code of conduct(s) for the certifying organization(s) the program’s counselors are certified under; and
10. Cooperate with complaint investigations.

6. **STAFF TRAINING AND SUPERVISION:**
Provider shall train and maintain appropriate supervision of all persons providing services under this Agreement with particular emphasis on the supervision of para-professionals, interns, students, and volunteers. Provider shall be responsible for the training of all appropriate staff on the State’s Drug and Alcohol/Narcotic Treatment Program Fiscal Reporting System requirements, and other State and County policies and procedures as well as on any other matters that County may reasonably require. Provider will submit to County annual proof that staff have been trained in Title 22
requirements.

a. **Information Privacy and Security Training**

   a. All workforce members who assist in the performance of functions or activities on behalf of the Department, or access or disclose Department PHI or PI must complete information privacy and security training, at least annually, at Provider’s expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member’s name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.

7. **PROGRAM SUPERVISION, MONITORING AND REVIEW:**

   A. Pursuant to County, State, and Federal requirements, all services hereunder shall be provided by Provider under the general supervision of Director. In accordance with applicable Laws and regulations, Director shall have the right to monitor and specify the kind, quality, appropriateness, timeliness, amount of services, and the criteria for determining the persons to be served. Therefore, in accordance with the terms of this section, and notwithstanding any other provision of this Agreement, Provider's performance shall be monitored accordingly. Program monitoring shall consist of but not be limited to, (1) whether the quantity of work or services are being performed as identified in Service Summary and Detail Forms; (2) whether the Provider has established quality standards and is monitoring them; (3) whether Provider is abiding by the terms of the Perinatal Services Network Guidelines, in the event that Perinatal services are provided under this Agreement; and 4) whether or not the Provider is meeting the minimum program requirements as per Attachment 1, Monitoring Checklist, which is incorporated into this Agreement by this reference.

   B. Provider shall provide accessible and appropriate services in accordance with federal and state statutes and regulations to all eligible persons. The Provider shall assure that in planning for the provision of services, the following barriers to accessible services are considered and addressed: (1) lack of educational materials or other resources for the provision of services; (2) geographic isolation and transportation needs of persons seeking services or remoteness of services; (3) institutional or cultural barriers; (4) language differences; (5) lack of service advocates; and (6) failure to survey or otherwise identify the barriers to service accessibility. Any amounts paid by County to Provider shall be used exclusively for providing alcohol and drug substance abuse recovery services consistent with the purpose of the funding.

   C. In addition to the above program monitoring and pursuant to The Federal Office of Management and Budget (OMB) Uniform Administrative Requirements, the Counties are required to monitor the activities of their Providers to ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of the contracts or grant agreements, and that performance goals are achieved. County shall ensure that Providers who expend more than the $750,000 in total federal funds in a fiscal year comply with OMB Uniform Administrative Requirements.

   Limited scope audits, on-site visits, and reviews of documentation supporting requests for reimbursement are monitoring procedures that are acceptable to OMB in meeting County monitoring objectives.

   1) Limited scope audits only include agreed-upon engagements that are (1) conducted in
accordance with either the American Institute of Certified Public Accountants’ generally accepted auditing standards or attestation standards; (2) paid for and arranged by pass-through entities (counties) and (3) address only one or more of the following types of compliance requirements: (i) activities allowed or disallowed; (ii) allowable costs/cost principles; (iii) eligibility; (iv) matching, level of effort and earmarking; and (v) reporting.

2) On-site visits focus on compliance and controls over compliance areas. These on-site visits may be conducted by the host County, with verification submitted to the County. The reviewer must make prior noticed site visits to the Provider’s location(s), and documents the visits using a checklist or program focusing on the compliance areas. All findings noted during the on-site monitoring shall be handled in the same manner as any exceptions noted during single or program-specific audits.

3) Reviews of supporting documentation submitted by Providers include, but are not limited to, reviews of copies of invoices, canceled checks, and time sheets.

4) Failure to comply with the above provisions shall constitute grounds for the County to terminate this Agreement for good cause upon a minimum of 30 days prior written notice, subject to the Provider’s right of appeal as referenced.

D. In the event County finds any material deficiencies with regard to Provider’s performance, County shall provide to Provider thirty days prior written notification of such deficiencies. Provider shall respond in writing to the particular County Contract Monitor within the time specified in the notification either acknowledging the reported deficiencies or presenting contrary evidence, and in addition, Provider shall submit a plan of correction for all deficiencies.

E. In the event of a State audit of this Agreement, if State Auditors disagree with County’s written instructions to Provider in its performance of this Agreement, and if such disagreement results in a State disallowance of any of Provider’s costs hereunder, then County shall be liable for Provider’s disallowed costs as determined by the State.

F. To assure compliance with this Agreement and for any other reasonable purpose relating to performance of this Agreement, and subject to the provisions of state and federal Law and Regulations, authorized County, State, and/or Federal representatives and designees shall have the right to enter Provider’s premises (including all other places where duties under this Agreement are being performed), with or without notice, to inspect monitor and/or audit Provider’s facilities, programs and procedures, or to otherwise evaluate the work performed or being performed; review and copy any records and supporting documentation pertaining to the performance of this Agreement; and elicit information regarding the performance of this Agreement or any related work. The representatives and designees of such agencies may examine, audit and copy such records at the site at which they are located. Provider shall provide access to facilities and shall cooperate and assist County, State, and/or Federal representatives and designees in the performance of their duties. Unless otherwise agreed upon in writing, Provider must provide specified data upon request by County, State, and/or Federal representatives and designees within twenty state working days for monitoring purposes.

Failure to comply with the terms of this Subparagraph F may constitute breach of this Agreement if not corrected, and may result in withholding payment per the terms of Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph J (Withholding Submission of Monthly Claim For Nonsubmission of County Data System Documentation and Other Information). Provider shall be required to pay County according to the method described in
Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph O (Payments Due to County/Method of Payment).

8. RECORDS AND AUDITS:

A. Records:

Direct Services and Indirect Service Records: Provider shall maintain a record of all direct services and indirect services rendered by all of the various professional, para-professional, intern, student, volunteer and other personnel to fully document all services provided under this Agreement to permit review for fiscal audits, program compliance and beneficiary complaints. All such records shall be maintained, retained, and made immediately available for inspection, program review, and/or audit during County’s normal business hours by authorized representatives of County, State, and/or Federal governments during the term of this Agreement for a minimum of ten years following discharge of the patient/client or termination of services, or until county, State or Federal audit findings applicable to such services are fully resolved, whichever is later. Such access shall include regular and special reports from Provider. Failure to comply with the terms of this Paragraph 8 (RECORDS AND AUDITS) may constitute breach of this Agreement if not corrected and may result in termination of this Agreement for cause. In the event that Provider does not correct deficiencies within the required timeframe, then Director at their sole discretion may request Provider to return any and all amounts paid by County to Provider for the provision of services under this Agreement during said period of non-compliance. Provider shall be required to pay County according to the method described in Paragraph 4 (FINANCIAL PROVISIONS), Subparagraph O (Payments Due to County/Method of Payment).

In addition to the requirements in this paragraph, and Paragraph 8 (RECORDS AND AUDITS), Subparagraph B (Audit), Provider shall comply with any additional patient/client record requirements described in the Service Exhibit(s) and shall adequately document the delivery of all services described in the Service Exhibit(s).

5) Patient/Client Records: Provider shall maintain treatment and other records of all direct services in accordance with all applicable County, State and Federal requirements on each individual patient/client.

  c) The Provider shall keep all documentation in the client’s individual patient record for a minimum of ten (10) years from the date of the last face-to-face contact between client and provider.

6) Provider guarantees that each Beneficiary referred to Program will be provided services within two weeks of the referral date. Each Beneficiary receiving services under the terms of this Agreement shall have on file a completed:

  a) Client Registration and Payor Financial Information;
  b) Initial Assessment within seven (7) days of intake;
  c) Episode Opening – Episode Closing to be completed as soon as feasible, but no later than the end of the month after the client enters the Provider’s program. Episode Closing to be submitted no later than the end of the month of the last billable date of service;
  d) Discharge Assessment immediately upon client discharge but no later than fifteen (15) days from date of discharge;
e) Consent for Treatment;

f) Release of Information;

g) Client Plan Completed no later than fifteen (15) days from the date of intake for new clients and updated every twelve (12) weeks thereafter; and

h) Completed Treatment Worksheets to identify client participation, integration, and principals learned.

7) Copies of Records: In accordance with applicable Laws and regulations, copies of records shall be provided to County from Provider and to Provider from County as necessary for the delivery and monitoring of services, and as specified under Paragraph 1 (TERM), Subparagraph B (Termination), item (3)(c).

8) Financial Records: In accordance with Provider’s governance standards, Provider shall prepare and maintain sufficient books, records, documents, and other evidence necessary for the County and/or State to audit contract performance and contract compliance. In accordance with Provider’s governance standards, Provider shall make these records available to the County and/or State, upon thirty (30) days prior written request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, records shall be reasonably sufficient to determine the reasonableness, allowability, and allocation of cost incurred by the Provider. All records must be capable of verification by qualified auditors.

i) Provider shall keep reasonably adequate and sufficient financial records and statistical data to support the year-end documents filed with the County.

j) Provider shall retain accounting records and supporting documents for a ten-year period from the date the year-end cost settlement report was approved by the County for interim settlement. When an audit has been started before the expiration of the ten-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit pursuant to Section 9535(e), Title 9 of the CCR. Final settlement shall be made at the end of the audit and appeal process. If an audit has not begun within three years, the interim settlement shall be considered as the final settlement.

k) Financial records shall be kept so that they reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs.

l) Provider shall require by written compliance plan that subcontractors comply, with the provisions of this Subparagraph A (Records).

m) In the event Provider’s subcontractor discontinues their contractual relationship with the Provider, or cease to conduct business in its entirety, the Provider assumes responsibility to retain fiscal and program records of the subcontractor for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to State funds.

n) Provider shall materially follow the statutory requirements contained in SAM as noted in Title 45 CFR, Part 96, Block Grants, Subpart C, Financial Management, Section 96.30, Fiscal and Administrative Requirements, which states in part, “Except where
otherwise required by Federal law or regulation, a State shall obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds."

