SISKIYOU COUNTY
Health and Human Services Agency

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DEPARTMENTAL PROCEDURES

SUBJECT: Clinical Screening and Assessment	POLICY NO. CLIN 301	EFFECTIVE DATE 2/14/2018
APPROVED BY: Sarah Collard, Ph.D., HHSA Director	SUPERCEDES: CLIN 16-07	PAGES 2

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) requires clients who request services to complete a documented assessment after an initial screening determines that they meet medical necessity criteria for specialty mental health services. The assessment allows BHD to document the nature of the client's mental health problems and is used as a foundation to create an appropriate client treatment plan.

The initial screening shall be completed within 10 calendar days, and the intake assessment shall be completed within 60 calendar days. Assessments are updated at least annually for children, at least biennially for adults, and as needed.

Required Components of a Clinical Assessment

Assessments will contain at least the following information:

- Client name, ID number, and date of birth
- Date of assessment
- Presenting problem
- Relevant conditions and psychosocial factors affecting the client's physical and mental health
- Mental health history
- Medical history
- Medications
- Allergies and adverse reactions to medications
- Substance exposure/substance use
- Client strengths in achieving client treatment plan goals
- Risks
- Mental status exam
- A complete five-axis diagnosis

PROCEDURE:

1. Screenings occur within 10 calendar days from initial contact. Screenings are performed by the Intake Coordinator or designee and may take place in person or by phone. If at screening it is determined that the individual does not meet medical necessity criteria for specialty mental health services, written notification will be given, including a NOABD, and a list of local private providers.

2. Assessments for clients who receive planned ongoing services shall be completed as a standard component of the initial intake process. Typical first points of entry are through a planned services intake appointment with a clinician.

3. The initial intake assessment shall be completed within 60 calendar days of intake.

4. Assessments are updated at least annually for children, at least biennially for adults, and as needed.

5. Assessments can be provided by licensed, waivered, registered staff (MD, NP, Ph.D., LCSW, LPCC, and LMFT), and master's student trainee (requires a licensed LPHA co-signature).

AUTHORITY: *CCR, Title 9, Chapter 11, Sections 1810.204 and 1840.112.*

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DEPARTMENTAL PROCEDURES

SUBJECT: Service Authorization Requests Organization/Contracted Providers	POLICY NO. CLIN 302	EFFECTIVE DATE 2/22/18
APPROVED BY: Sarah Collard, Ph.D., Director of BH Division	REVISED 5/15/2019	PAGES 4

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) contracts with organizational and contracted providers for delivery of specialty mental health services including therapeutic behavioral services (TBS), rehab services, individual and group therapy, psychological testing, assessment, plan development, collateral, intensive care coordination (ICC), and in-home behavioral services (IHBS). The BHD director or designee maintains a current list of providers.

The Behavioral Health Division is responsible for:

1. Determining a client's need for specialty mental health services provided by organizational and contracted providers;
2. Ensuring that the client has access to services;
3. Authorizing payment for these services; and
4. Supervising the quality of these services.

I. *Assessment Criteria for Services*

The assessment process will include the areas required by state law, as outlined in policy CLIN 300. The assessment and supporting documentation will be included with the service authorization form submitted to the organizational and contracted provider at the time of initial request for services.

II. *Access to Services*

BHD is responsible for ensuring medically necessary specialty mental health services are available for clients through its internal and organizational and contracted provider network. During the initial assessment at BHD, and throughout treatment, clients will be evaluated to determine level of service need, and referrals to appropriate organizational and contracted providers will be made based upon medical necessity criteria for specialty mental health services. Referrals may also be made in the event that the demand for services exceeds BHD's capacity at any given time.

BHD shall ensure that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

BHD shall work with contracted providers to ensure that timely access to services meet BHD standards (see III. Payment Authorization section F for details).

III. *Payment Authorization*

A. BHD will submit an initial service authorization form to the organizational and contracted provider at the time services are first requested. This service authorization form functions as both authorization for services and payment.

B. Payment authorization shall follow the authorization process outlined in the provider manual regarding medical necessity; assessments; involvement of licensed mental health professionals in the decision process; and meeting the requirements of Medi-Cal documentation standards per state regulations. BHD requires, at a minimum, the following documentation from its contracted providers:
   - Contracted Provider Agreement (contract)
   - Service Authorization Request (SAR) (to request new or continuing services) for the appropriate timeframe.
   - A description of the program (day rehab and day treatment intensive services only) with the SAR.
   - Evidence of staff ratios and staff credentials must be submitted with invoices (day rehab and day treatment intensive services only).
   - Clinical assessments that meet CCR title 9 regulations and the requirements of the Mental Health Plan contract (MHP contract) between BHD and the Department of Health Care Services must be submitted with invoices claiming assessment services and with a SAR for continuing services. Assessments must be updated annually or when there is a significant change to the client's condition.
   - Client plans that meet the requirements of the MHP contract must be submitted with invoices. Client plans must be updated annually or when there is a significant change to the client's condition.
   - Daily attendance logs must be submitted with invoices: track the date, arrival time, and exit time of each service for each client, each day of service (day rehab and day treatment intensive services only).
   - Daily progress notes and signature and degree/title of the provider must be submitted with invoices all services except for adult residential and day rehab services which are required weekly.
   - Weekly program schedules must be submitted with invoices (day rehab and day treatment intensive services only).

