***Submit completed worksheet to:***

*Siskiyou County Clerk, 311 Fourth St., Rm 201, Yreka, CA 96097 96097*

# **Agenda Worksheet WORKSHEET**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Regular** | | |  | | | |  | **Time Requested:** | | | | | | **N/A** | | | | | | **Meeting Date:** | | | | **3/1/2022** | | | | |
| ***OR*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consent** | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Contact Person/Department:** | | | | | | | | | | | | | **Shelly Davis, Director / Health & Human Services Agency – Public Health Division** | | | | | | | | | | | **Phone:** | | **841-2140** | | |
| **Address:** | | | | | **810 S Main Street, Yreka CA 96097** | | | | | | | | | | | | | | | | | | | | | | | |
| **Person Appearing/Title:** | | | | | | | | | | **Shelly Davis / Director of Public Health Division** | | | | | | | | | | | | | | | | | | |
| **Subject/Summary of Issue:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  | | --- | | The Siskiyou County Health and Human Services Agency - Public Health Division is respectfully requesting approval for the County Medical Services Program Governing Board Local Indigent Care Needs (LICN) Grant Program for the lead agency listed on Exhibit A (“Grantee”).  This allocation is for participating County Medical Services Program (“CMSP”) counties in accordance with the terms of its Request for Proposals (RFPs) for the CMSP Local Indigent Care Needs Grant Program in the form attached as Exhibit B (“RFP”). Grantee Application for the CMSP Local Indigent Care Needs Grant Program in the form attached as Exhibit C (the “Project”). The term will be February 1, 2022 to May 1, 2025. The County’s total allocation is $1,203,700.00, with spending authority through May 1, 2025. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Financial Impact:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NO** |  | *Describe why no financial impact:* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** |  | *Describe impact by indicating amount budgeted and funding source below* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Amount: | | | | | | | 1,203,700 | | | |  |  | | |  | | |  | | | | | | | | | | |
| Fund: | | | | | | | 2121 | | | |  | Description: | | | Public Health | | | Org.: | | | 401015 | | Description: | | | | Personal Health | |
| Account: | | | | | | | 540800 | | | |  | Description: | | | Health Admin | | |  | | | | | | | | | | |
| Activity Code: | | | | | | |  | | | |  | Description: | | |  | | |  | | | | | | | | | | |
| Local Preference: YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For Contracts – *Explain how vendor was selected:* N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Information: | | | | | | | | | **FY 21/22 $120,370.00; FY 22/23 $385,184.00; FY 23/24 $385,184.00; FY 24/25 $312,962.00**  **,** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Recommended Motion:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  | | --- | | Recommend that the Board of Supervisors approve and authorize the Chair to sign the County Medical Services Program Governing Board Local Indigent Care Needs (LICN) Grant Agreement for the term February 1, 2022 through May 1, 2025, in the amount of $1,203,700.00 and authorize the Auditor to establish budget appropriation and set expenditures per the agreement guidelines. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reviewed as recommended by policy:** | | | | | | | | | | | | | | | |  | ***Special Requests*:** | | | | | | | | | | | |
| County Counsel | | | | | |  | | | | | | | | | |
| *Certified Minute Order(s)* | | | | | Yes | | | *Quantity:* | | | 1 |
| Auditor | | | | | |  | | | | | | | | | |
|  | | |  | | | |
| Personnel | | | | | |  | | | | | | | | | | *Other:* | | Please return 3 signature pages to Angela Zambrano-Ford | | | | | | | | | |
| CAO | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |

***NOTE: For consideration for placement on the agenda, the original agenda worksheet and backup material must be submitted directly to the Board Clerk (after reviewing signatures have been obtained) by 10:00 a.m. on the Monday the week prior to the Board Meeting.*** Revised 8/9/2021