B. Audit

1) This Agreement, and any subcontracts, shall be subject to the examination and audit by the County and/or the California Bureau of State Audits for a period of three years from the date that final payment is made pursuant to the Agreement and Government Code Section 10527. This does not preclude access to records by the State, the Comptroller General of the United States, or any of their authorized representatives. Pursuant to Section 438.3(h), Title 42 of the CFR, records documenting use of funds shall be kept for a period of ten years from the end of the fiscal year or until completion of the annual audit and resolution of any resulting audit issues if the audit is not resolved within 10 years.

2) Pursuant to OMB Uniform Administrative Requirements, the County shall require and ensure that Providers expending $750,000 or more in Federal Awards in a fiscal year, have a single or program-specific audit performed.

a) The audit shall be performed in accordance with the most recent version of OMB Uniform Administrative Requirements.

b) The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, 1994 Revision, issued by the Comptroller General of the United States.

c) A copy of the audit performed in accordance with the most recent OMB Uniform Administrative Requirements (Revised June 2003) shall be submitted to the County within thirty (30) days of completion, but no later than nine (9) months following the end of the Provider’s fiscal year.

d) Where apportionment of the audit cost is necessary, such apportionment shall be made in accordance with generally accepted accounting principles, but shall not exceed the proportionate amount that the federal award funding represents of the Provider's total revenue.

e) The work papers and the audit reports shall be retained for a minimum of five years from the end of the fiscal year or until completion of the State’s annual audit and resolution of any resulting audit issues if the audit is not resolved within five years.

f) Audit work papers shall be made available upon request to the County, and copies shall be made as is reasonable and necessary.

g) Provider, in coordination with the County, shall ensure the Provider's responsibility for (1) developing a corrective action plan and (2) follow-up on any material audit findings in the single or program-specific audit report.

3) In accordance with applicable Laws and Regulations, Provider agrees that the County will have the right to review, obtain, and copy all records pertaining to the performance of this Agreement. In accordance with applicable Laws and Regulations, Provider agrees to provide the County with any and all relevant information requested.

4) All expenditures of State and federal funds furnished to Provider and Provider's subcontractors are subject to audit by the County and/or State. Pursuant to Section 9545(a), 9545(d), 9545(g), and 9545(h), Title 9, of the CCR, the written audit reports shall establish whether Provider expended funds in accordance with the provisions of the Act,
the requirements of this Chapter, and the County terms and conditions under which the funds were awarded. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) Uniform Administrative Requirements. Objectives of such audits may include, but not be limited to, the following:

a) to determine whether Units of Service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;

b) ;

c) to provide technical assistance in addressing current year activities and providing recommendations on internal controls, accounting procedures, financial records, and compliance with Laws and Regulations;

d) to determine the cost of services, net of related patient and participant fees, third-party payments, and other related revenues and funds;

e) to determine that expenditures are made in accordance with applicable State and federal laws and regulation and Agreement requirements; and/or

f) to determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Agreement objectives.

5) Provider shall comply, and shall require that subcontractors comply, with all terms and conditions of this Agreement and all pertinent County, State and federal statutes and regulations. The County, State, DHS, DHHS, Comptroller General of the United States, or other authorized state or federal agencies and representatives, will be allowed to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Agreement. Any and all books, records, and facilities maintained by the Provider and its subcontractors related to these services may be audited at any time during normal business hours. Unannounced visits that do not disrupt the Provider’s operations may be made at the discretion of the County. Provider’s employees who might have information related to such records may be interviewed.

6) The refusal of Provider or any subcontractor to permit access to and inspection of books, records, and facilities as described in this part constitutes an express and immediate breach of this Agreement and will be sufficient basis to terminate the Agreement for cause or default.

7) Pursuant to OMB Uniform Administrative Requirements, the State and/or County may impose sanctions against Provider for not submitting required single or program-specific audit reports, or failure to comply with all other audit requirements.

8) Audit reports by the State or County shall reflect all findings, recommendations, adjustments, and corrective action as a result of its findings in any areas.

9) Provider shall be responsible for any disallowances taken by the Federal government, the State, or the Bureau of State Audits, or the County as a result of any audit exception that is related to Provider’s responsibilities herein. Provider agrees to reasonably develop and implement any corrective action plans in a manner acceptable to the State or County in order to comply with recommendations contained in the audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the County within one year from the date of the plan. MCBHRS will conduct annual monitoring and annual site visits at a mutually
agreed upon time and date.

10) If differences cannot be resolved between State, County or Provider regarding the terms of the final audit settlements for funds expended under Part I, Provider may request an appeal in accordance with the County appeal process.

9. REPORTS

A. Financial Reports:

1) Fiscal forms, provided herein as the Service Summary, are required in accordance with County’s drug and alcohol fiscal reporting system requirements. Provider agrees to submit a Service Summary with the original Agreement and with each Agreement amendment.

2) Provider agrees to submit fiscal & billing information, as applicable, in accordance with the Modality and Service Elements as referenced in the attached Service Exhibits. Documentation may include but shall not limited to:

   (i) Monthly claims reflecting the number of services, type of service, multiplied by the rate as reflected in the Service Summary.

   (ii) Rosters, indicating clients’ attendance in Dosing. Rosters must be submitted on a quarterly basis, along with invoice/claim for payment (Roster format is referenced as Attachment 2 and incorporated by this reference).

   (iii) California Outcome Measurement System (CalOMS) Participant (Client Admission, Annual Update, and Discharge) Records shall be reported in accordance with DHCS guidelines, currently by the County in which the service is provided (Merced, Fresno, or Mariposa). Provider is responsible for providing County (Mariposa) with the data to be reported monthly, no later than 15 days after the report month. Provider will also be responsible for correcting any CalOMS errors reported by the State in a timely manner. Provider is also responsible to ensure Mariposa County’s CalOMS data is reported to the State in a manner that will be identified as Mariposa County’s data (county paying for services and special services contract number).

   (iv) Drug Abuse Treatment Access Report (DATAR) to the State – monthly, no later than 15 days after the report month.

   (v) National Survey of Substance Abuse Treatment Services (formerly UFDS) – Annually to the State (If you have questions or need additional blank forms, contact Mathematica Policy Research, Inc. 1-888-324-8337).


B. Additional Reports:

1) Provider agrees to submit in accordance with HSC, Section 11758.12(d), information required by the County and/or State. The information shall include, but is not limited to, utilization reports, compliance reports, financial reports, treatment and prevention services reports, demographic characteristics of service recipients, and data as required in Documents 1K and 1T. These documents are incorporated by this reference as follows:
a) Drug and Alcohol Treatment Access Report (DATAR) and Provider Waiting List Record (WLR)
b) Prevention Activities Data System (PADS) Forms, ADP 7235A-G
c) CalOMS Data Collection Guide – Submit CalOMS treatment data in the format prescribed in the CalOMS Data Collection Guide.

C. Provider agrees by signing this Agreement to use best efforts to submit data requested pursuant to this section in a manner identified or on forms provided by County, and to submit data by the due dates.

10. CONFIDENTIALITY:
Provider shall maintain the confidentiality of all records and information, including, but not limited to, claims, County records, patient/client records and information, and I/S records in accordance with applicable Laws and Regulations and the Business Associate Addendum, (Attachment 3), which is incorporated into this Agreement by this reference, to the extent required by 42 USC 1320d et seq.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (Public Law 111-5, Title XIII); and 42 CFR Part 2, to comply with the applicable requirements of the law(s), including any subsequent amendments thereto relating to protected health information and in accordance with WIC Sections 5328 through 5330, inclusive; Section 14100.2 of the W&I Code and Title 42 CFR Section 431.300 et seq. regarding the confidentiality of Beneficiary information, and all other applicable County, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and directives, relating to privacy/security, whichever is most restrictive. Provider shall require all its officers, employees, and agents providing services hereunder to acknowledge, in writing, understanding of, and agreement to fully comply with, all such confidentiality provisions. Provider shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all loss, damage, liability, and expense arising solely from any disclosure of such records and information by Provider, its officers, employees, or agents.

11. PATIENTS'/CLIENTS' RIGHTS:
Provider shall comply with all applicable Laws and Regulations regarding patients'/clients' rights provisions, including, but not limited to, WIC Section 5325 et seq., CCR Title 9, Section 850 et seq., and CCR Title 22. Further, Provider shall comply with all patients'/clients' rights policies provided by County. In accordance with applicable Laws and regulations, County Patients' Rights Advocates shall be given access by Provider to all patients/clients, patients'/clients' records, and Provider's personnel in order to monitor Provider's compliance with all applicable statutes, regulations, manuals and policies.