C. Discharge documentation (submitted to BHD within 30 days of last date of service) must be submitted with invoices.

D. BHD shall adhere to the following timelines:
   - Standard authorizations: BHD will provide notice of approval or denial of payment authorization as expeditiously as the beneficiary's health condition requires and/or within fourteen (14) calendar days following the receipt of invoices.

- Expedited authorizations: For cases in which the provider indicates, or BHD determines, that following the standard authorization timeframe could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, BHD will provide notice of approval or denial of payment authorization within 72 hours after receipt of invoices.

E. BHD will authorize services according to timeframes specified on the service authorization form.

F. Upon request for continuation of BHD payment authorization for services, BHD will authorize services utilizing the service authorization form.

G. Notification to the client and provider regarding denials or modified authorization shall follow the procedure outlined in the notice of adverse benefit determination (NOABD) policy, ADMIN 15-01. Authorized services are required to commence within 10 business days of authorization or notification to the client's parent or guardian must be made by BHD and shall follow the procedure outline in the NOABD policy, ADMIN 15-01. Exceptions to access to services being accomplished within 10 business days must be reported to BHD immediately so that notification can be made per policy ADMIN 15-01.

NOTE: BHD shall not delegate the payment authorization function to its organizational and contracted providers.

IV. Quality Management Activities

At least annually, BHD shall review the authorization process for specialty mental health services provided by organizational and contracted providers through the Quality Improvement Committee (QIC). BHD shall ensure that the authorization process is consistent and meets state and federal standards. Any necessary action to improve the process shall be implemented in a timely manner.

Timely review of documentation provided by organizational and contracted providers is completed retrospectively by the quality assurance manager or designee to oversee the quality of services being provided. If a service is denied, providers are notified in writing of the reason for the denial and may appeal. The provider appeal process is outlined in the BHD provider manual.

PROCEDURES:

Service Authorization and Reauthorization Process

1. For all service requests providers must complete the BHD service authorization form and submit it to BHD with supporting documentation, as appropriate (e.g. assessment, treatment plan).
   - The service authorization form and supporting documentation may be faxed or mailed to BHD.

2. Service authorization forms and supporting documentation will be reviewed and approved or denied by the CSOC supervisor or designee.
   - Review of the service authorization form will be completed by licensed/registered/waivered mental health professionals only.

- Licensed psychiatric technicians and licensed vocational nurses may approve or deny service authorization forms only when the provider indicates that the client has an urgent condition.

3. Timeframes:
   - Standard authorizations: BHD shall provide notice of approval or denial of services authorization within fourteen (14) calendar days following the receipt of the request for new or continued services.
   - Expedited authorizations: For cases in which the provider indicates, or BHD determines, that following the standard authorization timeframe could seriously jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, BHD will provide notice of approval or denial of service authorization within 72 hours after receipt of request for service authorization.
   - BHD will act on an authorization request for treatment for urgent conditions within one hour of the request.
   - If BHD does not meet the required authorization timeframes, BHD will provide the client with a Notice of Adverse Benefit Determination (NOABD) "Authorization Delay" within two (2) business days and inform the provider within 24 hours of the delayed decision.

4. Providers will be notified of service authorization approval or denial in writing via email or fax.

5. If BHD denies the requested services in part or in whole, BHD will document the denial using the service authorization log.
   - In addition, BHD is responsible for notifying the client of the denial by issuing the appropriate NOABD "Denial" to the client and the provider within two (2) business days of the decision, or within ten (10) business days if the service was previously authorized. For more information about the NOABD, refer to the BHD policy ADMIN 15-01.

AUTHORITY: CFR, title 42, section 438.210 (b)(3), (d)(1)(2); CCR, title 9, chapter 11, sections 1830.215(c), 1810.253, 1810.440(b)(1), (2), (3)*; MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e); *Referencing Policies- Admin 15-1; Clin 16-07

SISKIYOU COUNTY
Health and Human Services Agency

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DEPARTMENTAL PROCEDURES

SUBJECT: Access to Services Standards	POLICY NO. CLIN 303	EFFECTIVE DATE 3/27/18
APPROVED BY: Sarah Collard, Ph.D., Director of BH Division	SUPERCEDES NA	PAGES 2

POLICY: It is the policy of Siskiyou County Behavioral Health Services (SCBHS) to provide timely access to care and services, taking into account the urgency of the need for services. SCBHS will make all medically necessary covered Specialty Mental Health Services (SMHS) available in accordance with California Code of Regulations (CCR), Title 9, §1810.345 and §1810.405, and 42 Code of Federal Regulations (C.F.R.) § 438.210 and will ensure:

1. The availability of services to address beneficiaries' emergency psychiatric conditions 24 hours a day, 7 days a week.
2. The availability of services to address beneficiaries' urgent conditions as defined in CCR, Title 9, §1810.253, 24 hours a day, and 7 days a week.
3. Timely access to routine services determined by the Contractor to be required to meet beneficiaries' needs.

It is the policy of SCBHS to comply with the time and distance standards and the timely access standards as set forth by the Centers for Medicare and Medicaid Services (CMS) published in the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule).