12. REPORTING OF PATIENT/CLIENT ABUSE AND RELATED PERSONNEL REQUIREMENTS:
A. Elders and Dependent Adults Abuse: Provider, and all persons employed or subcontracted by Provider, shall comply with WIC Section 15630 et seq. and shall report all known or suspected instances of physical abuse of elders and dependent adults under the care of Provider either to an appropriate County adult protective services agency or to a local law enforcement agency, as mandated by WIC Sections 15630, 15631 and 15632. Provider and all persons employed or subcontracted by Provider, shall make the report on such abuse, and shall submit all required information, in accordance with WIC Sections 15630, 15633 and 15633.5.
B. **Minor Children Abuse:** Provider, and all persons employed or subcontracted by Provider, shall comply with California Penal Code (hereafter "PC") Section 11164 et seq. and shall report all known or suspected instances of child abuse to an appropriate child protective agency, as mandated by California PC 11164, 11165.8 and 11166. Provider, and all persons employed or subcontracted by Provider, shall make the report on such abuse, and shall submit all required information, in accordance with PC Sections 11166 and 11167.

C. **Provider Staff:** Provider shall implement policies and procedures pertaining to any person providing direct services hereunder:

1) Provider shall ensure that any person who enters into employment as a care custodian of elders, dependent adults or minor children, or who enters into employment as a health or other practitioner, prior to commencing employment, and as a prerequisite to that employment, shall sign a statement on a form provided by Provider in accordance with the above code sections to the effect that such person has knowledge of, and will comply with, these code sections.

2) Provider shall assure that clerical and other non-treatment staff who are not legally required to directly report suspected cases of abuse, consult with mandated reporters upon suspecting any abuse.

3) For the safety and welfare of elders, dependent adults, and minor children, Provider shall, to the maximum extent permitted by law, ascertain arrest and conviction records for all current and prospective employees and shall not employ or continue to employ any person convicted of any crime involving any harm to elders, dependent adults, or minor children.

4) Provider shall not employ or continue to employ, or shall take other appropriate action to fully protect all persons receiving services under this Agreement, any person whom Provider knows, or reasonably suspects, has committed any acts which are inimical to the health, morals, welfare, or safety of elders, dependent adults or minor children, or which otherwise make it inappropriate for such person to be employed by Provider.

13. **Nondiscrimination in Services:**

A. Provider shall not unlawfully discriminate in the provision of services hereunder because of race, religion, national origin, ancestry, sex, age, marital status, sexual preference, or physical or mental disability or medical conditions, in accordance with requirements of Federal and State law. For the purpose of this Paragraph 13, discrimination in the provision of services may include, but is not limited to, the following: denying any person any service or benefit or the availability of a facility; providing any service or benefit to any person which is different, or is provided in a different manner or at a different time, from that provided to others; subjecting any person to segregation or separate treatment in any matter related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment quota, eligibility, membership, or any other requirement or condition which persons must meet in order to be provided any service or benefit. Provider shall take affirmative action to ensure that intended Beneficiaries of this Agreement are provided services without regard to ability to pay or source of payment, race, religion, national origin, ancestry, sex, age, marital status, sexual preference or physical or mental disability, or medical conditions. (CCR, Title 9, Chapter 11, Section 1810.436(a)(2).

B. Provider shall establish and maintain written complaint procedures under which any person
applying for or receiving any services under this Agreement may seek resolution from Provider of a complaint with respect to any alleged unlawful discrimination in the rendering of services by Provider's personnel. Such procedures shall also include a provision whereby any such person, who is dissatisfied with Provider's resolution of the matter, shall be referred by Provider to Director for the purpose of presenting the complaint of the alleged discrimination. Such complaint procedures shall also indicate that if such person is not satisfied with County's resolution or decision with respect to the complaint of alleged discrimination, such person may appeal the matter to the State, if appropriate.

C. Provider shall have admission policies which are in accordance with CCR Title 9, Sections 526 and 527, and which shall be in writing and available to the public. Provider shall not employ unlawful discriminatory practices in the admission of any person, assignment of accommodations, or otherwise. By postings or other reasonable means such that, any person who applies for services under this Agreement, such person shall be advised by Provider of the complaint procedures described in the above Subparagraph A of this section. A copy of such complaint procedures shall be posted by Provider in a conspicuous place, available and open to the public, in each of Provider's facilities where services are provided under this Agreement.

D. Provider shall include non-discrimination and compliance provisions in all subcontracts. Provider's written procedures under which service participants are informed of their rights including their right to file a complaint alleging discrimination or a violation of their civil rights. Participants in programs funded hereunder shall be provided a copy of their rights that shall include the right of appeal and the right to be free from sexual harassment and sexual contact by members of the treatment, recovery, advisory, or consultant staff.

E. Provider shall conduct a self-evaluation and, where appropriate, a transition plan in accordance with the requirements contained in Title 28, CFR, Section 35.105, and Title 45, CFR, Section 84.6. The self-evaluation shall include an assessment of residential alcohol and other drug services consistent with the Voluntary Compliance Agreement between the Office of Civil Rights, DHHS, and the State. For services provided pursuant to a contract, Provider may perform the self-evaluation or require the subcontractor perform the self-evaluation. Provider agrees to comply with the terms and conditions contained in any applicable voluntary compliance agreements.

F. Provider shall keep records to document compliance with the provisions referenced in this Paragraph 13 and copies of the required Notice of Client's Rights, in order for the County to determine compliance with this section, and with the State and federal legal requirements including the Voluntary Compliance Agreement. In accordance with applicable Laws and regulations and Provider's governance standards, upon thirty (30) days prior written request by the County, Provider shall provide such records and other data, which may include a valid and appropriate fire clearance for residential facilities, to County within 30 calendar days of request.

G. No state or federal funds shall be used by Provider or any subcontractor to provide direct, immediate or substantial support to any religious activity.

14. NONDISCRIMINATION IN EMPLOYMENT:

A. Provider certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated without regard to, or because of, race, religion, national origin, ancestry, sex, age (over 40), marital status, sexual preference, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), status as disabled veteran or veteran of
the Vietnam era, use of family care leave, or political affiliation, and in compliance with all applicable Federal and State anti-discrimination laws and regulations.

B. Provider shall take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to race, religion, national origin, ancestry, sex, age, marital status, sexual preference, physical or mental disability, or political affiliation. Such action shall include, but is not limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

C. Provider agrees to post and further agrees to require its subcontractors to post, in a conspicuous place, notices available to all employees and applicants for employment setting forth the provisions of the Equal Opportunity Act [42 USC 2000(e)] in conformance with Federal Executive Order No. 11246, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans’ Readjustment Assistance Act of 1974 (38 USC 4212). Provider agrees to comply, and further agrees to require its Subcontractors to comply, with the provisions of the Rehabilitation Act of 1973 (29 USC 794).

D. Provider shall deal with its subcontractors, bidders, or vendors without regard to or because of race, religion, ancestry, national origin, sex, age, marital status, sexual preference, physical or mental disability, or political affiliation.

E. In accordance with applicable Laws and regulations and Provider’s governance standards, Provider shall allow County representatives access to its employment records during regular business hours to verify compliance with the provisions of this Paragraph 14 when so requested a minimum of 30 days prior written notice by Director.

F. If County finds that any of the above provisions has been violated, the same shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement. While County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Provider has violated State or Federal anti-discrimination laws or regulations shall constitute a finding by County that Provider has violated the anti-discrimination provisions of this Agreement.

G. In the event that Provider violates any of the anti-discrimination provisions of this Paragraph 14, County shall be entitled, at its option, to the sum of FIVE HUNDRED DOLLARS ($500) pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

15. FAIR LABOR STANDARDS:

Provider shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its officers, employees, and agents, from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for services performed by Provider’s employees for which County may be found jointly or solely liable.

16. INDEMNIFICATION AND INSURANCE:

A. Indemnification: Provider shall indemnify, defend and hold harmless County, and their elected and appointed officers, employees, and agents, from and against any and all liability and expense, including defense costs and legal fees, arising from or connected with claims
and lawsuits for damages or workers' compensation benefits relating solely to Provider's operations or its services, which result from bodily injury, death, personal injury, or property damage, including physical damage or loss of Provider's property in the care, custody or control of Provider. Provider shall not be obligated to indemnify for liability and expense arising from the actions, omissions or negligence of the County.

B. Insurance: Without limiting Provider indemnification, Provider shall procure and maintain for the duration of this Agreement, insurance (or comparable self insurance) against claims for injuries to persons or damages to property that may arise from, or be in connection with the performance of the work hereunder by Provider, Provider's agents, representatives, employees, and/or subcontractors. At the very least, Provider shall maintain the insurance coverage, limits of coverage and other insurance requirements as described in Insurance requirements for County Contracts (Attachment 4) to this Agreement. Certificates evidencing the maintenance of Provider's insurance coverage shall be filed with County. Said certificates must be on file before payment for services will be released.

17. WARRANTY AGAINST CONTINGENT FEES:
Provider warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon any agreement or understanding for any commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Provider for the purpose of securing business. For Provider's breach or violation of this warranty, County may, in its sole discretion, deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

18. CONFLICT OF INTEREST:
A. No County employee whose position in County enables such employee to influence the award or administration of this Agreement or any competing agreement, and no spouse or economic dependent of such employee, shall be employed in any capacity by Provider or have any direct or indirect financial interest in this Agreement. No officer or employee of Provider who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.

B. Provider and County shall comply with all conflict of interest laws, ordinances and regulations now in effect or hereafter to be enacted during the term of this Agreement. Provider warrants that it is not now aware of any facts, which create a conflict of interest. If Provider hereafter becomes aware of any facts, which might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to County. Full written disclosure shall include, without limitation, identification of all persons implicated and complete description of all relevant circumstances.

19. UNLAWFUL SOLICITATION:
Through its Compliance Plan, Provider shall require all of its employees to acknowledge, in writing, understanding of, and agreement to comply with the provisions of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of California Business and Professions Code (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to insure that there is no violation of such provisions by its employees. INDEPENDENT STATUS OF PROVIDER:

A. This Agreement is by and between County and Provider and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint

Page 31
venture, or association, as between County and Provider. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Provider shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Agreement all compensation and benefits. County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of Provider.

C. Provider understands and agrees that all persons performing services pursuant to this Agreement are, for purposes of workers' compensation liability, the sole employees of Provider and not employees of County. Provider shall be solely liable and responsible for furnishing any and all workers' compensation benefits to any person as a result of any injuries arising from or connected with any services performed by or on behalf of Provider pursuant to this Agreement.

D. Provider shall obtain and maintain on file an executed Provider's Employee Acknowledgment of Employer (Attachment 5), or similar document, for each of its employees performing direct clinical services under this Agreement. Such Acknowledgments shall be executed by each such employee on or within 60 days after the commencement date of this Agreement but in no event later than the date such employee first performs services under this Agreement.

20. DELEGATION AND ASSIGNMENT:

Provider shall not delegate its duties or assign its rights under this Agreement, or both, either in whole or in part, without the prior written consent of County (which shall not be unreasonably withheld), and any prohibited delegation or assignment shall be null and void. Any payments by County to any delegate or assignee on any claim under this Agreement, in consequence of any such consent, shall be subject to set off, recoupment, or other reduction for any claim which Provider may have against County.

21. SUBCONTRACTING:

A. No performance of this Agreement, or any portion thereof, shall be subcontracted by Provider without the prior written consent of County as provided in this Paragraph 20 (which shall not be unreasonably withheld). Any attempt by Provider to subcontract any performance, obligation, or responsibility under this Agreement, without the prior written consent of County, shall be null and void and shall constitute a material breach of this Agreement. Notwithstanding any other provision of this Agreement, in the event of any such breach by Provider, this Agreement may be terminated forthwith by County. Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

B. If Provider desires to subcontract any portion of its performance, obligations, or responsibilities under this Agreement, Provider shall make a written request to County for written approval to enter into the particular subcontract. Provider’s request to County shall include:

1) The reasons for the particular subcontract.

2) A detailed description of the services to be provided by the subcontract.

3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the degree of competition involved.
4) A description of the proposed subcontract amount and manner of compensation, together with Provider's cost or price analysis thereof.

5) A copy of the proposed subcontract which shall contain the following provision: "This contract is a subcontract under the terms of the prime contract with the County of Mariposa and shall be subject to all of the provisions of such prime contract."

6) A copy of the proposed subcontract, if in excess of $10,000 and utilizes State funds, shall also contain the following provision: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7)."

In accepting funding pursuant this Agreement and HSC, Sections 11814(a) and (b), Provider shall (1) establish, and shall require subcontractors to establish, written accounting procedures consistent with the County, State, and Federal requirements, and (2) shall be held accountable for audit exceptions taken by the County, State, and Federal government staff, against the Provider and it’s subcontractors for failure to comply with the requirements of this Agreement.

7) Provider shall provide any other information and/or certifications requested by County.

C. County shall review Provider's request to subcontract within 30 days of said request and shall determine, in its good faith reasonably discretion, whether or not to consent to such request on a case by case basis.

D. Provider shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and legal fees, solely arising from or related solely to Provider's use of any subcontractor, including any officers, employees, or agents of any subcontractor, in the same manner as required for Provider, its officers, employees, and agents, under this Agreement.

E. Notwithstanding any County consent to any subcontracting, Provider shall remain fully liable and responsible for any and all performance required of it under this Agreement, and no subcontract shall bind or purport to bind County. Further, County approval of any subcontract shall not be construed to limit in any way Provider's performance, obligations, or responsibilities, to County, nor shall such approval limit in any way any of County's rights or remedies contained in this Agreement. Additionally, County approval of any subcontract shall not be construed in any way to constitute the determination of the allowability or appropriateness of any cost or payment under this Agreement.

F. In the event that County consents to any subcontracting, such consent shall be subject to County’s right to terminate, in whole or in part, any subcontract at any time upon thirty (30) days prior written notice to Provider when such action is deemed by County to be in its best interest. County shall not be liable or responsible in any way to Provider, to any subcontractor, or to any officers, employees, or agents of Provider or any subcontractor, for any liability, damages, costs, or expenses arising from or related to County’s exercise of such right.

G. In the event that County consents to any subcontracting, each and all of the provisions of this Agreement and any amendment thereto shall extend to, be binding upon, and inure to the benefit of, the successors or administrators of the respective parties.

H. In the event that County consents to any subcontracting, such consent shall apply to each particular subcontract only and shall not be, or be construed to be, a waiver of this Paragraph 22 or a blanket consent to any further subcontracting.
I. In the event that County consents to any subcontracting, Provider shall be solely liable and responsible for any and all payments and/or other compensation to all subcontractors and their officers, employees, and agents. County shall have no liability or responsibility whatsoever for any payment and/or other compensation for any subcontractors or their officers, employees, and agents.

J. Provider shall deliver to the County Contract Monitor a fully executed copy of each subcontract entered into by Provider pursuant to this Paragraph 22, on or immediately after the effective date of the subcontract but in no event later than the date any services are performed under the subcontract.

K. In the event that County consents to any subcontracting, Provider shall obtain and maintain on file an executed Subcontractor’s Employee Acknowledgment of Employer Attachment 6 for each of the subcontractor’s employees performing services under the subcontract. Such Acknowledgments shall be delivered to the County Contract Monitor or immediately after the commencement date of the particular subcontract but in no event later than the date such employee first performs any services under the subcontract.

L. County shall have no liability or responsibility whatsoever for any payment or other compensation for any subcontractor or its officers, employees, and agents.

M. Director is hereby authorized to act for and on behalf of County pursuant to this Paragraph 22, including, but not limited to, consenting to any subcontracting.

22. GOVERNING LAW, JURISDICTION AND VENUE:

This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Provider agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Mariposa, California. Further, this Agreement shall be governed by, and construed in accordance with, all laws, regulations, and contractual obligations of County under its agreement with the State.

23. COMPLIANCE WITH APPLICABLE LAW:

A. Provider shall comply with all applicable Federal and State statutes and regulations, including, but not limited to, laws and regulations, Title XIX of the Social Security Act, HIPAA, State, and local laws, ordinances, rules, regulations, manuals, guidelines, Americans with Disabilities Act (ADA) standards, and directives applicable to its performance hereunder or whichever is most restrictive. Further, all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference [CCR, Title 9, Chapter 11, section 1810.436(a)(5)].

B. Provider shall indemnify and hold harmless County from and against any and all liability, damages, costs or expenses, including, but not limited to, defense costs and reasonable attorneys’ fees, arising solely from or related solely to any violation on the part of Provider, its officers, employees, or agents, of any such Federal, State or local laws, ordinances, rules, regulations, manuals, guidelines, ADA standards, or directives. Provider shall not be obligated to indemnify County for any liability and expense arising from the actions, omissions or negligence of the County.

C. Provider shall maintain in effect an active compliance program in accordance with the recommendations set forth by the Department of Health and Human Services, Office of the Inspector General.

24. THIRD PARTY BENEFICIARIES:
Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

25. LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES:

A. Provider shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certificates (including, but not limited to, certification as a Narcotic Treatment Program provider if Narcotic Replacement Therapy Services are provided hereunder), as required by all Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines, and directives, which are applicable to Provider's facility(ies) and services under this Agreement. Provider shall further ensure that all of its officers, employees, and agents, who perform services hereunder, shall obtain and maintain in effect during the term of this Agreement all licenses, permits, registrations, accreditations, and certificates which are applicable to their performance hereunder. A copy of each such license, permit, registration, accreditation, and certificate (including, but not limited to, certification as a Drug Medi-Cal provider if as required by all applicable Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines and directives) shall be provided, in duplicate, to County's Contract Monitor.

B. If Provider is a participant in the Drug Medi-Cal program, Provider shall keep fully informed of all current Drug Medi-Cal Policy Letters, including, but not limited to, procedures for maintaining MediCal certification of all its facilities. A copy of the current Drug Medi-Cal certification shall be provided to the County annually.

C. Provider shall ensure that any material reduction of covered services or relocation of services are not implemented until approval is issued by the State, which shall not be unreasonably withheld. Provider shall notify County Quality Management Division immediately in writing upon intent for reduction in covered services or relocation. Within 35 days of County's receiving notification of Provider's intent to materially reduce covered services or relocate, Provider shall submit a DMC certification application to the State. The DMC certification application must be submitted to the State 60 days prior to the desired effective date of the reduction of covered services or relocation.

26. TERMINATION FOR INSOLVENCY:

A. County may terminate this Agreement immediately in the event of the occurrence of any of the following:

1) Insolvency of Provider: Provider shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Provider is insolvent within the meaning of the Federal Bankruptcy Code.

2) The filing of a voluntary or involuntary petition regarding Provider under the Federal Bankruptcy Code.

3) The appointment of a Receiver or Trustee for Provider.

4) The execution by Provider of a general assignment for the benefit of creditors.