This Policy and Procedure:
- Establishes timeliness and access standards for appointments
- Establishes policy for extending timeliness standards
- Establishes standards for ongoing scheduled appointments

PROCEDURES:

A. Appointments for beneficiaries must comply with the following standards:
   a. For psychiatry, the standards are as follows:
      i. Timely Access - Within 15 business days from request to offered appointment
      ii. Time and Distance - Up to 60 miles or 90 minutes from the beneficiary's place of residence
   b. The standards for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services are as follows:

i. Timely Access - Within 10 business days from request to offered appointment
ii. Time and Distance - Up to 60 miles or 90 minutes from the beneficiary's place of residence

c. Urgent Appointments
i. For services that do not require a prior authorization – Offered within 48 hours of a request
ii. For services that do require a prior authorization – Offered within 96 hours of a request

B. The applicable appointment time standards may be extended if the referring or treating provider, or the health professional providing triage or screening services has determined and noted in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary.

C. Periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.

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DEPARTMENTAL PROCEDURES

SUBJECT: Specialty Mental Health Service Provision Standards	POLICY NO. CLIN 305	EFFECTIVE DATE 2/25/2019
APPROVED BY: Sarah Collard, Ph.D., HHSA Director	SUPERCEDES: CLIN 13-14	PAGES 8

Purpose: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) shall provide a range of outpatient and inpatient mental health services. BHD may also contract with outside providers to deliver these mental health services. Specialty Mental Health Services (SMHS) directly provided by BHD and its provider shall include at least the following:

1. Mental Health Services, including: collateral services; plan development; rehabilitation services; assessment; individual and group therapy.
2. Targeted Case Management Services
3. Medication Support Services
4. Crisis Intervention Services
5. Therapeutic Behavioral Services (TBS)
6. Intensive Care Coordination (ICC)
7. Intensive Home Based Services (IHBS)

BHD shall also ensure that the following SMHS are available, depending on the assessed needs of each individual client:

1. Day Treatment and Day Rehabilitation Services: BHD contracts with Youth Group Homes, which may provide these services as necessary.
2. Crisis Stabilization Services
3. Adult Residential Treatment Services
4. Crisis Residential Treatment Services

5. Psychiatric Health Facility Services
6. Therapeutic Foster Care Services
7. Psychiatric Inpatient Hospital Services

Specialty Mental Health Services are provided by Medi-Cal-certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements, or by non-licensed providers who agree to abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by the Department of Health Care Services (DHCS), to the extent authorized under state law.

BHD shall designate a Director of Local Mental Health Services in compliance with current state and federal regulations. In addition, organizational providers under contract with BHD for mental health services shall designate a Head of Service in compliance with current state and federal regulations. All Specialty Mental Health Services shall be provided in Medi-Cal-certified mental health provider sites.

Procedures:

Types of Services;

BHD and its providers shall offer an array of mental health services to children, transition age youth, adults, and older adults. Services are offered in English and Spanish; other language resources (interpreter services; large print) are available as needed and will be provided at no charge. These services shall comply with the following standards, as outlined by Title IX of the California Code of Regulations:

These specialty mental health services shall comply with the following standards, as outlined by Title IX of the California Code of Regulations and the Medi-Cal Specialty Mental Health Services State Plan Amendment.

- **Mental Health Services** - Individual, group or family-based interventions that are designed to provide reduction of the beneficiary's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Theseservice functions include the following:

    - Collateral Services - A service activity to a significant support person or persons in a client's life for the purpose of providing support to the client in achieving client plan goals.

    - Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a beneficiary's progress toward meeting goals and objectives identified on the client plan.

- Rehabilitation Services - This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. Rehabilitation also includes support resources, and/or medication education.

- Assessment- A service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

- Individual Therapy - A service activity that is a therapeutic intervention provided to an individual client that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Services will be delivered by a licensed/waivered professional (LMFT, LPC, LCSW or Psychologist) within their scope of practice.

- Group Therapy- A service activity that is a therapeutic intervention provided in a group setting that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments.

  - Individual and Group Therapy will be delivered by a Licensed, Waivered or Registered Mental Health Professional (Physician, Psychologist, LCSW, LPCC, or LMFT) within their scope of practice.

- **Medication Support Services** - Services that include the prescribing, administration, dispensing or monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service shall include evaluation of side effects and results of medication. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated.

- **Crisis Intervention** - An unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

- **Targeted Case Management Services** - Services designed to assist clients to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to,

communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

- **Intensive Care Coordination (ICC)** - A targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for children and youth who are assessed to be in need of ICC..

- **Intensive Home Based Services (IHBS)** - Mental health rehabilitative services provided to children and youth who are assessed to be in need of IHBS. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help and child/youth successfully function in the home and community.

- **Therapeutic Behavioral Services (TBS)** - TBS is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental service for children/youth with serious emotional problems who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a high level group home or a locked facility for the treatment of mental health needs, including acute care; or to enable a transition from any of those levels to a lower level of residential care. TBS is intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a lower level of placement. The purpose of providing therapeutic behavioral services is to further the child/youth's overall treatment goals by providing additional therapeutic services during a short-term period.

- **Day Treatment Intensive** - A structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting.

- **Day Rehabilitation** - A structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development.