B. The rights and remedies of County provided in this Paragraph 25 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

27. TERMINATION FOR DEFAULT:

A. County or Provider may, by written notice of default to the other party, terminate this
Agreement immediately in any one of the following circumstances:

1) If, as determined in the good faith reasonable judgment of the non-breaching party, the other party fails to perform any services or fulfill any obligation within the times specified in this Agreement or any extension thereof as the non-breaching party may authorize in writing; or

2) If, as determined in the good faith reasonable judgment of the non-breaching party, the other party fails to perform and/or comply with any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in either of these two circumstances, does not cure such failure within a period of fifteen days (or such longer period as the non-breaching party may authorize in writing) after receipt of notice from the non-breaching party specifying such failure.

B. In the event that County terminates this Agreement as provided in Subparagraph A above, County may procure, upon such terms and in such manner as County may deem appropriate, services similar to those so terminated.

C. The rights and remedies of either party provided in this Paragraph 26 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

28. TERMINATION FOR IMPROPER CONSIDERATION:

County may, by written notice to Provider, immediately terminate the right of Provider to proceed under this Agreement if it is found that consideration, in any form, was offered or given by Provider, either directly or through an intermediary, to any County officer, employee or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment or extension of the Agreement or the making of any determinations with respect to the Provider's performance pursuant to the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Provider as it could pursue in the event of default by the Provider.

Provider shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made to the County Health and Human Services Agency Director.

Among other items, such improper consideration may take the form of cash, discounts, and service, the provision of travel or entertainment, or tangible gifts.

29. SEVERABILITY:

If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

30. CAPTIONS AND PARAGRAPH HEADINGS:

Captions and paragraph headings used in this Agreement are for convenience only and are not a part of this Agreement and shall not be used in construing this Agreement.

31. ALTERATION OF TERMS:

Other than the shifting of funds by County during the Cost Report Settlement process, no addition to, or alteration of, the terms of the body of this Agreement, or the SFC’s within the Service Summary(ies) or Service Exhibit(s) hereto, whether by written or oral understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the form of a written
amendment to this Agreement which is formally approved and executed by the parties in the same manner as this Agreement.

32. ENTIRE AGREEMENT:

The body of this Agreement; Service Summary(ies), Service Exhibit(s) | Exhibit A - Narcotic Replacement Therapy Services | Attachment(s) | 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 |

attached hereto and incorporated herein by reference including any addenda thereto, which are hereby incorporated herein by reference but not attached shall construe the complete and exclusive statement of understanding between the parties which supersedes all previous agreements, written or oral, and all other communications between the parties relating to the subject matter of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or schedule, or the contents or description of any service or other work, or otherwise, between the body of this Agreement and the other referenced documents, or between such other documents, such conflict or inconsistency shall be resolved by giving precedence first to the body of this Agreement then to such other documents according to the following priority:

1. Service Summary(ies)
2. Service Exhibit(s)
3. Attachments.

33. WAIVER:

No waiver by County or Provider of any breach of any provision of this Agreement shall constitute a waiver of any other breach of such provision. Failure of County or Provider to enforce at any time, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this Paragraph 34 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

34. EMPLOYMENT ELIGIBILITY VERIFICATION:

Provider warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others and that all its employees performing services hereunder meet the citizenship or alien status requirements set forth in Federal statutes and regulations. Provider shall obtain, from all covered employees performing services hereunder, all verification and other documentation of employment eligibility status required by Federal statutes and regulations as they currently exist and as they may be hereafter amended. Provider shall retain all such documentation for the period prescribed by law. Provider shall indemnify, defend, and hold harmless County, its officers and employees from and against any employer sanctions and any other liability which may be assessed against Provider or County in connection with any alleged violation of any Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

35. PUBLIC ANNOUNCEMENTS AND LITERATURE:

In public announcements and literature distributed by Provider for the purpose of apprising patients/clients and the general public of the nature of its treatment services, Provider shall clearly indicate that the services, which it provides under this Agreement, are in whole or in part funded by the County of Mariposa.

36. AUTHORIZATION WARRANTY:
Provider represents and warrants that the person executing this Agreement for Provider is an authorized agent who has actual authority to bind Provider to each and every term, condition, and obligation of this Agreement and that all requirements of Provider have been fulfilled to provide such actual authority.

37. LOBBYING AND RESTRICTIONS AND DISCLOSURE CERTIFICATION:
(Applicable to federally funded contracts in excess of $100,000 per Section 1352 of Title 31, U.S.C.)

A. Certification and Disclosure Requirements

1) A Provider who receives a contract which is subject to Section 1352 of Title 31, U.S.C., and which exceeds $100,000, shall file a certification (in the form set forth in Attachment 8, consisting of one page, entitled “Certification Regarding Lobbying”, incorporated by this reference) that the Provider has not made, and will not make, any payment prohibited by Paragraph 39 (PROHIBITION).

2) Provider shall file a disclosure (in the form set forth in Attachment 9, entitled “Disclosure of Lobbying Activities” Standard Form-LLL, incorporated by this reference) if such Provider has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or any amendment of that contract, which would be prohibited under Paragraph 39 (PROHIBITION) if paid for with appropriated funds.

3) Provider shall require that the language of this certification be included in the award of documents for all sub awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

4) Provider shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed under this Paragraph 38, Subparagraph A, Section (1) and Subparagraph A, Section (2) herein. An event that materially affects the accuracy of the information reported includes:

   a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

   b) A change in the person(s) or individual(s) influencing or attempting to influence a covered federal action; or

   c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

38. PROHIBITION:

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

39. LIMITATION ON USE OF FUNDS FOR PROMOTION OF LEGALIZATION OF CONTROLLED SUBSTANCES:
None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or substance included in Schedule 1 of Section 202 of the Controlled Substances Act (21 USC 812).

**40. RESTRICTION ON DISTRIBUTION OF STERILE NEEDLES:**
No funds made available through this Agreement shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

**41. NALTREXONE TREATMENT SERVICES**
Contractors will ensure that Beneficiaries meet all the following criteria prior to providing Naltrexone treatment services: 1) has a confirmed, documented history of opiate addiction, 2) is at least (18) years of age, 3) is opiate free, and 4) is not pregnant.

**42. PERINATAL SERVICES TB (Tuberculosis)**
Contractor must comply with the perinatal program requirements outlined in the Perinatal Services Network Guidelines. Contractors will ensure screening pregnant and parenting women for TB, and identify individuals who are at high risk of becoming infected.

**43. MINIMUM DRUG TREATMENT STANDARDS**
Contractors will comply with all Minimum Drug Treatment Standards required by CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC.

**44. RESTRICTIONS ON SALARIES:**
Provider agrees that no part of any federal funds provided under this Agreement shall be used by the Provider or any subcontractor to pay the salary of an individual at a rate in excess of Level 1 of the Executive Schedule. Salary schedules may be found at [http://www.opm.gov/oca](http://www.opm.gov/oca).

**45. CHILD SUPPORT COMPLIANCE ACT:**
Provider acknowledges that it recognizes the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the California Family Code, and to the best of Provider’s knowledge is fully complying with the earnings assignment orders of all employees and is providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department.

**46. PROVIDER RESPONSIBILITY AND DEBARMENT:**
A. A responsible Provider is a Provider who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the function of this Agreement. It is the County’s policy to conduct business only with responsible providers.

B. Provider is hereby notified that, in accordance with County Policy, if the County acquires confirmed and accurate information concerning the performance of Provider on this or other Agreements which indicates that Provider is not responsible, County may, in addition to other remedies provided within this Agreement, upon a minimum of 30 days prior written notice, debar Provider from bidding on County contracts for a specified period of time not to exceed three (3) years, and terminate any or all existing contracts Provider may have with the County.

C. The County may debar Provider if the Board of Supervisors finds, in its good faith reasonable discretion, Provider has done any of the following: (1) violated any material term of an
Agreement with the County; (2) committed any act or omission which negatively reflects on Provider’s quality, fitness or capacity to perform a contract with County or any other public entity, or engaged in a pattern or practice which negatively reflects on same; (3) committed an act or offense which indicates a lack of business integrity or business honesty; or (4) made or submitted a false claim against County or any other public entity.

D. If there is evidence that Provider may be subject to debarment, the Department will notify Provider upon 30 days prior written notice of the evidence, which is the basis for the proposed debarment and will advise Provider of the scheduled date for a debarment hearing before the Provider Hearing Board.

E. The Provider Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Provider and/or Provider’s representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Provider Hearing Board shall prepare a proposed decision, which shall contain a recommendation regarding whether Provider should be debarred, and, if so, the appropriate length of time of the debarment. If Provider fails to avail itself of the opportunity to submit evidence to the Provider Hearing Board, Provider may be deemed to have waived all rights of appeal.

F. A record of the hearing, the proposed decision and any other recommendation of the Provider Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny or adopt the proposed decision and recommendation of the Hearing Board.

G. These terms shall also apply to subcontractors/subconsultants of Provider.

47. PROVIDER’S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM:

Provider hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Provider will notify Director in writing within thirty (30) calendar days from receipt of the fully executed Agreement of: (1) any event that would require Provider or a staff member’s mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Provider or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Provider shall screen all staff employed or retained to provide services related to this Agreement to ensure that they are not designated as “Ineligible” or “Excluded” as defined hereunder. Screening shall be conducted against both the California “Medi-Cal Suspended and Ineligible List”, and the United States, Health and Human Services, Office of Inspector General (OIG) “List of Excluded Individuals/Entities”. Provider shall screen prospective staff prior to hire or engagement.

Provider shall screen all current staff at least monthly, and will notify Director in writing that Provider and Provider’s staff are eligible to participate in Federally funded programs. This notification shall be performed by completing Attachment 7, Attestation Regarding Federally Funded Programs attached and incorporated herein per this reference.

Provider and staff shall be required to disclose to the Director immediately any debarment, exclusion or other event that makes any individual an Ineligible or Excluded person. If the Provider becomes aware that a staff member has become an Ineligible or Excluded person, Provider shall remove such individual from responsibility for, or involvement with, County business operations related to this Agreement.

There are a variety of different reasons why an individual or entity may be excluded from participating in a Federally funded health care program. Sometimes, the exclusion is mandatory and in other
cases the OIG has the discretion not to exclude.

The mandatory basis for exclusion include: (1) felony convictions for program related crimes, including fraud or false claims, or for offenses related to the dispensing or use of controlled substances, or (2) convictions related to patient abuse.

Permissive exclusions may be based on: (1) conviction of a misdemeanor related to fraud or financial misconduct involving a government program; (2) obstructing an investigation; (3) failing to provide access to documents or premises as required by federal healthcare program officials; (4) conviction of a misdemeanor related to controlled substances; (5) failing to disclose information about the entity itself, its subcontractors or its significant business transactions; (6) loss of a state license to practice a healthcare profession; (7) default on a student loan given in connection with education in a health profession; (8) charging excessive amounts to a Federally funded health care program or furnishing services of poor quality or which are substantially in excess of the needs of the patients; (9) paying a kickback or submitting a false or fraudulent claim. Persons controlling or managing excluded entities who knew of the conduct leading to the exclusion can themselves be excluded, and entities, which are owned and controlled by excluded individuals, can also be excluded.

Provider shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Provider or its staff members from such participation in a Federally funded health care program.

Failure by Provider to meet the requirements of this Paragraph 45 shall constitute a material breach of Agreement upon which County may immediately terminate or suspend this Agreement.

48. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (“HIPAA”). Provider understands and agrees that it is a “Covered Entity” under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Provider understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Provider's behalf. Provider has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Provider's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

Provider and County understand and agree that each is independently responsible for HIPAA compliance and agree to take all necessary and reasonable actions to comply with the requirements of HIPAA law and implementing regulations related to Transactions and Code Sets, Privacy, and Security. Each party further agrees to indemnify and hold harmless the other party (including their officers, employees and agents), for its failure to comply with HIPAA.

49. UNION ORGANIZING:

A. Provider, by signing this Agreement, hereby acknowledges the applicability of California Government Code Sections 16645 through Section 16649 to this Agreement.

B. Provider will not assist, promote, or deter union organizing by employees performing work
on a State or County service contract.

C. No State or County funds received under this Agreement will be used to assist, promote, or deter union organizing.

D. Provider will not, for any business conducted under this Agreement, use any State or County property to hold meetings with employees or supervisors, if the purpose of such meeting is to assist, promote or deter union organizing unless the State or County property is equally available to the general public for holding meetings.

E. If Provider incurs costs, or makes expenditures to assist, promote, or deter union organizing, Provider will maintain records sufficient to show that no reimbursement from State or County funds has been sought for these costs, and Provider shall provide those records to the Attorney General upon request.

50. DRUG-FREE WORK PLACE:

By signing this Agreement Provider certifies that Provider will comply, and require that subcontractors comply, with the requirements of the Drug-Free Work Place Act of 1990 (California Government Code, Title 2, Chapter 1, Division 5.5, Section 8350 et seq.) and will provide a drug-free work place by taking the following actions:

A. Publish a statement notifying all employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's or organization's work place and specifying the actions that will be taken against employees for violations of the prohibitions as required by the California Government Code, Section 8355(a).

B. Establish a drug-free awareness program as required by the California Government Code, Section 8355(b) to inform all employees about all of the following:
   1) the dangers of drug abuse in the work place;
   2) the person's or organization's policy of maintaining a drug-free work place;
   3) any available drug counseling, rehabilitation, and employee assistance programs; and
   4) the penalties that may be imposed upon employees for drug abuse violations.

C. Provide, as required by the California Government Code, Section 8355(c) that every employee engaged in the performance of the Agreement:
   1) be given a copy of the Provider's drug-free policy statement; and
   2) as a condition of employment on the contract, agree to abide by the terms of the statement.

D. Failure to comply with these requirements for a drug-free work place may result in suspension of payments under the Agreement or termination of the Agreement or both, and Provider or its subcontractors may be ineligible for future County contracts if County determines that any of the following has occurred:
   1) Provider has made false certification; or
   2) Provider has violated the certification by failing to carry out the requirements as noted above.
51. **NO UNLAWFUL USE OR UNLAWFUL USE MESSAGES REGARDING DRUGS:**

Provider agrees that information produced through these funds, and which pertains to drug- and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug- or alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (Health and Safety Code Section 11999). By signing this Agreement, the Provider agrees that the Provider and its subcontractors will enforce these requirements.

52. **SMOKING PROHIBITION REQUIREMENTS:**

Provider shall comply, and require that subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18 if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

53. **ADHERENCE TO COMPUTER SOFTWARE COPYRIGHT LAWS:**

Provider certifies that it has appropriate systems and controls in place to ensure that State, Federal, or County funds available under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws. (Reference: Executive Order D-10-99 and Department of General Services Management Memo 00-02).

54. **TIMELINESS:**

Time is of the essence in this Agreement.

55. **PUBLIC NOTICE:**

Acknowledgement of funding from the State Department of Alcohol and Drug Programs and the Mariposa County Health and Human Services Agency shall be included in all publicity materials.

56. **SITE INSPECTION:**

The County and State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Provider or its subcontractors, the Provider shall provide and shall require its Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

57. **REFERENCES TO LAWS AND RULES:**

All references in this Agreement and written arrangements by the designated County Alcohol and Drug Administrator, to the California Administrative Code, HSC, Welfare and Institutions Code, and to any other laws, regulations, and policies may from time to time be changed by appropriate authority during the term of this Agreement, and are agreed to be binding upon Provider and County.

58. **FORCE MAJEURE:**
Neither Provider nor County shall be liable or responsible for damages, delays or failures in performance resulting from events beyond the reasonable control of such party and without fault or negligence of such party. Such events shall include but not be limited to acts of God, strikes, lockouts, pandemics, covid, riots, acts of war, acts of terrorism, epidemics, acts of government, fire, flood, other natural disasters, power failures, nuclear accidents, earthquakes, embargo, freight, governmental statutes or regulations superimposed after the fact, unusually severe weather, or other disasters, whether or not similar to the foregoing, and acts or omissions or failure to cooperate of the other party or third parties (except as otherwise specifically provided herein).

59. COUNSELOR CERTIFICATION:

Any individual providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in an ADP licensed or certified program is required to be certified as defined in CCR, Title 9, Division 4, Chapter 8. (Document 3H, as incorporated by this reference).

60. LIMITED ENGLISH PROFICIENCY:

To ensure equal access to quality care by diverse populations, Provider shall:

A. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally diverse work environment.

B. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

C. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

D. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

E. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

F. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.

G. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in the service area.

H. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

I. Ensure that the clients primary spoken language and self-identified race/ethnicity are included in the Providers management information system as well as any client records used by Provider staff.

61. INTRAVENOUS DRUG USE (IVDU) TREATMENT:
Provider shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo treatment (42 USC 200x-23(b) of PHS Act).

62. TUBERCULOSIS TREATMENT:

Provider shall ensure the following related to Tuberculosis (TB).

A. Services are available to each individual with TB to receive treatment for substance abuse;
B. Reduce barriers to patients accepting TB treatment; and
C. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

63. NOTICES:

All notices or demands required or permitted to be given under this Agreement shall be in writing and shall be delivered with signed receipt or mailed by first class, registered or certified mail, postage pre-paid, addressed to the parties at the following addresses and to the attention of the persons named. Director shall have the authority to execute all notices or demands which are required or permitted by County under this Agreement. Addresses and persons to be notified may be changed by either party by giving ten days prior written notice thereof to the other party and will not require an amendment to the Agreement.

Provider: AEGIS TREATMENT CENTERS, LLC
Administration: Contracting
1317 Route 73 North, Suite 200
Mount Laurel, NJ 08054
(484) 888-8867 Phone

County: Mariposa County Health and Human Services Agency
Director: Shannon Gadd
P.O. Box 99
Mariposa, CA 95338
Phone 209-966-2000
Fax: 209-742-0996

Shannon Gadd, Director, Mariposa County Health and Human Services
Baljit Hundal, Division Director of Health Services

Fiscal: Fiscal Department
P.O. Box 99
Mariposa, CA 95338
Phone 209-966-2000
Fax: 209-742-0996

Randy Ridenhour, Sr. Administrative Analyst

64. CONTRACT RESOLUTION PROCESS:

In the event Provider and County have a difference of opinion in regards to this Agreement, Provider shall initially work with the assigned County Contract Monitor. If satisfaction is not received, County’s Provider Problem Resolution Process shall be followed. Provider may contact County at the address and/or phone number as shown in Paragraph 62 (NOTICES), to obtain a copy of County’s Provider
Problem Resolution Process. All differences of opinion shall be handled at the lowest possible level and with a cooperative spirit.

Provider shall continue to carry out its responsibilities under this Agreement during any disputes, unless Director or Director’s designee recommends services be discontinued pending resolution.

65. APPLICABLE LAW AND FORUM:
This Agreement shall be construed and interpreted according to California Law and action to enforce the terms of this Agreement for breach thereof shall be brought and tried in the County of Mariposa.