- **Crisis Stabilization** - An unplanned, expedited service provided to both youth and adults lasting less than 24 hours, to or on behalf of a client to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The

goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the client or others, or substantially increase the risk of the client becoming gravely disabled.

- **Adult Residential Treatment Services** - Recovery focused rehabilitative services, provided in a non-institutional, residential setting, for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

- **Crisis Residential Treatment Services** - Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term - 3 months or less) as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care.

- **Psychiatric Health Facility Services** - Therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitation services provided in a psychiatric health facility licensed by the Department of Health Care Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders.

- **Therapeutic Foster Care Services** - The TFC service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised, and supported TFC parents. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.

- **Psychiatric Inpatient Hospital Services** - 24-hour inpatient services provided by a hospital to clients for whom the facilities, services and equipment described in the California Code of Regulations (CCR) Title 9 Section1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with CCR Title 9 Section 1820.205.

Provider Qualifications

Specialty mental health services mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by the Department of Health Care Services, to the extent authorized under state law.

Services are provided by or under the direction (for those providers that may direct services) of the following Mental Health Professionals functioning within the scope of his or her professional license and applicable state law.

The following specific minimum provider qualifications apply for each individual delivering or directing services.

1) Physicians
   Physicians must be licensed in accordance with applicable State of California licensure requirements. Physicians may direct services.

2) Psychologists

   Psychologists must be licensed in accordance with applicable State of California licensure requirements. Psychologists may direct services.

   A psychologist may also be a Waivered Professional who has a waiver of psychologist licensure to the extent authorized under State law. Waivered Psychologists may also direct services under the supervision of a Licensed Mental Health Professional in accordance with laws and regulations governing the waiver.

3) Licensed Clinical Social Workers (LCSW)

   Licensed clinical social workers must be licensed in accordance with applicable State of California licensure requirements. Licensed clinical social workers may direct services.

   A clinical social worker may also be a Waivered/Registered Professional who has (1) registered with the State licensing authority for clinical social workers for the purpose of acquiring the experience required for clinical social work licensure in accordance with applicable statutes and regulations or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California, and whose experience is sufficient to gain admission to the appropriate licensing examination, but who requires time in which to make arrangements for and take the appropriate licensing examination.

4) Licensed Professional Clinical Counselors (LPCC)

   Licensed professional clinical counselors must be licensed in accordance with applicable State of California licensure requirements. Licensed professional clinical counselors may direct services.

   A professional clinical counselor may also be a Waivered/Registered Professional who has (1) registered with the State's licensing authority for professional clinical counselors for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California, and whose experience is sufficient to gain admission to the appropriate licensing examination, but who requires time in which to make arrangements for and take the appropriate licensing examination.

5) Marriage and Family Therapists (MFT)

   Marriage and family therapists must be licensed in accordance with applicable State of California licensure requirements. Marriage and family therapists may direct services.

A marriage and family therapist may also be a Waivered/Registered Professional who has (1) registered with the State licensing authority for marriage and family therapists for the purpose of acquiring the experience required for marriage and family therapist licensure, in accordance with applicable statutes and regulations, or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California, and whose experience is sufficient to gain admission to the appropriate licensing examination, but who requires time in which to make arrangements for and take the appropriate licensing examination.

6) Registered Nurses (RN)

Registered nurses must be licensed in accordance with applicable State of California licensure requirements. Registered nurses may direct services.

7) Certified Nurse Specialists (CNS)

Certified nurse specialists must be licensed in accordance with applicable State of California licensure requirements. Certified nurse specialists may direct services.

8) Nurse Practitioners (NP)

Nurse practitioners must be licensed in accordance with applicable State of California licensure requirements. Nurse practitioners may direct services.

The following providers may provide services under the direction of those Licensed Mental Health Professionals (listed above) who may direct services.

A) Licensed Vocational Nurses (LVN)
Licensed vocations nurses must be licensed in accordance with applicable State of California licensure requirements.

B) Psychiatric Technicians (PT)

Psychiatric technicians must be licensed in accordance with applicable State of California licensure requirements.

C) Mental Health Rehabilitation Specialists (MHRS)

A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting.

D) Physician Assistants (PA)

Physician assistants must be licensed in accordance with applicable State of California licensure requirements.

E) Pharmacists

Pharmacists must be licensed in accordance with applicable State of California licensure requirements.

F) Occupational Therapists (OT)

Occupational therapists must be licensed in accordance with applicable State of California licensure requirements.

G) Other Qualified Provider

An individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service.

Reference: Medi-Cal Specialty Mental Health Services State Plan Amendment, SPA #10-016, approved December 18, 2012; CCR Title 9, Chapter 11, Section 1810.249; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, Third Edition, January 2018.

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DEPARTMENTAL PROCEDURES

SUBJECT: Continuity of Care	POLICY NO. CLIN 307	EFFECTIVE DATE 2/25/19
APPROVED BY: Sarah Collard, Ph.D., HHSA Director	SUPERCEDES NA	PAGES 5

This Policy and Procedure provides the Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) continuity of care requirements for Medi-Cal beneficiaries who receive specialty mental health services (SMHS) from BHD.