66. INTELLECTUAL PROPERTY:
Provider shall have no proprietary interest in programs or data they develop solely for County. The compensation provided to Provider by this Agreement shall be deemed fair and adequate compensation for all work performed.

TRAFFICKING VICTIMS PROTECTION ACT of 2000:
Contractor and its subcontractors that provide services covered by this Contract shall comply with the Trafficking Victims Protection Act of 2000 (22 United States Code (USC) 7104(g)) as amended by section 1702 of Pub. L. 112-239.

County may terminate this Agreement or take any of the other remedial actions authorized under (22 U.S.C. 7104(c)), without penalty, if the Provider engages in, or uses labor recruiters, brokers, or other agents who engage in acts listed in (22 U.S.C. 7104(g)).

1. The contractor, the contractor’s employees, subcontractors, and subcontractors’ employees may not engage in:
   a. severe forms of trafficking in persons;
   b. the procurement of a commercial sex act during the period of time that the grant, contract, or cooperative agreement is in effect;
   c. the use of forced labor in the performance of the grant, contract, or cooperative agreement; or
   d. acts that directly support or advance trafficking in persons, including the following acts:
      i. destroying, concealing, removing, confiscating, or otherwise denying an employee access to that employee’s identity or immigration documents.
      ii. Failing to provide return transportation or pay for return transportation costs to an employee from a country outside the United States to the country from which the employee was recruited upon the end of employment if requested by the employee, unless:
         1. Soliciting a person for the purpose of employment, or offering employment, by means of materially false or fraudulent pretenses, representations, or promises regarding that employment.
         2. exempted from the requirement to provide or pay for such return transportation by the Federal department or agency providing or entering into the grant, contract, or cooperative agreement; or
         3. the employee is a victim of human trafficking seeking victim services or legal redress in the country of employment or a witness in a human trafficking enforcement action.
e. Soliciting a person for the purpose of employment, or offering employment, by means of materially false or fraudulent pretenses, representations, or promises regarding that employment.

f. Charging recruited employees unreasonable placement or recruitment fees, such as fees equal to or greater than the employee’s monthly salary, or recruitment fees that violate the laws of the country from which an employee is recruited.

g. Providing or arranging housing that fails to meet the host country housing and safety standards.

h. The contractor must inform authorized MCBHRS official immediately of any information received from any source alleging a violation of a prohibition of the TVPA.

County may unilaterally terminate this award, without penalty, if the contractor or a subrecipient that is a private entity, is determined to have violated a prohibition of the TVPA of this award term, or has an employee who is determined by an authorized County official to have violated a prohibition of the TVPA through conduct that is associated with performance under this award or imputed to the the contractor or subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, “OMB Guidelines to Agencies on Government–wide Debarment and Suspension (Nonprocurement).”

67. GOVERNING AGREEMENT COMPLIANCE:

By signing this Agreement, Provider acknowledges that, as a sub-recipient of Federal and State funding, Provider is obligated to adhere to all terms and conditions defined in the governing agreement(s) including those incorporated by reference, in effect at the time services are provided between County and California Department of Health Care Services (DHCS), under the “Substance Use Disorder Services” agreement, and any future terms and conditions contained in any subsequent agreements or amendments to those agreements. Such terms and conditions are in reference to “subcontractor”, and are available at Mariposa County Health and Human Services, incorporated by reference as if incorporated herein. Noncompliance with the aforementioned terms and conditions may result in termination of this Agreement by giving written notice as detailed in Paragraph 28 TERMINATION FOR DEFAULT.

68. DOCUMENTS. Notwithstanding any provision to the contrary, any and all documents, policies, procedures, standards or processes to which Provider agrees hereunder to follow, adhere to, cooperate with or comply with shall be provided to Provider in writing a minimum of thirty (30) days prior to its effective date as to Provider.

County shall notify in writing the Provider contacts listed in Paragraph 62 NOTICES, of any amendments of the governing agreements. The amendments will then be posted on the Contractor Resources webpage referenced above for review.

///

///

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement the day and year first above written.
Susan D. Hoeflich, VP, Managed Care
AEGIS TREATMENT CENTERS, LLC

Marshall Long
Mariposa County Board of Supervisors

APPROVED AS TO FORM:

Steven W. Dahlem
County Counsel
NARCOTIC REPLACEMENT THERAPY SERVICES

DOSSING AND COUNSELING SERVICES

(SERVICE CODE 48)

C. General:

Methadone – This service element is comprised of the provision of methadone as prescribed by a physician to alleviate the symptoms of withdrawal from narcotics; and other required/appropriate activities and services provided in compliance with CCR Title 9, Chapter 4, beginning with Section 10000. Services include intake, assessment and diagnosis, all medical supervision, urine drug screening, individual and group counseling, admission physical examinations and laboratory tests.

Group Counseling – Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. For Drug Medi-Cal reimbursement, groups must have a minimum of four and a maximum of 10 persons; at least one must be a Medi-Cal eligible beneficiary.

Individual Counseling – Face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits do not qualify as a Medi-Cal reimbursable unit of service.

For Drug Medi-Cal, a unit of service is reimbursed in 10-minute increments for both group and individual counseling sessions. The State reimburses a Provider up to a maximum of 200 minutes (20 units of service) of counseling (combination of group and/or individual) per calendar month, per beneficiary.

II. PERSONS TO BE SERVED: Drug Medi-Cal outpatient Narcotic Replacement Therapy (NRT) services shall be provided to Mariposa County Beneficiaries.

A. SERVICE DELIVERY SITES: Narcotic Replacement Therapy services will be provided only in Provider’s Drug Medi-Cal certified sites that have been approved by County and DHCS.

   a. The County and DHCS have approved Aegis Merced and Aegis Fresno sites.
   b. Provider shall notify county and request approval of a new site as may be required in the event a Mariposa County resident and beneficiary with Mariposa County of responsibility Medi-Cal appears for service at another location. Provider will provide documentation required to set up the new site and receive DHCS approval so that the Medi-Cal claims can be successfully submitted from the new site.

B. PROGRAM ELEMENTS AND SERVICES: Narcotic Treatment Program shall provide services to beneficiaries of Mariposa County in accordance with State and Federal regulations, this Agreement and any addenda thereto for the term of the Agreement.

I. Provider shall provide a program of Drug Medi-Cal outpatient Narcotic Replacement Therapy (NRT) services for Mariposa County Beneficiaries in accordance with the terms of this Agreement.

II. NRT is a comprehensive treatment including the use of synthetic opiates approved by the United States Food and Drug Administration for opiate-addicted patients. Services under this Agreement shall include, but are not limited to:
III. Methadone medication treatment.

IV. Drug screening and other testing as appropriate.

V. Individual and Group consultation/counseling services regarding methadone detox and methadone maintenance.

VI. Provider shall develop and maintain a community advisory committee, including but not limited to, members from law enforcement, local neighbors, and program alumni. The community advisory committee shall be organized in advance and called upon for the purpose of addressing neighborhood concerns as they arise.

V. PERFORMANCE OBJECTIVES: Narcotic Treatment Program will be evaluated by the following performance objectives:

III. A minimum of 50% of all discharged Beneficiaries who were in treatment at least 90 days will be considered as successfully completing treatment. Successful completion as a minimum will be defined as being achieved when the following criteria are also met:

IV. Within 90 days of admission, 60% of patients will be illicit opiate free; and

V. All patients will attend individual counseling sessions monthly.
# Monitoring Checklist for NTP PROVIDER
(Narcotic Replacement Therapy)

<table>
<thead>
<tr>
<th>Program</th>
<th>Yes</th>
<th>No</th>
<th>Improvement needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the program currently licensed and certified with the State Department of Alcohol and Drug Programs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did this program assist clients in completing treatment plans utilizing the results of the ASI and client input?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Did 50% of all discharged Behavioral Health clients successfully complete treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Did 75% of clients meet aftercare goals for three months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have 50% of clients who have successfully completed treatment either gained employment, enrolled in an educational program, and/or involved in community service?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Did this program call/contact GCBH/probation if clients left treatment or were found to be under the influence of drugs and/or alcohol?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are contract agreed upon staffing levels (1 paid staff per 7 clients) maintained at all times?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are client satisfaction forms being completed, and reported in aggregate every 6 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9.</td>
<td>Did this agency contact Behavioral Health one week prior to discharge with ongoing recommendations for treatment and a discharge plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Was a written treatment plan completed within the first ten days of treatment, and reviewed every 14 days?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Was the contract agreed upon treatment activities, including group, individual, and case delivered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Are status reports provided as requested for ongoing treatment and court compliance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Are all treatment groups provided at the residential certified site?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Do the staff treatment counselors meet the contract agreed upon experience/certification requirements (2 years experience &amp; certified AOD counselor by 6-30-04 for day/evening shifts) (1 year experience &amp; working toward certification for overnight [after 9 PM] staff)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiscal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Is the year-end cost settlement report submitted in complete form within 60 days after the close of the fiscal year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Are budgets and cost reports submitted as needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Are billings submitted on a monthly basis for current Behavioral Health client caseloads with billing source identified and client treatment days listed on monthly roster?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Are management staff attending meetings with GCBH staff as needed to discuss fiscal and treatment issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 52
## DOSING RECORD