PURPOSE: The intent of this policy is to provide guidelines for a transition of care process to ensure continued access to services during a beneficiary's transition from a Medi-Cal Managed Care Plan (MCP) to BHD, from another county Mental Health Plan (MHP) to BHD, or from a Medi-Cal fee-for-service (FFS) provider to BHD, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. This policy is also intended to align BHD policy and procedure with state and federal requirements for continuity of care and the Parity in Mental Health and Substance Use Disorder Services Final Rule.

POLICY:

A. It is the policy of BHD that all eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to BHD will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of BHD or a contracted organizational or network provider).

B. SMHS will continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by BHD, in consultation with the beneficiary and the provider, and consistent with good professional practice.

C. This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

1. The provider has voluntarily terminated employment or the contract with BHD;
2. The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program;
3. Transitioning from another county MHP to BHD due to a change in the beneficiary's county of residence;
4. Transitioning from a MCP to BHD; or,
5. Transitioning from a Medi-Cal FFS provider to BHD.

PROCEDURES:

A. Out-of-Network Providers

At the request of a beneficiary or the beneficiary's authorized representative, BHD will provide for the completion of SMHS by a non-participating (i.e., out-of-network) provider, for a period of up to 12 months. BHD will provide continuity of care with an eligible out-of-network Medi-Cal provider if all of the following conditions are met:

1. BHD is able to determine that the beneficiary has an existing relationship with the provider (i.e., the beneficiary has received mental health services from the provider at least once during the 12 months prior to their initial enrollment with BHD);
2. The provider type is consistent with the Medi-Cal State Plan Amendment for Rehabilitative Mental Health Services and the provider meets the applicable professional standards under State law;
3. The provider agrees, in writing, to be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers, including, but not limited to, credentialing, utilization review, and quality assurance. BHD may enter into "single case agreements" or other appropriate payment mechanisms with providers to deliver SMHS to one or more specific beneficiaries for a period of up to 12 months;
4. The provider agrees, in writing, to comply with State requirements for SMHS, including documentation requirements in accordance with the MHP contract with the California Department of Health Care Services (DHCS);
5. The provider supplies BHD with all relevant treatment information, for the purposes of determining medical necessity, including documentation of a current assessment, a current treatment plan, and relevant progress notes, as long as it is allowable under federal and State privacy laws and regulations;
6. The provider is willing to accept the higher of BHD's provider contract rates or Medi-Cal FFS rates; and,
7. BHD has not identified, verified, and documented disqualifying quality of care issues to the extent that the provider would not be eligible to provide services to any other beneficiaries of BHD.

If the provider does not agree to comply or does not comply with these contractual terms and conditions, BHD may not approve the continuity of care request. If the continuity of care request is denied for any reason, BHD will notify the beneficiary and/or the beneficiary's authorized representative.

B. Terminated Providers

At the request of a beneficiary or the beneficiary's authorized representative, BHD will provide for the completion of SMHS by a terminated network provider, for a period of up to 12-months. The completion of SMHS will be provided by a terminated network provider to a beneficiary who, at the time of the contract's termination, was receiving SMHS from that provider. Termination means the following:

1. The provider voluntarily terminated employment or contract; or,
2. The MHP terminated employment or the provider's contract, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medicaid program.

BHD may require the terminated network provider, whose services are continued beyond the contract termination date, to agree, in writing, to be subject to the same contractual terms and conditions, including rates of compensation, that were imposed upon the provider prior to termination. BHD may enter into "single case agreements" or other appropriate payment mechanisms with providers to deliver SMHS to one or more specific beneficiaries for a period of up to 12 months. If the provider does not agree to comply or does not comply with these contractual terms and conditions, the MHP may not approve the beneficiary's continuity of care request.

C. Procedures for Continuity of Care Requests

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to BHD for continuity of care. Beneficiaries may request continuity of care in person, in writing, or via telephone and are not required to submit an electronic or written request. BHD will provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

1. Validating Existing Provider Relationships
   An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the 12 months prior to the following:
   a. The beneficiary establishing residence in the county;
   b. Upon referral by another MHP or MCP; and/or,
   c. BHD determines that the beneficiary meets medical necessity criteria for SMHS.

2. A beneficiary or provider may make available information to the MHP that provides verification of their pre-existing relationship with a provider.

3. Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary

D. Timeline Requirements

All continuity of care request must be completed within the following timelines:

1. Thirty calendar days from the date the MHP received the request;
2. Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
3. Three calendar days if there is a risk of harm to the beneficiary

BHD will retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:

1. The provider meets the continuity of care requirements outlined in this policy and procedure.
2. Services were provided after a referral was made to the MHP (this includes self-referrals made by the beneficiary); and
3. BHD determines that the beneficiary meets medical necessity criteria for SMHS.

A continuity of care request is considered complete when:

1. BHD informs the beneficiary and /or the beneficiary's authorized representative, that the request has been approved; or,
2. BHD and the out-of-network provider are unable to agree to a rate and BHD notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,
3. BHD has documented quality of care issues with the provider and notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,
4. BHD makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days and notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied.

E. Procedures Following Completion of a Continuing Care Request

If the provider meets all of the required conditions and the beneficiary's request is granted, BHD will allow the beneficiary to have access to that provider for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between BHD and the out-of-network provider. When the continuity of care agreement has been established, BHD will work with the provider to establish a Client Plan and transition plan for the beneficiary. Upon approval of a continuity of care request, BHD will notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

1. The MHPs approval of the continuity of care request;
2. The duration of the continuity of care arrangement;
3. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
4. The beneficiary's right to choose a different provider from BHD's provider network.