**Chico**

**Methadone Inventory Transactions**
**From 12/02/2011 to 12/04/2011**

<table>
<thead>
<tr>
<th>Transacting Date</th>
<th>Time</th>
<th>Code</th>
<th>Description</th>
<th>Inventory</th>
<th>Transaction</th>
<th>Forecast</th>
<th>Commit</th>
<th>Unit</th>
<th>Box</th>
<th>Result</th>
<th>Batch Nos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/02/2011</td>
<td>11:30:25</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3625</td>
<td>Opened</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:50:34</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3627</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:50:44</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3628</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:50:55</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3629</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:51:00</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3630</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:51:05</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3631</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:51:10</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3632</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td>12/02/2011</td>
<td>11:51:15</td>
<td>AM</td>
<td>ChicoTestHM12.M2</td>
<td>3633</td>
<td>Patient Dose</td>
<td>0.000000</td>
<td>0.0000</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td>363</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th></th>
<th>490</th>
<th>490</th>
</tr>
</thead>
</table>

**Requested By:**  
**Requested Date:** 12/2/2011  
**Requested Time:** 11:23 am  
**Report Id:** DI124
72. ATTACHMENT 3- Business Associate Agreement (BAA)

Please refer to separate BAA document (County of Mariposa Board Res. 2018-525, dated November 13, 2018)

P1
STANDARD INSURANCE REQUIREMENTS

Before the commencement of work, Contractor shall submit Certificates of Insurance and Endorsements evidencing that Contractor has obtained the following forms of coverage and minimal amounts specified:

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder and the results of that work by the Contractor, his agents, representatives, employees or subcontractors.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

A. Commercial General Liability (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than $2,000,000 per occurrence. 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.

B. Automobile Liability: ISO Form Number CA 00 01 covering any auto (Code 1), or if Contractor has no owned autos, hired, (Code 8) and non-owned autos (Code 9), with limit no less than $1,000,000 per accident for bodily injury and property damage.

C. Workers' Compensation: 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.

D. Professional Liability (Errors and Omissions): Insurance appropriate to the Contractor's profession, with limit no less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. (If applicable).

If the contractor maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or the higher limits maintained by the contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the County.

OTHER INSURANCE PROVISIONS

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status

The County, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed
by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10 11 85 or if not available, through the addition of both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 if a later edition is used).

**Primary Coverage**

For any claims related to this contract, the Contractor's insurance coverage shall be primary coverage at least as broad as ISO CG 20 01 04 13 as respects the County, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

**Notice of Cancellation**

Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to the County.

**Waiver of Subrogation**

Contractor hereby grants to County a waiver of any right to subrogation which any insurer of said 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.

**Self-Insured Retentions**

Self-insured retentions must be declared to and approved by the County. The County may require the Contractor to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County.

**Acceptability of Insurers**

Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the County.

**Claims Made Policies**

If any of the required policies provide claims-made coverage:

- The Retroactive Date must be shown, and must be before the date of the contract or the beginning of contract work.
- Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.
If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of work.

**Verification of Coverage**

Contractor shall furnish the County with original Certificates of Insurance including all required endorsements (or copies of the applicable policy language effecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements to entity before work begins. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

**Special Risks or Circumstances**

County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.
I understand that ________________________________, is my sole employer for purposes of this employment.

I rely exclusively upon ________________________________, for payment of all salary and any and all other benefits payable to me or on my behalf during the period of this employment.

I understand and agree that I am not an employee of Mariposa County for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Mariposa during the period of this employment.

I understand and agree that I do not have and will not acquire any rights or benefits pursuant to any contract between my employer, ________________________________, and the County of Mariposa.

ACKNOWLEDGED AND RECEIVED:

NAME: ____________________________________________

DATE: ____________________________________________

NAME: ____________________________________________

Print

When completed, this form must be maintained on file by PROVIDER in accordance with all applicable County, State and Federal requirements and made available for inspection and/or audit by authorized representatives of County, State and/or Federal governments.
SUBCONTRACTOR EMPLOYEE
ACKNOWLEDGMENT OF EMPLOYER

I understand that ________________________________ is my sole employer for purposes of this employment.

I rely exclusively upon ________________________________ for payment of all salary and any and all other benefits payable to me or on my behalf during the period of this employment.

I understand and agree that I am not an employee of Mariposa County for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Mariposa during the period of this employment.

I understand and agree that I do not have and will not acquire any rights or benefits pursuant to any contract between my employer, ________________________________, and the County of Mariposa.

ACKNOWLEDGED AND RECEIVED:

NAME: ________________________________

DATE: ________________________________

NAME: ________________________________

Print

When completed, this form must be maintained on file by PROVIDER in accordance with all applicable County, State and Federal requirements and made available for inspection and/or audit by authorized representatives of County, State and/or Federal governments.
In accordance with the Narcotic Replacement Therapy Services Agreement's Paragraph 47 (PROVIDER'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned certify that I am not presently excluded from participation in federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any federally funded health care program, nor am I otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I further certify as the official responsible for the administration of Aegis Treatment Centers, LLC, (hereinafter “Provider”) that all of its officers, employees, agents and/or sub-contractors are not presently excluded from participation in any federally funded health care programs, nor is there an investigation presently pending or recently concluded of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federally funded health care program, nor are any of its officers, employees, agents and/or sub-contractors otherwise likely to be found by a federal or state agency to be ineligible to provide goods or services under the federally funded health care programs.

I understand and certify that I will notify County's Health and Human Services Agency Director immediately, in writing of:

A. Any event that would require Provider or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federally funded health care programs, or

B. Any suspension or exclusionary action taken by an agency of the federal or state government against Provider, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federally funded healthcare program payment may be made.

C. The Personnel Policies Checklist Form must be updated monthly, and sent to Billing Analyst within 10 (ten) days of the end of the billing period.

Name and Title of authorized official | Susan D. Hoeflich, VP, Managed Care

Please Print Name and Title

Signature of authorized official _____________________________ Date _______
Personnel Policies Checklist
County ____________________

<table>
<thead>
<tr>
<th>Date:</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
</tr>
<tr>
<td>Breeze (CA licensing board)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OIG/ LEIE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MediCal Ineligible Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sam.gov/EPLS (Excluded Parties list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death Master search (Survey only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPPES (when applicable, new hires)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
<td>Initial</td>
</tr>
<tr>
<td>Breeze (CA licensing board)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OIG/ LEIE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Ineligible Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sam.gov/EPLS (Excluded Parties list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death Master search (Survey only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPPES (when applicable, new hires)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide a list of employee names, licensures, certifications, NPI's, and titles etc.

Provide employees start date, and term date if employee is no longer working at facility.**
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor __________________________ Printed Name of Person Signing for Contractor __________________________

Contract / Grant Number __________________________ Signature of Person Signing for Contractor __________________________

Date __________________________ Title __________________________
**DISCLOSURE OF LOBBYING ACTIVITIES**

<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
<th>2. Status of Federal Action:</th>
<th>3. Report Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] a. contract</td>
<td>[ ] a. bid/offers/application</td>
<td>[ ] a. initial filing</td>
</tr>
<tr>
<td>b. grant</td>
<td>b. initial award</td>
<td>b. material change</td>
</tr>
<tr>
<td>c. cooperative agreement</td>
<td>c. post-award</td>
<td>For Material Change Only:</td>
</tr>
<tr>
<td>d. loan</td>
<td></td>
<td>Year ____ quarter ____</td>
</tr>
<tr>
<td>e. loan guarantee</td>
<td></td>
<td>date of last report ____</td>
</tr>
<tr>
<td>f. loan insurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Name and Address of Reporting Entity:</th>
<th>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Prime</td>
<td></td>
</tr>
<tr>
<td>☐ Subawardee</td>
<td></td>
</tr>
<tr>
<td>Tier ___, if known:</td>
<td></td>
</tr>
<tr>
<td>Congressional District, if known:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Federal Department/Agency</th>
<th>7. Federal Program Name/Description:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. Federal Action Number, If Known:</th>
<th>9. Award Amount, If Known:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.a Name and Address of Lobbying Registrant (if Individual, last name, first name, MI):</th>
<th>10.b Individuals Performing Services (including address if different from 10a. (Last name, First name, MI):</th>
</tr>
</thead>
</table>

| 11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material statement of fact upon which reliance was placed by the issuer when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure. | |

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Print Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title:</th>
<th>Telephone No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorized for Local Reproduction
Standard Form-LLL (Rev. 7-97)
## DHCS 100186 Drug Medi-Cal (DMC) Claim Submission Certification - County Contracted Provider

<table>
<thead>
<tr>
<th>State of California Health and Human Services Agency</th>
<th>Department of Health Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER</td>
<td></td>
</tr>
</tbody>
</table>

**County Name:**

**Provider Name (Legal Entity):**

**DMC Number(s):**

**Service Facility Location NPI(s):**

**DMC Submission Identifier:**

**For County Use Only:**

- **Receipt Date:**
- **EDI File Name:**
- **EDI File Submission Date:**

### COUNTY CONTRACTED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above is true, accurate and complete. I understand that payment of this claim file will be from Federal, State, and/or County Realignment funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.

I hereby agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals under the State's Title XIX and Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Department of Health Care Services or the Department of Health and Human Services may require. I further agree to accept as payment in full the amount paid by the Medi-Cal program for those claim files submitted for payment under the program with the exception of authorized deductibles, co-insurance, or similar cost sharing charge.

I certify that the services identified in the above identified DMC submission were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the provider.

**Printed Name:** AUTHORIZED SERVICE PROVIDER  

**Signature:** AUTHORIZED SERVICE PROVIDER  

**Phone Number**  

**Date Signed**

DHCS 100186 (Revised 6/2014)