If the continuity of care request is denied, the written notification will include the following information:

1. BHD's denial of the beneficiary's continuity of care request;
2. A clear explanation of the reasons for the denial;
3. The availability of in-network SMHS;
4. How and where to access SMHS from BHD;
5. The beneficiary's right to file an appeal based on the adverse benefit determination; and,
6. BHD's beneficiary handbook and provider directory

At any time, beneficiaries may change their provider to an in-network provider whether or not a continuity of care relationship has been established. BHD will provide SMHS and/or refer beneficiaries to appropriate organizational or network providers without delay and within established appointment time standards.

BHD will notify the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

F. Repeated Requests for Continuity of Care

After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in the BHD network for SMHS. If the beneficiary later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the MHP for SMHS, the 12-month continuity of care period may start over one time.

If a beneficiary changes county of residence more than once in a 12-month period, the 12-month continuity of care period may start over with the second MHP and third MHP, after which, the beneficiary may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the MHP should communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

G. Beneficiary and Provider Outreach and Education

BHD will inform beneficiaries of their continuity of care protections and will include information about these protections in beneficiary informing materials and handbooks. This information will include how the beneficiary and provider initiate a continuity of care request with the BHD. This information will be available in threshold languages and made available in alternative formats, upon request. MHPs will provide training to staff that come into regular contact with beneficiaries about continuity of care protections.

H. Reporting Requirement

BHD will report to DHCS all requests, and approvals, for continuity of care. BHD will submit a continuity of care report, with its quarterly network adequacy submissions, that includes the following information:

1. The date of the request;
2. The beneficiary's name;
3. The name of the beneficiary's pre-existing provider;
4. The address/location of the provider's office;
5. Whether the provider has agreed to BHD's terms and conditions; and,
6. The status of the request, including the deadline for making a decision regarding the beneficiary's request.

AUTHORITY: CFR, title 42, Section 438.62(b)(1)-(2); MHP Contract Exhibit A, Attachment 10

SISKIYOU COUNTY
Health and Human Services Agency

SARAH COLLARD, PH.D.
HHSA Director
TRACIE LIMA, LCSW
Clinical Director of Behavioral Health

DEPARTMENTAL PROCEDURES

SUBJECT: Authorization of Specialty Mental Health Services	POLICY NO. CLIN 310	EFFECTIVE DATE 7/11/19
APPROVED BY: Sarah Collard, Ph.D., Director of HHSA	REVISED NA	PAGES 6

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) is committed to ensuring beneficiaries have appropriate access to Specialty Mental Health Services (SMHS). Authorization and utilization management of services provided by the BHD adhere to the following principles:

- Are based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
- Are developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
- Are evaluated, and updated if necessary, at least annually; and
- Are disclosed to the BHD's beneficiaries and network providers.

PROCEDURE:

BHD ensures that all medically necessary covered SMHS are sufficient in amount, duration and scope to achieve the purpose for which the services are rendered. BHD will not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. In addition, BHD shall, through policy and utilization review, ensure consistent application of review criteria for authorization decisions, and shall consult with requesting providers when appropriate.

Communication Requirements:

BHD shall adhere to the following communication requirements:

- Notify the Department of Health Care Services (DHCS) and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are

aware of the procedures and timeframes necessary to obtain authorization for these services;
- Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of outpatient services requiring prior authorization;
- A physician shall be available for consultation and for resolving disputed requests for psychiatric inpatient hospital or PHF authorizations;
- Disclose to DHCS, organizational providers, beneficiaries and members of the public, upon request, the utilization review policies and procedures that BHD or its' contracted providers use to authorize, modify, or deny SMHS. These policies and procedures shall be available electronically and in hard-copy upon request
- Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for services authorizations and/or referrals for SMHS; and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

Concurrent Review for Psychiatric Inpatient Hospital/Psychiatric Health Facility (PHF) Services:

BHD shall conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services. Concurrent review of treatment authorizations shall be conducted on the day following the first day of admission. BHD may elect to authorize multiple days, however, each day of treatment must meet medical necessity and/or continued stay criteria.

Beneficiaries must meet the following medical necessity criteria for voluntary or involuntary admission to a hospital for psychiatric inpatient hospital services:
- Have an included diagnosis
- Cannot be safely treated at a lower level of care, except that the beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met with criterion; and
- Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:
  1. Has symptoms or behaviors due to a mental disorder that:
     - Represent a current danger to self or others, or significant property destruction.
     - Prevent the beneficiary from providing for, or utilizing food, clothing, or shelter.
     - Present a severe risk to the beneficiary's physical health.
     - Represent a recent, significant deterioration in ability to function.
  2. Require admission for one of the following:
     - Further psychiatric evaluation.
     - Medication treatment.
     - Other treatment that can be reasonably provided only if the beneficiary is hospitalized.

Continued stay services shall be authorized by BHD when a beneficiary experiences one of the following:
- Continued presence of indications that meet the medical necessity criteria;
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
- Presence of new indications that meet medical necessity criteria; and,
- Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

Authorization of Psychiatric Inpatient/PHF Services:

BHD does not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a PHF whether the admission is voluntary or involuntary when the beneficiary meets medical necessity criteria for inpatient services. Upon notification by a hospital, BHD shall authorize payment services when a BHD beneficiary with an emergency psychiatric condition is admitted to a hospital/PHF to receive inpatient services. After the date of admission, hospitals must request authorization for continued stay services. BHD shall ensure that services furnished to beneficiaries are medically necessary and meet all requirements necessary for Medi-Cal reimbursement. All authorization determinations are made by a Licensed Practitioner of the Healing Arts (LPHA).

1. Within 24-hours of placement of a Siskiyou County Medi-Cal beneficiary or individual without a third-party payor source (hereafter referred to as 'client') placed by Siskiyou County, the hospital/PHF shall contact the Siskiyou County Access Line (800) 842-8979 and request to speak with the Crisis Supervisor to review status of the beneficiary/client and request initial authorization. Initial authorization may be made for multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.
2. After hours, on weekends and holidays, authorization requests will be routed by Alameda Crisis directly to the on-call Crisis Supervisor.
3. If a Medi-Cal beneficiary placed by Siskiyou County has Medi-Cal from another county, concurrent review and authorization will not be conducted by Siskiyou County. The hospital/PHF shall be responsible to coordinate authorization and payment with the county of responsibility.
4. Prior to the expiration of the current authorization, the hospital/PHF shall contact the Crisis Supervisor who will complete the Inpatient Authorization Form. The Crisis Supervisor will make authorization determination based upon medical necessity criteria and inform the hospital/PHF in writing via facsimile within 24 hours. The Crisis Supervisor will then route the form to the program coordinator, who shall be responsible for logging and tracking inpatient authorizations in the Inpatient Census Log. The hospital/PHF may be required to submit documentation to support medical necessity for authorization of services.
5. In the event an authorization request is disputed, the Crisis Supervisor will request consultation from the BHD Psychiatrist.
6. In the case of concurrent review, if BHD denies or modifies the request for authorization, care shall not be discontinued until the beneficiary's treating provider(s) have been notified of the decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. Beneficiaries must be notified, in writing, of the adverse benefit determination prior to services being discontinued.

Authorization of Administrative Days:

Hospitals/PHSs may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services, but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for administrative day services, BHS shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (excepting weekends and holidays). Once five contacts have been made and documented, any remaining days within a seven-consecutive-day period from the day the beneficiary is placed on administrative status may be authorized.

BHD may waive the five contacts per week requirement if there are fewer than five appropriate, non-acute

residential treatment facilities available as placement options. The lack of available treatment facilities and the contacts made to appropriate facilities shall be documented and include:

- Status of placement
- Date of contact
- Signature of person making contact

Examples of appropriate placement status options include, but may not be limited to:

- The beneficiary's information packet is under review
- An interview with the beneficiary has been scheduled for (date);
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a wait list;
- The beneficiary has been accepted and will be discharged to a facility on (date);
- The beneficiary has been rejected from a facility due to (reason); and/or,
- A conservator deems the facility to be inappropriate for placement.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services:

The BHD does not require prior authorization for Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Authorization for CRTS and ARTS must be by referral and/or concurrent review.

If the BHD refers a beneficiary to a facility for CRTS or ARTS, the referring LPHA will complete the CR/AR Services Form and specify the number of days authorized. BHD shall then reauthorize medically necessary CRTS and ARTS services, as appropriate, using the concurrent review process outlined above.

If BHD does not initiate the referral for CRTS or ARTS, the BHD shall conduct concurrent review of treatment authorizations following the first day of admission to the facility through discharge. The BHD may elect to authorize multiple days as long as the services are medically necessary.

Notification of decisions to approve, modify, or deny requests for authorization of CRTS or ARTS shall follow the notification procedure outlined above for notification to hospitals/PHF.

Prior Authorization or BHD Referral for Outpatient SMHS:

The BHD shall not require prior authorization for the following services/service activities:

- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services;
- Targeted Case Management; and,
- Medication Support Services.

As a regular practice, assessments are conducted by the BHD's clinical staff. The BHD shall not require prior authorization in the event that an organizational provider conducts an assessment, however, prior to the commencement of services, BHD's Quality Assurance Manager (QAM) or designee shall review and approve the beneficiaries' completed assessment and Client Plan. This approval serves as the authorization for services as outlined/identified in the client plan. Assessments and Client Plans completed by organizational providers may be faxed to 530-841-4702.

BHD requires prior authorization or referral for the following services:

- Intensive Home Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

Initial authorization for these services will be provided by referral on the Service Authorization Request (SAR) form and shall specify the amount, scope and duration of the treatment BHD has authorized. All authorizations will be completed by an LPHA. Prior to the expiration of the initial referral, BHD requires organizational providers to request payment authorization for the continuation of services at the following intervals:

- Every month
  - Day Treatment Intensive
  - Therapeutic Behavioral Services
  - Therapeutic Foster Care
- Every six months
  - Intensive Home Based Services
  - Day Rehabilitation

BHD shall document all authorization determinations on the SAR Log.

If BHD denies or modifies an authorization request, notification will be given to the beneficiary, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow guidelines outlined in ADMIN 15-01.

Outpatient Authorization Timeframe:

BHD shall review and make authorization determinations regarding provider request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the receipt of the information reasonably necessary and requested by BHD to make the determination. In cases where BHD or the provider determine that the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receipt of the request for service.

BHD may extend the timeframe for making an authorization decision for up to 14 additional calendar days if the following conditions are met:

- The beneficiary, or the provider, request an extension; or
- BHD justifies (to the Department of Health Care Services upon request), and documents a need for additional information and how the extension is in the beneficiary's best interest.

Retrospective Authorization Requirements:

BHD's QAM or designee conducts retrospective authorization of inpatient and outpatient SMHS under the following circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payor (e.g., for inpatient psychiatric hospital services).

BHD communicates retrospective authorizations decisions to the individual who received the services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination in a manner consistent with state requirements.

Utilization Review:

BHD conducts utilization review and/or auditing activities in accordance with state and federal requirements, and may disallow claims and/or recoup funds, as appropriate, in accordance with BHD's obligations to DHCS.

Authority: MHSUDS Information Notice No.: 19-026; CCR, Title 9, Division 1, Chapter II, Sections 1820.205 1820.230, 1820.225, 1810.440; Title 42, Code of Federal Regulations, Sections 438.210, 438.330, 438.608, Health & Safety Code, Sections 1367.01, 1371.4, Welfare & Institutions Code, Section 14705, MHP Contract, State Plan, Section 3, Supplement 3 to Attachment 3.1-A page 2c

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/5/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER InterWest Insurance Serv., LLC License #0B01094 P.O. Box 8110 Chico CA 95927-8110 License#: 0B01094	CONTACT NAME: Jessica Monlux, CISR PHONE (A/C, No, Ext): 530-897-3138 FAX (A/C, No): E-MAIL ADDRESS: jmonlux@iwins.com
INSURED Remi Vista, Inc. P. O. Box 494100 Redding CA 96049-4100 REMIV-1	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Nonprofits' Insurance Alliance of California — 11845 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 1666305444 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY	Y		2021-03304	4/4/2021	4/4/2022	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 500,000
							MED EXP (Any one person)	$ 20,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:						Emp. Ben.	$ Included
A	AUTOMOBILE LIABILITY			2021-03304	4/4/2021	4/4/2022	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	N / A					E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Siskiyou County Behavioral Health as Additional Insured as respects to Liability only for insured's normal work when required by written contract, permit or agreement as stated in the attached policy form. Insurance is primary as stated in the attached policy form.

CERTIFICATE HOLDER

County of Siskiyou
Behavioral Health Services
2060 Campus Drive
Yreka CA 96097

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/5/2021

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PRODUCER InterWest Insurance Serv., LLC License #0B01094 P.O. Box 8110 Chico CA 95927-8110 License#: 0B01094	CONTACT NAME: Jessica Monlux, CISR PHONE (A/C, No, Ext): 530-897-3138 FAX (A/C, No): E-MAIL ADDRESS: jmonlux@iwins.com
INSURED Remi Vista, Inc. P. O. Box 494100 Redding CA 96049-4100 REMIV-1	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Nonprofits' Insurance Alliance of California — 11845 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 237727756 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY / PRO-JECT / LOC OTHER:	Y		2021-03304	4/4/2021	4/4/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Emp. Ben.	$ 1,000,000 $ 500,000 $ 20,000 $ 1,000,000 $ 3,000,000 $ 3,000,000 $ Included
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY			2021-03304	4/4/2021	4/4/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
A	X UMBRELLA LIAB / X OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $			2021-03304-UMB	4/4/2021	4/4/2022	EACH OCCURRENCE AGGREGATE 	$ 2,000,000 $ 2,000,000 $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A A	Professional Liab Abuse/Molestation			2021-03304 2021-03304	4/4/2021 4/4/2021	4/4/2022 4/4/2022	Agg/Occ Agg/Occ	3M/1M 1M/1M

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

County of Siskiyou as Additional Insured as respects to Liability only for insured's normal work when required by written contract, permit or agreement as stated in the attached policy form.

CERTIFICATE HOLDER

County of Siskiyou
Human Services Dept.
Attn: Deputy Director
2060 Campus Drive
Yreka CA 96097

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Chip Crandall

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/8/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher & Co.
Insurance Brokers of California, Inc. LIC# 0726293
1255 Battery Street #450
San Francisco CA 94111

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : NonProfits' United Workers' Compensation Group	
INSURER B : Safety National Casualty Corporation	15105
INSURER C : Response Indemnity Company of California	10970
INSURER D :	
INSURER E :	
INSURER F :	

INSURED NONPUNI-01
Remi Vista Inc
PO Box 494100
Redding, CA 96049

COVERAGES **CERTIFICATE NUMBER:** 372034806 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			NPU-WCG 001-2021	1/1/2021	1/1/2022	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
C	XSWC - Buffer Layer			ABL1000013-00	1/1/2021	1/1/2022	XS of $500,000	$250,000 (EL & WC)
B	XSWC			SP4064079	1/1/2021	1/1/2022	XS of $750,000	$2,000,000 (EL)
							XS of $750,000	Statutory (WC)

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

County of Siskiyou Behavioral Health Services
2060 Campus Drive
Yreka CA 96097

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE