Founded in 1960 by the residents of Pomona, Claremont and La Verne.

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GOVERNING BOARD

Jed Leano, Chair (Claremont)
Wendy Lau, Vice Chair (La Verne)
Lorraine Canales, Member (Pomona)
Sandra Grajeda, Member (Claremont)
Paula Lantz, Member (Pomona)
Elizabeth Ontiveros-Cole, Member (Pomona)
Trent West, Member (La Verne)

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Wellness Center
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TRI-CITY MENTAL HEALTH AUTHORITY

AGENDA

GOVERNING BOARD REGULAR MEETING

WEDNESDAY, APRIL 15, 2026 AT 5:00 P.M.
MHSA ADMINISTRATION BUILDING
2001 NORTH GAREY AVENUE, POMONA, CA 91767

To join the meeting on-line clink on the following link:
https://tricitymhs-org.zoom.us/j/83872904626?pwd=dWhHSLafcJtR2z2f2aSeteicmWbawB.1
Passcode: awFL+Wy4

Public Participation. *Section 54954.3 of the Brown Act provides an opportunity for members of the public to address the Governing Board on any item of interest to the public, before or during the consideration of the item, that is within the subject matter jurisdiction of the Governing Board. Therefore, members of the public are invited to speak on any matter on or off the agenda. If the matter is an agenda item, you will be given the opportunity to address the legislative body when the matter is considered. If you wish to speak on a matter which is not on the agenda, you will be given the opportunity to do so at the Public Comment section.* ***No action shall be taken on any item not appearing on the Agenda. There is a 3-minute limit on duration of comments.***

In-person participation: *raise your hand when the Governing Board Chair invites the public to speak.*

Online participation: *you may provide audio public comment by connecting to the meeting online through the zoom link provided; and use the Raise Hand feature to request to speak.*

Please note that virtual attendance is a courtesy offering and that technical difficulties shall not require that a meeting be postponed.

Written participation: *you may also submit a comment by writing an email to molmos@tricitymha.ca.gov. All email messages received by 3:00 p.m. will be shared with the Governing Board before the meeting.*

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by Tri-City Mental Health Authority to all or a majority of the Governing Board less than 72 hours prior to this meeting, are available for public inspection at 1717 N. Indian Hill Blvd., Suite B, in Claremont during normal business hours.

In compliance with the American Disabilities Act, any person with a disability who requires an accommodation in order to participate in a meeting should contact JPA Administrator/Clerk Mica Olmos at (909) 451-6421 at least 24 hours prior to the meeting.

GOVERNING BOARD CALL TO ORDER

Chair Leano calls the meeting to Order.

ROLL CALL

Board Members Lorraine Canales, Sandra Grajeda, Paula Lantz, Elizabeth Ontiveros-Cole, and Trent West; Vice Chair Wendy Lau; and Chair Jed Leano.

POSTING OF AGENDA

The Agenda is posted 72 hours prior to each meeting at the following Tri-City locations: Clinical Facility, 2008 N. Garey Avenue in Pomona; Wellness Center, 1403 N. Garey Avenue in Pomona; Royalty Offices, 1900 Royalty Drive #180/280 in Pomona; MHSA Office, 2001 N. Garey Avenue in Pomona; and on the TCMHA's website: http://www.tricitymha.ca.gov

CONSENT CALENDAR

1. APPROVAL OF MINUTES OF THE MARCH 18, 2026 REGULAR MEETING OF THE GOVERNING BOARD

Recommendation: "A motion to approve the Minutes of the Governing Board Regular Meeting of March 18, 2026."

2. ONTSON PLACIDE, EXECUTIVE DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

3. DIANA ACOSTA, CHIEF FINANCIAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

4. LIZ RENTERIA, CHIEF PROGRAM OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

5. SEEYAM TEIMOORI, MEDICAL DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

6. DANA BARFORD, DIRECTOR OF MHSA AND ETHNIC SERVICES MONTHLY REPORT

Recommendation: "A motion to receive and file."

7. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

8. CONSIDERATION OF RESOLUTION NO. 850 ADOPTING A REVISED MASTER CLASSIFICATION AND SALARY SCHEDULE TO UPDATE THE JOB DESCRIPTIONS FOR BEHAVIORAL HEALTH SPECIALIST I/II/III

Recommendation: "A motion to adopt Resolution No. 850 revising the Job Descriptions for the Behavioral Health Specialist I/II/III, and updating the Master Classification and Salary Schedule to include these changes."

9. CONSIDERATION OF RESOLUTION NO. 851 APPROVING A MEMORANDUM OF UNDERSTANDING (MOU) WITH THE CITY OF CLAREMONT FOR MOBILE CRISIS CARE SERVICES, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE SAID MOU EFFECTIVE APRIL 15, 2026

Recommendation: "A motion to adopt Resolution No. 851 approving a three-year MOU with the City of Claremont for Mobile Crisis Care services effective April 15, 2026, and authorizing the Executive Director to execute the MOU."

NEW BUSINESS

10. CONSIDERATION OF RESOLUTION NO. 852 APPROVING THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS) BEHAVIORAL HEALTH SERVICES ACT (BHSA) PERFORMANCE CONTRACT NO. 26-60076 EFFECTIVE JULY 1, 2026; AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE CONTRACT

Recommendation: "A motion to adopt Resolution No. 852 approving the three-year Performance Contract No. 26-60076 with the California Department of Health Care Services BHSA, effective July 1, 2026, and authorizing the Executive Director to execute the contract and any amendments thereafter."

11. CONSIDERATION OF RESOLUTION NO. 853 ADOPTING THE TRI-CITY MENTAL HEALTH AUTHORITY'S BEHAVIORAL HEALTH SERVICES ACT (BHSA) INTEGRATED PLAN (IP) FOR FISCAL YEARS 2026-29

Recommendation: "A motion to adopt Resolution No. 853 approving the Authority's Behavioral Health Services Act (BHSA) Integrated Plan for Fiscal Years 2026-29, as recommended by the TCMHA Mental Health Commission."

12. CONSIDERATION OF RESOLUTION NO. 854 APPROVING THE NAME CHANGE OF ITS ADVISORY BOARD FROM "TRI-CITY MENTAL HEALTH COMMISSION" TO "TCMHA BEHAVIORAL HEALTH COMMISSION", AND REVISING THE BYLAWS OF THE COMMISSION PURSUANT TO PROPOSITION 1 (SB 326)

Recommendation: "A motion to adopt Resolution No. 854 approving the name change of the Tri-City Mental Health Commission to "TCMHA Behavioral Health Commission", revising the Commission Bylaws, and directing updates to organizational documents, website content, social media profiles and stakeholder notification."

13. CONSIDERATION OF RESOLUTION NO. 855 APPROVING FINANCING IN THE AMOUNT OF $2,160,000 FOR THE DEVELOPMENT, CONSTRUCTION, FINANCING, AND OPERATION OF SENIOR AFFORDABLE AND PERMANENT SUPPORTIVE HOUSING UNITS IN THE ST. AMBROSE EPISCOPAL CHURCH PROJECT LOCATED AT 155 N. MOUNTAIN AVENUE IN CLAREMONT, CALIFORNIA AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE LOAN AGREEMENT AND TAKE OTHER RELATED ACTIONS

Recommendation: "A motion to adopt Resolution No. 855 approving financing in the amount of $2,160,000 for the Senior Affordable and Permanent Supportive Housing in the St. Ambrose Episcopal Church Project located at 155 N. Mountain Avenue in Claremont, California, and authorizing the Executive Director to execute all related documents and take related actions."

GOVERNING BOARD COMMENTS

Members of the Governing Board may make brief comments or request information about behavioral health needs, services, facilities, or special problems that may need to be placed on a future Governing Board Agenda.

PUBLIC COMMENT

The Public may at this time speak regarding any Tri-City Mental Health Authority related issue, provided that no action shall be taken on any item not appearing on the Agenda. There is a 3- minute limit on duration of comments.

ADJOURNMENT

The Governing Board will meet next in a Regular Joint Meeting with the Mental Health Commission to be held on **Wednesday, May 20, 2026 at 5:00 p.m.** in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

MICAELA P. OLMOS, CPMC
JPA ADMINISTRATOR/CLERK

MINUTES

REGULAR MEETING OF THE GOVERNING BOARD
MARCH 18, 2026 – 5:00 P.M.

The Governing Board Regular Meeting was held on Wednesday, March 18, 2026, at 5:31 p.m. in the MHSA Administrative Office located at 2001 North Garey Avenue, Pomona, California.

CALL TO ORDER Vice-Chair Lau called the meeting to order at 5:31 p.m.

ROLL CALL Roll call was taken by JPA Administrator/Clerk Olmos.

GOVERNING BOARD

PRESENT: Wendy Lau, City of La Verne, Vice-Chair
Sandra Grajeda, City of Claremont, Board Member
Paula Lantz, City of Pomona, Board Member
Elizabeth Ontiveros-Cole, City of Pomona, Board Member
Trent West, City of La Verne, Board Member
Katie Wand, City of Claremont, Alternate Board Member

ABSENT: Lorraine Canales, City of Pomona, Board Member
Jed Leano, City of Claremont, Chair

STAFF

PRESENT: Ontson Placide, Executive Director
Steven Flower, General Counsel
Diana Acosta, Chief Financial Officer
Seeyam Teimoori, Medical Director
Dana Barford, Director of MHSA & Ethnic Services
Natalie Majors-Stewart, Chief Compliance Officer
Micaela P. Olmos, JPA Administrator/Clerk

CONSENT CALENDAR

Board Member West requested to pull Items No. 2, 4, 5, 6, 7, 8, 10 from the Consent Calendar for further discussion.

Vice-Chair Lau opened the meeting for public comment; and there was no public comment.

There being no further comment, Board Member West moved, and Board Member Lantz seconded, to approve the Consent Calendar Item Nos. 1, 3, 9, and 11 - 14. The motion was carried by the following vote: AYES: Alternate Board Member Wand; Board Members Grajeda, Lantz, Ontiveros-Cole, and West; and Vice Chair Lau. NOES: None. ABSTAIN: None. ABSENT: Board Member Canales and Chair Leano.

DRAFT

1. APPROVAL OF MINUTES THE FEBRUARY 18, 2026, REGULAR JOINT MEETING OF THE GOVERNING BOARD

Recommendation: "A motion to approve the Minutes of the Governing Board Regular Meeting of February 18, 2026."

3. DIANA ACOSTA, CHIEF FINANCIAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

9. CONSIDERATION OF RESOLUTION NO. 843 APPROVING AN AGREEMENT WITH WBCP, INC. TO CONDUCT AN EXECUTIVE SEARCH FOR TCMHA'S CHIEF ADMINISTRATIVE OFFICER IN THE AMOUNT OF $36,800, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE AGREEMENT

Recommendation: "A motion to adopt Resolution No. 843 approving the Agreement for recruiting services for a Chief Administrative Officer, and authorizing the Executive Director to execute the Agreement with WBCP, Inc., in the amount of $36,800.00."

11. CONSIDERATION OF RESOLUTION NO. 845 APPROVING THE PURCHASE OF CORE NETWORK HARDWARE FOR TCMHA NEW OFFICES LOCATED AT 1902 ROYALTY IN POMONA, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE PURCHASE ORDER FROM CDW-G IN THE AMOUNT OF $31,395.17

Recommendation: "A motion to adopt Resolution No. 845 authorizing the Executive Director to purchase core network hardware in the amount of $31,395.17 for new offices located at 1902 Royalty in Pomona."

12. CONSIDERATION OF RESOLUTION NO. 846 APPROVING THE PURCHASE OF SERVER AND BACKUP INFRASTRUCTURE FOR TCMHA NEW OFFICES LOCATED AT 1902 ROYALTY IN POMONA, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE PURCHASE ORDER FROM INTELLI-TECH IN THE AMOUNT OF $29,998.75

Recommendation: "A motion to adopt Resolution No. 846 authorizing the Executive Director to purchase network infrastructure in the amount of $29,998.75 for new offices at 1902 Royalty in Pomona."

13. CONSIDERATION OF RESOLUTION NO. 847 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE A MEMORANDUM OF UNDERSTANDING WITH THE CLAREMONT UNIFIED SCHOOL DISTRICT (CUSD) FOR SPECIALTY MENTAL HEALTH SERVICES FOR THREE YEARS EFFECTIVE APRIL 1, 2026

Recommendation: "A motion to adopt Resolution No. 847 approving the three-year MOU with the CUSD for specialty mental health services and authorizing the Executive Director to execute the MOU."

DRAFT

14. CONSIDERATION OF RESOLUTION NO. 848 AUTHORIZING THE EXECUTIVE DIRECTOR TO NEGOTIATE WITH XEROX BUSINESS SOLUTIONS (XBS) AND SHARP BUSINESS SYSTEMS (SBS) BETTER AGREEMENT TERMS, AND TO EXECUTE THE AGREEMENT OF AN ANNUAL AMOUNT NOT TO EXCEED $150,000.00

Recommendation: "A motion to adopt Resolution No. 848 authorizing the Executive Director to negotiate better agreement terms with XBS and SBS for the lease of multifunction workstations, and to execute the agreement in an annual amount not to exceed $150,000, for three years with an option to extend two additional years."

NEW BUSINESS

2. ONTSON PLACIDE, EXECUTIVE DIRECTOR MONTHLY REPORT

Board Member West requested that future revisions of the Integrated Plan include clear revision markings, page numbers, and identification of feedback incorporated, to allow stakeholders to track changes more easily.

Executive Director Placide stated that staff are incorporating feedback as it is received, while also awaiting additional guidance and feedback from the State, and confirmed that future revisions would identify the source of changes.

Board Member Lantz inquired whether a roll call vote would be required for each action item. General Counsel Flower advised that a single roll call vote would be sufficient.

4. LIZ RENTERIA, CHIEF CLINICAL OFFICER MONTHLY REPORT

Board Member West requested an overview of the various types of therapy certifications and licensure at a high level and asked for clarification on the TCMHA's status, goals, and path forward along with the agency's current standing, objectives, and strategies for achieving those goals. Chief Clinical Officer Renteria stated that staff would provide the requested information and noted that all tracking related to licensure and certifications are documented. She further referenced that the report reflects ongoing work to implement new evidence-based practices.

5. SEEYAM TEIMOORI, MEDICAL DIRECTOR MONTHLY REPORT

Board Member West asked which agency would be providing the new Electronic Health Record (EHR) system. Chief Compliance Officer Majors stated that staff is currently conducting a vetting process, and a selection has not been made, pointing out which EHR system TCMHA is currently utilizing. Board Member West further inquired if there were any deficiencies in the current EHR system in use and if the Integrated Plan included funding for transitioning to a new EHR system, and about the criteria for selecting a new EHR system. Chief Compliance Officer Majors indicated that the assessment was ongoing, that the selection criteria would be brought forward at a future meeting, and confirmed that funds were allocated for new EHR system. Chief Financial Officer Acosta added that allocated funds within the CFTN would cover the costs.

DRAFT

6. DANA BARFORD, DIRECTOR OF MHSA AND ETHNIC SERVICES MONTHLY REPORT

Board Member West requested additional information regarding how social media campaigns are measured, noting that reported information was limited in detailing outcomes and success metrics; and also asked how effectiveness is evaluated, including whether engagement, clicks, and intake pathways are tracked, and whether individuals are asked how they learned about Tri-City during the intake process. Director of MHSA and Ethnic Services Barford stated that outcome measures related to social media efforts would be included. Chief Compliance Officer Majors added that referrals are currently tracked and that staff would review whether social media can be incorporated as a referral source.

7. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER MONTHLY REPORT

Board Member West requested an overview of the Quality Improvement (QI) process, including the scope of chart reviews, staffing involved, volume of reviews conducted, and how quality is determined; he also inquired about process outcomes, and requested whether there are staffing openings, and expressed interest in job descriptions; and whether chart reviews are conducted manually or with the assistance of Artificial Intelligence (AI).

Chief Compliance Officer Majors responded that while the county requires review of 5% of charts, TCMHA conducts reviews on approximately 20% of charts, noting that both strategic and comprehensive audits are performed; announced that that a detailed presentation outlining QI processes would be presented to the Governing Board; and explained that while some audit functions may incorporate automated tools, many reviews remain manual, and the use of AI in healthcare auditing remains widely debated due to data sensitivity and HIPAA considerations. Executive Director Placide added that the use of AI-assisted tools would require State approval and significant guidance from the State and County, noting that the topic is currently under discussion at the state level, including within CBHDA, and that there is ongoing debate and caution regarding implementation. Lastly he stated that staff intend to continue presenting data-driven information to the Board on a quarterly basis.

8. CONSIDERATION OF RESOLUTION NO. 842 ADOPTING A REVISED MASTER CLASSIFICATION AND SALARY SCHEDULE TO ADD THE JOB DESCRIPTIONS FOR PATIENT FINANCIAL SERVICES WORKER I/II, CHIEF PROGRAM OFFICER, QUALITY ASSURANCE SPECIALIST I & II, AND QUALITY ASSURANCE SPECIALIST III

Board Member West recommended revising program language by replacing the term “disenfranchised” with “eligible for services.” Executive Director Placide agreed to make the change.

Board Member Lantz raised a question regarding the creation of three new positions and one revised job description, seeking clarification that updates to the job description would not disqualify individuals currently serving in the role. Executive Director Placide confirmed that this concern had already been considered, noting that the employee’s current scope of practice exceeds the existing job description and that the revision accurately reflects duties already being performed.

DRAFT

10. CONSIDERATION OF RESOLUTION NO. 844 APPROVING A MEMORANDUM OF UNDERSTANDING WITH PARENTS ANONYMOUS (PA) FOR USE OF DESIGNATED SPACE AT TCMHA'S WELLNESS CENTER FOR FAMILYRELATED SUPPORT PROGRAMS AND APPROVED PA'S RESEARCH ACTIVITIES

Board Member West inquired whether the PA would use group space or office space. Director of MHSA and Ethnic Services Barford replied that only group space would be utilized. Board Member West asked whether the rental rate was appropriate. Executive Director Placide responded that the arrangement is governed by a rental contract and noted that PA has been a tenant for several years. Wellness Center Manager Polanco confirmed that the relationship has been in place for approximately two years.

Executive Director Placide further explained that the agreement differs from a standard Memorandum of Understanding due to PA's request to conduct research, requiring the establishment of specific guard rails. General Counsel Flower confirmed that these provisions would be memorialized in the agreement.

Board Member West asked whether PA would recruit its own research subjects or involve existing Wellness Center participants. Executive Director Placide clarified that PA would work with its current members. Board Member West asked whether research results could be shared, and Executive Director Placide confirmed that results would be provided.

Vice-Chair Lau opened the meeting for public comment; and there was no public comment.

There being no further comment, Board Member Grajeda moved, and Board Member West seconded, to approve the Consent Calendar Items Nos. 2, 4, 5, 6 and 7 [to receive and file monthly staff reports], Agenda Item No. 8 [adopting Resolution No. 842 establishing the Job Descriptions for the Patient Financial Services Worker I/II, and Quality Assurance Specialist I, II, and III Classifications; revising the Chief Program Officer Job Description; and updating the Master Classification and Salary Schedule to include these changes], and Agenda Item No. 10 [adopting Resolution No. 844 approving an MOU with Parents Anonymous, and authorizing the Executive Director to execute the MOU.] The motion was carried by a unanimous vote. AYES: Alternate Board Member Wand; Board Members Grajeda, Lantz, Ontiveros-Cole, and West; and Vice Chair Lau. NOES: None. ABSTAIN: None. ABSENT: Board Member Canales and Chair Leano.

15. CONSIDERATION OF RESOLUTION NO. 849 DECLARING AN EMERGENCY DUE TO MECHANICAL FAILURE OF THE ELEVATOR AT AUTHORITY'S PROPERTY LOCATED AT 2008 N. GAREY AVE. IN THE CITY OF POMONA, CALIFORNIA, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO AWARD A CONTRACT AND REPLACE THE ELEVATOR ON AN EMERGENCY BASIS AND WITHOUT GIVING NOTICE FOR BIDS TO LET CONTRACTS

Chief Financial Officer Acosta reported that the elevator was operational following a recent malfunction, which required five business days to repair due to the age of the equipment and difficulty obtaining replacement parts.

Board Member Lantz shared experience serving in another board where partial elevator repairs ultimately required full replacement and asked what approach was planned for this facility.

Chief Financial Officer Acosta responded that staff is planning to replace the entire elevator system and is currently gathering expert feedback, noting that the facility currently has only one elevator. Board Member Lantz expressed encouragement regarding this approach.

Vice-Chair Lau asked whether the estimated fiscal impact of $80,000 to $100,000 reflected total replacement costs or only parts, and whether a contingency amount should be approved given the emergency nature of the issue. Chief Financial Officer Acosta stated that the estimate was intended to cover the full replacement but remains preliminary. Executive Director Placide noted that staff had requested information related to full replacement costs. General Counsel Flower clarified that the resolution does not include a spending cap, but that contracts would not exceed $120,000.

Discussion ensued regarding elevator issues, and anticipated timeline for replacement, which at this time is not available but will obtained after proposals and estimates are received. It was also noted that no other businesses are located in the second floor, only TCMHA offices.

Vice-Chair Lau opened the meeting for public comment; and there was no public comment.

There being no further comment, Alternate Board Member Wand moved, and Board Member Lantz seconded, to approve Resolution No. 849 declaring an emergency to elevator failure; awarding an agreement to replace the elevator and authorizing executive director to execute the agreement. The motion was carried by the following vote: AYES: Alternate Board Member Wand; Board Members Grajeda, Lantz, and West; and Vice Chair Lau. NOES: None. ABSTAIN: None. ABSENT: Board Member Canales and Chair Leano.

16. COLLECTION OF FEEDBACK AFTER PRESENTATION OF THE PROPOSED TRI-CITY MENTAL HEALTH AUTHORITY'S BEHAVIORAL HEALTH SERVICES ACT (BHSA) INTEGRATION PLAN (IP)

MHSA Projects Manager Sara Rodriguez presented an overview of the Mental Health Services Act (MHSA), the Behavioral Health Services Act (BHSA), and provided a land acknowledgment, stating that Tri-City Mental Health Authority humbly recognizes that it operates on Tongva land, the original caretakers of the cities of Pomona, Claremont, and La Verne. She then talked about the history of MHSA, which California voters passed back in 2004 as Proposition 63 and funded through the Millionaires Tax consisting of five funding components: Community Services and Supports (CSS), which represents approximately 76% of funding; Prevention and Early Intervention (PEI), representing approximately 19%; Innovation (INN), representing approximately 5%; and any excess funds could be allocated to Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET). She explained that CSS was the largest component and historically provided the greatest flexibility in funding distribution. She then talked about Proposition 1 which was passed by California voters in March 2024, expanding MHSA through the Behavioral Health Services Act (BHSA) that consolidates MHSA funding into three required components: Full Service Partnerships (FSP) at 35%, Behavioral Health Services and Supports (BHSS) at 35%, and Housing Interventions at 30%. She explained that BHSA will allow funds to be used for individuals with a primary diagnosis of substance use disorders and that it will officially go into effect on July 1, 2026, and noting that the transition as a significant undertaking for all entities involved.

MHSA Projects Manager Rodriguez reviewed and discussed the difference between MHSA and BHSA funding, and provided an overview of community planning and participation efforts, noting that Community Program Planning (CPP) activities included community forums and that, to date, 13 presentations had been provided to staff and the community. She reported that surveys were conducted, focus groups created that continue to this date, and about how workgroups are being used to gather feedback in real time. She also reported that there was a shift in terminology from "stakeholder" to "community partner; and acknowledged that outreach and engagement efforts need continued improvement, and that staff is ramping up visibility in the community through site tours, participation in pop-up events, informal interviews, and intentional efforts to connect with community members. She reported that MHSA required input from "diverse pools" and that BHSA identifies 29 specific community groups, noting that the State requires documentation demonstrating meaningful outreach efforts. She also discussed TCMHA's priority goals which include increasing access to care and reducing homelessness, institutionalization, justice involvement, removal of children from the home, and untreated behavioral health conditions; emphasizing care experience as a key focus area, stating that improved care experience is associated with improved outcomes; increased engagement in school and work, improved quality of life and social connection, prevention and treatment of co-occurring physical health conditions; and reductions in overdoses and suicides.

MHSA Projects Manager Rodriguez then presented an overview of the Integrated Plan (IP) stating that it was a comprehensive document exceeding 150 pages in length; that it serves as a core framework and includes general background information as well as detailed sections addressing service delivery and responsibility, accountability measures, community engagement and transparency efforts, approval processes, and compliance requirements. She explained that it is a statewide report that every county and local mental health authority is required to submit with the purpose of demonstrating how local planning aligns comprehensively with all applicable state requirements and funding structures. She reported that a draft of the IP was submitted to the State on February 20, 2026, noting that this was the first time the State required submission of a draft document prior to final approval; that the IP draft remains available for public comment which can be submitted through TCMHA's website; and that all feedback received during the public comment period will be included and addressed in the final version of the Integrated Plan. She also reported that a Public Hearing on the IP is scheduled to occur on April 14th during the Mental Health Commission meeting, following Governing Board approval at its meeting on April 15, 2026, and required to be submitted to the State by June 2026.

MHSA Projects Manager Rodriguez reviewed the three new primary funding buckets established under the Behavioral Health Services Act (BHSA), noting that these allocations are required under Proposition 1. She explained that BHSS requires counties to allocate 35% of their local BHSA funds to foundational services and infrastructure, and BHSS consolidates several components previously established under the MHSA, including WET and CFTN into a single flexible category focused on system sustainability and early intervention. She explained that Full Service Partnerships (FSP) require counties to allocate 35% of their local BHSA funding to intensive, comprehensive treatment services utilizing a "whatever it takes" approach, noting that these services prioritize the State's most vulnerable populations, specifically individuals experiencing Serious Mental Illness (SMI) or Substance Use Disorders (SUD). She also stated that Housing Interventions require counties to allocate 30% of their local BHSA funds toward housing for individuals with Serious Mental Illness or Substance Use Disorders, and pointed out that Proposition 1 shifts the focus of behavioral health funding toward direct housing solutions for the State's most vulnerable populations. She presented a funding forecast for Fiscal Year 2026–27,

noting that projected funding includes carryover funds and that multiple allocation scenarios were reviewed. She then provided an overview of the Behavioral Health Services and Supports (BHSS) funding buckets and the associated systems of care. She explained that the BHSS category includes specific programmatic breakdowns by system of care and that several programs initially identified for potential sunsetting were highlighted in green and subsequently granted a two-year extension. She reported that the Children's System of Care includes non-FSP programs focused on stigma reduction, family wellbeing, and housing intervention services; that the Adult and Older Adult System of Care includes non-FSP programs such as Community Navigators, Community Mental Health Training, Ending the Silence and NAMI 101 programs, stigma reduction initiatives, peer mentors, family wellbeing services, housing intervention programs, the Therapeutic Community Garden, and the Wellness Center; that the Outreach and Engagement is a new program model in which the individual conducting outreach is considered part of the treatment process, with an emphasis on maintaining rapport and continuity of relationships; that Early Intervention programs, which are non-FSP services, include the Access to Care Program, Mobile Crisis Care, Peer Mentors, Community Wellbeing Grants, and First Episode Psychosis services; and that the Outreach and Engagement Program, also non-Full Service Partnership, includes the Direct Treatment Link Outreach Team.

MHSA Projects Manager Rodriguez then reviewed evidence-based practices incorporated within the BHSS framework which include Assertive Community Treatment (ACT) that represents the highest level of care and utilizes a "whatever it takes" approach with low client-to-staff caseload ratios; Forensic Assertive Community Treatment (FACT), a modification of the ACT model designed to support justice-involved individuals experiencing mental illness; Intensive Case Management (ICM), a service model for individuals requiring a higher level of care who do not meet medical necessity criteria for ACT or FACT; the Individual Placement and Support (IPS) model, a vocational program that follows a "place then train" approach, rather than a readiness-based model; and High Fidelity Wraparound (HFW), an intensive, team-based approach focused on children and youth and incorporates family involvement and coordination across systems. She then talked about Housing Interventions under BHSA which has its own funding bucket, and that 50% of Housing Intervention funds must support individuals experiencing chronic homelessness, that is lasting 12 months or longer or four or more occurrences within the past three years; and that up to 25% of Housing Intervention funds may be used for capital development, including Permanent Supportive Housing and other housing projects. She explained that Housing Intervention funds are restricted to housing-related assistance and cannot be used for specialty mental health services; and discussed allowable uses such as rental subsidies established as either scattered-site or project-based assistance, operating subsidies related to day-to-day physical operation of housing projects, shared housing arrangements, and family housing for eligible children and youth, including housing that accommodates family caregivers of BHSA-eligible individuals; as well as to cover the non-federal share of certain transitional rent, providing an example in which BHSA-eligible individuals may receive an additional six months of rental subsidy when placed in an interim housing setting.

MHSA Projects Manager Rodriguez also reported that TCMHA serves individuals with moderate to severe behavioral health conditions; and reported that WET, Innovation programs, and CFTN will continue during the period of July 1, 2026 through June 30, 2029. She explained that Prevention and WET programs will transition to State administration, and pointed out that staff will evaluate how services will be provided once these programs move from local administration to State-level oversight. She then talked about several State-administered grant programs that will be available to Community-Based Organizations (CBOs), Tribes, schools, and other eligible

entities, including the Community Defined Evidence-Based Practices Grant Program, the Trusted Messenger Campaign Grant Program, Training and Technical Assistance Grants, and the 988 and Suicide Crisis Lifeline Outreach Campaign Grant Program. She also explained the WET initiatives that will be administered by the State that include the Medi-Cal Behavioral Health Student Loan Repayment Program, which will provide student loan repayment assistance for behavioral health practitioners; the Medi-Cal Behavioral Health Scholarship Program, which will provide scholarship payments while participants complete their education; and the Medi-Cal Behavioral Health Recruitment and Retention Program. She added that the Recruitment and Retention Program will support workforce stability through funding for bonuses, supervision, licensure and certification costs, and training backfill for practitioners serving the Medi-Cal population in safety-net settings. Lastly, she discussed of the transition timeline from MHSA TO BHSA programming, noting that the transition process will begin the day after Governing Board approval, which is scheduled for April 15, 2026.

Board Member West inquired whether 10% of Prevention and Early Intervention (PEI) funding would be redirected to the State, and if the State had identified which programs it intends to implement. MHSA Projects Manager Rodriguez responded that the State released a final document two days prior and that staff will review and analyze the guidance to determine what is appropriate for Tri-City Mental Health Authority. She stated that the agency has several years to finalize its approach.

Vice-Chair Lau asked whether a transition plan exists for programs that received a two-year extension and what would occur after that period. MHSA Projects Manager Rodriguez responded that while the two-year extension is guaranteed, the long-term structure remains unknown; however, staff intends to develop a solid transition plan for the community, and emphasized the importance of continued participation in meetings to provide public feedback. Director of MHSA and Ethnic Services Barford added that when programming at the State level is available, staff will work with those programs. Vice-Chair Lau expressed concern noting that change is difficult for individuals who rely on these services and emphasized the need for a seamless transition that does not undermine progress, and requested that the Board remain informed of future plans as there is existing community concern and anxiety. Executive Director Placide stated that from a mental health service provider perspective, the agency is experiencing a shift in both funding and focus, and explained that staff are exploring what services can be augmented, and that the State has indicated it will provide some services, though not to the same extent as TCMHA.

Vice-Chair Lau also raised concerns regarding geographic access and transportation barriers, pointing out the importance of ensuring access for clients. MHSA Projects Manager Rodriguez stated that staff continues to encourage individuals not to disengage from services and noted that self-advocacy from the community strengthens the agency's position, and reported that prevention funding is anticipated to be approximately 4%.

Board Member Lantz noted that TCMHA receives realignment funds and stated that if the Governing Board strongly prioritizes the Wellness Center, then it may need to evaluate how other funding sources are allocated; and stated that a commitment to the Wellness Center would require TCMHA to identify solutions. Executive Director Placide encouraged continued questions and feedback from the Board.

Board Member West inquired how Fiscal Year 2026–27 financial plan compares to current funding levels. Executive Director Placide replied that funding projections are provided by the State and change annually.

Vice-Chair Lau asked whether projected funding would be sufficient to sustain generated services. Board Member West further inquired how revenue fluctuations and the eventual depletion of carryover funds would affect programming and whether programs are funded based on current projections. Chief Financial Officer Acosta reported that current funding is supported by carryover balances derived from previously received funds, noting that approximately 50% of those funds have one year remaining, and the remainder have two years remaining; and that all funds must be expended within a three-year period. Executive Director Placide added that under the previous MHSA structure, CSS and PEI funding totaled approximately $10.5 million, and that under BHSA this amount shifts to approximately $6.3 million, noting that the agency's ability to maintain current services is dependent on carryover funding. Chief Financial Officer Acosta added that total funding is approximately $18 million and is dependent on the Millionaires Tax, which fluctuates significantly.

Board Member West expressed concern regarding the reported 4% penetration rate, stating that the system is not reaching all individuals in need, and emphasized the urgency of serving individuals who are mentally ill and unhoused, and stated that he would like to see penetration rates increase over time. Executive Director Placide explained that the penetration data is derived from CalMHSA and county sources, noting that TCMHA data is not disaggregated; however, TCMHA's internal data collection is more accurate than State data which indicates better performance than many jurisdictions, and that the agency's impact report will provide improved metrics since more data and refined metrics are forthcoming. Chief Compliance Officer Majors added that the agency is required to use State-mandated data and cannot substitute internal data for reporting purposes. Board Member West stated that the data is not as granular as desired and encouraged staff to establish a baseline using a methodology the agency believes in, even if it differs from State measures.

Board Member West asked whether outreach and treatment teams can make referrals. Chief Clinical Officer Renteria confirmed that they can, but referrals must still be routed through Los Angeles County, and that CARE Court referrals also must originate through Los Angeles County before being referred to TCMHA. Board Member Lantz asked whether referrals always return to TCMHA. Chief Clinical Officer Renteria replied in the negative, stating that it depends on where individuals choose to receive care.

Executive Director Placide stated that TCMHA's non-county status places the agency at a disadvantage in data collection and emphasized the importance of developing homegrown data that correlates with county data. He stated that TCMHA produces more output data than input data due to county-level service area structures.

Board Member West asked about assumed growth rates and whether the agency can expand services if the plans are successful. Executive Director Placide indicated that projections involve experimentation and educated estimates, noting that some programs may grow while others may not, pointing out that the uncertainty is shared statewide. Board Member West stated that he would like concerns to be elevated to the Governing Board as early as possible and emphasized a desire to expand capacity. Chief Compliance Officer Majors stated that this approach aligns with agency priority measures and that the goal is continuous improvement. Executive Director

Placide stated that growth under BHSA is expected, noting that many mandated services previously provided by Los Angeles County will now be delivered by TCMHA. Chief Financial Officer Acosta stated that staff can return to the Governing Board with amendments if needed and that budget includes maintaining capacity to recruit personnel.

Board Member West noted vacancy levels of approximately 15% and asked whether the budget assumes full staffing. Chief Financial Officer Acosta responded that budgeting is based on client service levels. Vice-Chair Lau noted that recruitment remains a challenge. Executive Director Placide clarified that BHSA represents one funding stream, while medical and FFP funding operate alongside it as separate but coordinated systems.

Board Member West referenced cross-training noted in the Integrated Plan and asked how many staff are needed for the service delivery diagram and staffing approach, since that outreach may require teams of four to five individuals. Chief Clinical Officer Renteria stated that staffing depends on the scenario, explaining that sometimes one or two staff respond while other situations require larger teams, noting the use of scheduled rotations, coordination with outreach teams, consistency, and personalized care. Executive Director Placide added that street psychiatry represents another service component and acknowledged recruitment challenges, while noting the existence of multiple touchpoints for engagement.

Board Member West stated that he had reviewed Point-in-Time (PIT) count data that was updated on a monthly basis and inquired if CARE Act efforts align with reducing homelessness. Board Member Lantz stated that it was her understanding that PIT counts were conducted annually since it requires a coordinated effort from all cities to go out on the streets and count; however, she expressed interest in understanding what was the monthly data changes that Board Member Westy pointed out. Board Member West stated that he would provide citations. Chief Clinical Officer Renteria stated that staff hope to engage more deeply in conversations to maximize impact.

Board Member Lantz stated that she was unclear on how CARE Court operates and expressed interest in TCMHA serving as a resource within a residential scope. Chief Clinical Officer Renteria stated that to date, TCMHA has not received any CARE Court referrals and that all CARE Court processing occurs through Norwalk. Board Member West noted that some proceedings can occur remotely from Pomona. Executive Director Placide stated that CARE Court has been the subject of criticism regarding effectiveness and efficiency, and stated that CARE Court is not currently a high priority for TCMHA and that staff focuses on serving individuals before CARE Court involvement. He emphasized a bottom-up approach focused on meeting individuals where they are. Board Member West asked about key metrics related to CARE Court engagement. Chief Clinical Officer Renteria stated that the data tells a story. Executive Director Placide expressed support for continued monitoring.

Board Member West asked whether individuals presenting with substance use disorders are treated by the same therapists. Chief Clinical Officer Renteria stated that TCMHA treats co-occurring mental health and substance use disorders and does not provide substance use disorder-only treatment; that counselors and peer support specialists are trained accordingly; and that Full Service Partnership teams include substance abuse counselors and therapists, with staff utilizing shared expertise. Board Member West asked how 12-step programs are incorporated. Chief Clinical Officer Renteria responded that participation is based on individual preference and that TCMHA maintains relationships with organizations providing those services. Board Member

West asked how individuals with only substance use disorders are served, and Chief Clinical Officer Renteria stated that TCMHA works with partner organizations and seeks to connect individuals whenever possible.

Board Member West asked about discrepancies in Integrated Plan charts and whether counts reflect unique individuals or repeated participation. Chief Compliance Officer Natalie Majors stated that both individuals touched and individuals enrolled are counted. Board Member West asked whether individuals participating in multiple groups are counted more than once, and Ms. Majors stated that staff would verify and report back.

Board Member West asked whether direct treatment outreach and outreach programs are separate. MHSA Projects Manager Rodriguez stated that services span moderate to intensive levels of care, with outreach focused on building trust, and pointed out that outreach includes community navigators and represents a lower level of care, with two outreach approaches: education and awareness, and targeted engagement for individuals eligible for services. Board Member West stated that in the Integrated Plan both types of outreach were listed as only one type of outreach and encouraged staff to revise it for clarity.

Board Member West asked when the first direct treatment outreach team would be operational. Executive Director Placide stated that direct outreach is part of new ICM and FSP programs and that the goal is readiness by June for implementation in July, noting that the State is allowing flexibility and that staff is working to recruit as many personnel as possible early in the implementation period. Board Member Lantz asked whether outreach teams are currently operating. Executive Director Placide confirmed that some outreach teams are already in place. Board Member West requested and Vice-Chair Lau requested reports about statistics to be clearly tied back to the Integrated Plan.

Board Member West raised questions regarding financial tables in the Integrated Plan, stating that Table 10 appeared conservative and questioned whether it reflected uncertainty in funding. Chief Financial Officer Acosta stated that programs can bill within those structures. Board Member West asked whether FSP are self-funded and whether funds could be exhausted. Chief Financial Officer Acosta stated that there is a high probability of funding stability. Executive Director Placide stated that the challenge lies in the requirement to expend FSP funds and the flexibility in transfers. Board Member West stated that the State mandates 35% allocation to FSP while TCMHA's existing funding model already supports those services, suggesting potential excess. Executive Director Placide stated that the challenge is identifying what is FSP-fundable versus non-billable. Chief Clinical Officer Renteria stated that the Direct Link Team is included and that staff will conduct events and outreach to community partners.

Board Member West asked about staff reaction to upcoming changes. Chief Clinical Officer Renteria stated that FSP teams already operate under similar models and that changes will primarily involve concentration of services. Board Member West asked whether job descriptions would need to change, and Chief Clinical Officer Renteria stated that they would not. Executive Director Placide stated that Proposition 1 reinforces existing service focus.

Board Member West asked whether staff should formally communicate concerns to the State regarding fiscal constraints. Executive Director Placide stated that staff will identify appropriate avenues to provide feedback and noted that advocacy groups are aware of these concerns and that they have been communicated to the State.

At 7:33 p.m., Board Member Ontiveros-Cole (City of Pomona representative) left the meeting, which effectively concluded the meeting due to a lack of quorum. The next Regular Meeting of the Governing Board will be held on Wednesday, April 15, 2026, at 5:00 p.m., in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

_____

Micaela Perez Olmos, CPMC
JPA Administrador/Clerk

DRAFT

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: April 15, 2026

TO: Governing Board of Tri-City Mental Health Authority

FROM: Ontson Placide, LMFT, Executive Director

SUBJECT: Monthly Executive Director Report

I. EXECUTIVE SUMMARY

BHSA Integrated Plan

The draft Behavioral Health Services Act (BHSA) Integrated Plan (IP) has been formally returned from the California Department of Health Care Services (DHCS) with required revisions. Tri-City Mental Health Authority has incorporated all required DHCS changes, along with community stakeholder input and Governing Board comments received through the public participation and review process. These updates have been integrated into the final version of the Integrated Plan to ensure full alignment with statutory, regulatory, and programmatic requirements under BHSA. The revised Integrated Plan is now ready for Governing Board consideration and approval at today's meeting. Upon Board approval, the final Integrated Plan will be submitted to DHCS for final review and approval, allowing Tri-City to proceed with implementation in accordance with BHSA timelines.

Ongoing Planning

Tri-City Mental Health Authority continues preparations for Behavioral Health Services Act (BHSA) implementation effective July 1, 2026. Ongoing efforts include cross-departmental implementation planning, large-scale recruitment and hiring, development of new programs and service models, and expansion of administrative, fiscal, and information systems. These activities are focused on ensuring organizational readiness, operational sustainability, and compliance with BHSA requirements.

UPDATE ON THE MHSA to BHSA REVERSION PROJECTS

Three approved projects are in progress. The St Ambrose Housing Development is in the final closing stage with C.O.R.E and all parties involved. Presentation of various documents will be presented in this April Meeting. It is anticipated to close by June 30, 2026. The Tiny Home Project with City of Pomona was approved by the City Council at the March 16th meeting. Planning for the property has begun. Ongoing updates about the status of this project will continue. The Baseline Senior Project is underway and monthly reports regarding expenditures are occurring.

II. DEPT. OPERATIONAL ITEMS / PROGRAMS & SERVICES

A. Dept/Program Priorities / Projects – See Individual Executive Team Reports

B. Human Resources – Month Ending December 2025:

Staffing – Month Ending March 2026

- Total Staff is 226 full-time and 10 part-time plus 43 full-time vacancies 4 part-time vacancies for a total of 276 full-time equivalent positions.
- There were 4 new hires in March 2026.
- There were 2 separations in March 2026.

Workforce Demographics in March 2026

- American Indian or Alaska Native = 0.42%
- Asian = 8.47%
- Black or African American = 7.63%
- Hispanic or Latino = 62.71%
- Native Hawaiian or Other Pacific Islander = 0.42%
- Other = 2.54%
- Two or more races = 2.12%
- White or Caucasian = 15.68%

New Posted Positions in March 2026

- Behavioral Health Specialist – Adult FSP (1 FTE)
- Clinical Therapist I/II – Mobile Crisis (2 FTEs)
- Human Resources Analyst (1 FTE)

C. Information Technology (IT)

1. Technology preparation for new 1902 building continues along with new 431 Baseline Admin building.

2. The agency plans to start using Teams for virtual communication in May, while continuing Ring Central for telehealth and phone services.

III. NATIONAL & STATEWIDE UPDATES IN BEHAVIORAL HEALTH

National & Ca Government

Private Health Data Still Being Given to ICE, California Says - *The Trump administration has defied a federal judge's order by sharing private information,*

including street addresses, of millions of low-income Americans with immigration officers who are conducting mass deportations, California and other states say in a court filing. The Trump administration doesn't appear to be denying it. U.S. District Judge Vince Chhabria of San Francisco issued an injunction last August ordering the U.S. Department of Health and Human Services to stop providing data about recipients of Medicaid to U.S. Immigration and Customs Enforcement officials. The 78 million Americans who receive health care in the program, including 15 million Californians in Medi-Cal, provide personal information that the states forward to the federal government to verify their eligibility. San Francisco Chronicle (CBHDA Contact: Nikki Paschal)

Medi-Cal immigrant enrollment is dropping, due to Trump's policies- *For months, a cloud of fear has hovered over the immigrant community in San Bernardino, making it hard for María González to do her job as a community health worker in this city where almost a quarter of residents are foreign-born. It started building over the summer, fed by news of immigration raids across Southern California, Trump administration plans to share Medicaid data with Immigration and Customs Enforcement, and the passage of state and federal restrictions on immigrant Medicaid eligibility. Then in November, the federal government released a new "public charge" proposal that, if enacted, could block certain immigrants from obtaining permanent legal residency if they or family members have used public benefits, including Medicaid. Los Angeles Times / Kaiser Health News*

California billionaire tax is a no-brainer for progressive Democrats, right? Wrong.- *The health care union behind the tax measure argues its plan is the only viable fix for federal funding cuts to Medi-Cal. But even some of the most liberal lawmakers and labor unions aren't convinced yet. CalMatters*

Mental Health

This detox may erase 10 years of social media brain damage, researchers say- *The young woman described to a jury what it was like to lose control of her life to social media. She began as a child, she said, and over time the habit expanded to fill nearly every available hour — late nights bleeding into early mornings, sleep gradually displaced. She would try to stop and find herself returning in a loop she could not escape. As her use intensified, so did her distress: anxiety, depression and a growing fixation on her appearance. Washington Post*

These simple lifestyle changes could decrease dementia risk by 25%- *Are you sitting right now? If you want to protect your brain, you should take a walk and be sure to go to bed early. Regular exercise and about seven hours of sleep a night could protect brain health in the long term, a study published Wednesday in the journal PLOS One found. Long bouts of sedentary behavior may increase dementia risk. It's the latest data to show that people don't need elaborate and expensive*

longevity hacks to stay mentally sharp as they age. Simple lifestyle changes could reduce a person's risk of late-onset dementia by as much as 25%, according to the study. NBC News

SUD

California bill to prevent vaping among student-athletes heads to state assembly- *California lawmakers want schools to include nicotine in drug tests already given to student-athletes, some as young as seventh graders. The effort is aimed at targeting tobacco use among teens, as concern grows over the rise in youth vaping. "Watching the increase of vaping in our youth is heartbreaking," said Assemblywoman Heather Hadwick, who represents District 1. A new bill designed to crack down on nicotine use among student-athletes is moving forward in the state legislature. The proposal would allow schools that already have student-athlete drug testing programs to also include nicotine in those screenings. Newsweek*

24.3% downtrend in US long-term opioid therapy: Study*- Long-term opioid therapy, defined as prescribed opioid use 90 days or longer, among U.S. patients declined from 5.6 million in 2015 to 4.2 million in 2023 — a 24.3% relative decrease, according to an April 8 research letter published in JAMA. Researchers from Ann Arbor, Mich.-based University of Michigan School of Public Health and Medical School analyzed data from 2015 through 2023 in the IQVIA Longitudinal Prescription Database, which contains more than 90% of U.S. retail pharmacy claims across 51 jurisdictions. Here are six things to know: Here are six things to know: Becker's Behavioral Health*

Homelessness

Op-ed | Will Los Angeles Mayor Karen Bass Ever Embrace Long-Term Solutions for Homelessness?- *The Los Angeles Times recently reported a number of unsettling findings about how Los Angeles Mayor Karen Bass is addressing the homelessness crisis, finding that 40 percent of unhoused participants of her Inside Safe program were back on the street. Additionally, the L.A. Times revealed that the longer Inside Safe exists, "the greater the share of participants who have returned to 'unsheltered' homelessness." The mayor's approach needs a swift overhaul that's focused on root causes and long-term solutions. Davis Vanguard*

END>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Diana Acosta, CPA, Chief Financial Officer**

SUBJECT: **Monthly Report of Finance and Facilities**

I. EXECUTIVE SUMMARY

UNAUDITED FINANCIAL STATEMENTS FOR THE EIGHT MONTHS ENDED FEBRUARY 28, 2026 (2026 FISCAL YEAR-TO-DATE):

The financials presented herein are the PRELIMINARY and unaudited financial statements for the eight months ended February 28, 2026. These financial statements include the activities from the clinical outpatient operations as well as activities from the implemented MHSA programs under the CSS, PEI, INN, WET and CFTN plans.

The increase in net position (income) is approximately $2.2 million. MHSA operations accounted for approximately $1.6 million of the increase, which is primarily the result of recognizing MHSA revenues on hand at the beginning of the fiscal year. MHSA non-operating revenues are reflected when MHSA funds have been received and are eligible to be spent.

During fiscal 2025, Tri-City received MHSA funding of approximately $21.4 million, of which $12.9 million were for approved programs for fiscal 2025-26 MHSA operations and was reflected as MHSA Revenue Restricted for Future Period on the Statement of Net Position (balance sheet) at June 30, 2025. These restricted MHSA revenues have now been recorded as non-operating revenues in fiscal 2025-26. In addition, during this current fiscal year 2025-26 approximately $11.6 million in MHSA funding has been received of which $2.0 million was identified and approved for use in the current fiscal year 2025-26 and recorded as non-operating revenues, bringing the total MHSA non-operating revenues recognized to date up to approximately $14.9 million. Unlike the requirement to reflect all available and **approved** MHSA funding when received as non-operating revenues, MHSA operating costs are reflected when incurred. Therefore, the matching of revenue to expense is not consistent as the timing of expenditures will lag behind the timing of revenue recognition.

The decrease in net position of approximately $624 thousand is from Clinic outpatient operations, which is the result of operations for the eight months ended February 28, 2026 which includes one-time payments made at the beginning of the year.

The total cash balance at February 28, 2026 was approximately $63.5 million, which represents a decrease of approximately $6.1 million from the June 30, 2025 balance of approximately $69.6 million. Outpatient Clinic operations, after excluding any intercompany receipts or costs resulting from MHSA operations, had a decrease in cash of approximately $485 thousand primarily as a result timing of cash receipts from LADMH. MHSA operations reflected a decrease in cash of approximately $6.6 million, after excluding intercompany receipts or costs resulting from clinic operations. Total decrease in MHSA cash reflects the receipt of approximately $11.6 million in MHSA funds offset by the use of cash for MHSA operating activities.

Approximately $4.8 million in Medi-Cal cash receipts have been collected for both Outpatient Clinic Operations and MHSA Operations within the eight months ended February 28, 2026. An additional $5.1 million has been received through April 8, 2026.

II. DEPT OPERATIONAL ITEMS / PROGRAMS & SERVICES

We continue to closely monitor for any new developments, changes to legislation and updated revenue projections from CBHDA, specifically with regard to MHSA as these revenues continually fluctuate and as evidenced in the past, significantly differ from original projections as well as revised projections. As such, planning appropriately to ensure we meet the needs of our community, and having the ability to make changes as we go will be necessary in the upcoming years, especially if projections wind up being significantly different than currently projected.

Overall Facilities Update

The new leases have been executed and design work has begun on the new spaces at the 1902 Royalty site. Escrow has closed on the new administrative building at 431 W. Baseline Road, next steps will be preparing to occupy the building, the current tenants vacated the building as of March 31, 2026. Next steps will be brought to Board as they develop.

III. ADMINISTRATIVE UPDATES

External

- Preparation for new reporting requirements under BHSA, final draft of the Integrated Plan has been released, initial comments from DHCS have been addressed and provided back to DHCS
- PERS has started an audit of the reporting of longevity pay (20 different municipalities are included in the audit).
    - The final report has been received and management is working with PERS to make the necessary corrections with the PERS reporting system

- Reversion calculations have been completed by DHCS as of July 1, 2025. DHCS has determined that TCMHA owes approximately $30 thousand in housing plan funds to be reverted. Management has appealed the initial reversion decision and that appeal has been accepted by DHCS, as a result, there is no reversion as of June 30, 2025.

Internal

- Preparation for the BHSA Integrated Plan

IV. ATTACHMENTS

Attachment 3-A: February 28, 2026 Unaudited Monthly Financial Statements

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF NET POSITION

	AT FEBRUARY 28, 2026			AT JUNE 30, 2025		
	TCMH	MHSA	Consolidated	TCMH	MHSA	Consolidated
	Unaudited	Unaudited	Unaudited	Audited	Audited	Audited
Current Assets						
Cash	$ 19,846,768	$ 43,676,100	$ 63,522,867	$ 17,961,366	$ 51,687,939	$ 69,649,305
Accounts receivable, net of reserve for uncollectible accounts $850,278 at February 28, 2026 and $527,386 at June 30, 2025	5,039,731	6,248,676	11,288,407	5,537,192	4,375,601	9,912,793
	24,886,499	49,924,775	74,811,274	23,498,558	56,063,540	79,562,098
Property and Equipment						
Land, building, furniture and equipment	4,095,629	13,218,519	17,314,148	4,232,362	10,168,006	14,400,368
Accumulated depreciation	(2,865,808)	(5,202,013)	(8,067,822)	(2,942,061)	(5,194,991)	(8,137,053)
Rights of use assets-building lease	2,195,359	-	2,195,359	-	-	-
Accumulated amortization-building lease	(267,383)	-	(267,383)	-	-	-
Rights of use assets-SBITA	1,298,467	-	1,298,467	1,298,467	-	1,298,467
Accumulated amortization-SBITA	(897,052)	-	(897,052)	(897,052)	-	(897,052)
Total Property and Equipment	3,559,212	8,016,505	11,575,717	1,691,716	4,973,014	6,664,730
Other Assets						
Deposits and prepaid assets	419,426	287,745	707,171	124,101	62,745	186,846
Note receivable-Housing Development Project	-	2,868,538	2,868,538	-	2,800,000	2,800,000
Total Noncurrent Assets	3,978,638	11,172,788	15,151,426	1,815,817	7,835,759	9,651,576
Total Assests	28,865,137	61,097,563	89,962,700	25,314,375	63,899,299	89,213,674
Deferred Outflows of Resources						
Deferred outflows related to the net pension liability	5,355,114	-	5,355,114	5,355,114	-	5,355,114
Total Deferred Outflows of Resources	5,355,114	-	5,355,114	5,355,114	-	5,355,114
Total Assets and Deferred Outflows of Resouces	**$ 34,220,251**	**$ 61,097,563**	**$ 95,317,814**	**$ 30,669,489**	**$ 63,899,299**	**$ 94,568,788**
LIABILITIES						
Current Liabilities						
Accounts payable	439,133	87,637	526,770	624,755	552,315	1,177,070
Accrued payroll liabilities	352,021	647,466	999,487	117,583	350,534	468,118
Accrued vacation and sick leave	666,258	1,413,961	2,080,219	636,548	1,292,202	1,928,750
Deferred revenue	230,498	-	230,498	852,457	-	852,457
Reserve for Medi-Cal settlements	4,466,968	4,421,392	8,888,359	4,324,954	4,161,537	8,486,491
Current portion of lease liability	133,691	-	133,691	-	-	-
Current portion of SBITA liability	272,492	-	272,492	272,492	-	272,492
Total Current Liabilities	6,561,060	6,570,456	13,131,516	6,828,789	6,356,588	13,185,378
Intercompany Acct-MHSA & TCMH	1,335,374	(1,335,374)	-	(65,052)	65,052	-
Long-Term Liabilities						
Lease liability	1,794,285		1,794,285	-	-	-
SBITA liability	128,923		128,923	128,923	-	128,923
Net pension liability	9,878,611	-	9,878,611	9,878,611	-	9,878,611
Unearned MHSA revenue	-	16,042,844	16,042,844	-	6,358,247	6,358,247
Total Long-Term Liabilities	11,801,819	16,042,844	27,844,663	10,007,534	6,358,247	16,365,781
Total Liabilities	19,698,253	21,277,925	40,976,179	16,771,271	12,779,888	29,551,159
Deferred Inflow of Resources						
MHSA revenues restricted for future period	-	-	-	-	12,920,180	12,920,180
Deferred inflows related to the net pension liability	66,044	-	66,044	66,044	-	66,044
Total Deferred Inflow of Resources	66,044	-	66,044	66,044	12,920,180	12,986,224
NET POSITION						
Invested in capital assets net of related debt	1,229,821	8,016,505	9,246,326	1,290,301	4,973,014	6,263,315
Restricted for MHSA programs	-	31,803,133	31,803,133	-	33,226,218	33,226,218
Unrestricted	13,226,132	-	13,226,132	12,541,872	-	12,541,872
Total Net Position	14,455,953	39,819,638	54,275,591	13,832,173	38,199,232	52,031,405
Total Liabilities, Deferred Inflows of Resources and Net Position	**$ 34,220,251**	**$ 61,097,563**	**$ 95,317,814**	**$ 30,669,489**	**$ 63,899,299**	**$ 94,568,788**

Definitions:
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
EIGHT MONTHS ENDED FEBRUARY 28, 2026 AND 2025

	PERIOD ENDED 2/28/26			PERIOD ENDED 2/28/25		
	TCMH Unaudited	**MHSA Unaudited**	**Consolidated Unaudited**	**TCMH Audited**	**MHSA Audited**	**Consolidated Audited**
OPERATING REVENUES						
Medi-Cal FFP	$ 2,680,640	$ 3,713,984	$ 6,394,624	$ 2,815,496	$ 3,904,837	$ 6,720,333
Medi-Cal FFP FYE Prior Year	197	9,247	9,444	1,076,815	1,188,733	2,265,548
Medi-Cal SGF-EPSDT	392,542	1,210,296	1,602,838	704,770	1,306,161	2,010,931
Medi-Cal SGF-EPSDT Prior Year	-	385	385	174,562	174,613	349,175
Medicare	9,796	6,210	16,006	6,447	5,243	11,691
Contracts	-	47,464	47,464	-	21,550	21,550
Patient fees and insurance	-	261	261	-	-	-
Rent income - TCMH & MHSA Housing	8,624	37,847	46,471	8,624	58,115	66,740
Other income	585	622	1,207	490	587	1,077
Net Operating Revenues	**3,092,384**	**5,026,315**	**8,118,699**	**4,787,205**	**6,659,839**	**11,447,043**
OPERATING EXPENSES						
Salaries, wages and benefits	6,588,779	13,946,261	20,535,040	5,358,613	12,448,911	17,807,525
Facility and equipment operating cost	412,868	1,326,942	1,739,810	426,819	1,091,437	1,518,255
Client lodging, transportation, and supply expense	12,232	2,060,131	2,072,363	41,326	460,503	501,828
Depreciation & amortization	212,204	447,151	659,355	199,759	418,924	618,683
Other operating expenses	750,024	1,835,151	2,585,176	639,846	1,628,730	2,268,576
Total Operating Expenses	**7,976,107**	**19,615,637**	**27,591,744**	**6,666,363**	**16,048,504**	**22,714,867**
OPERATING (LOSS) (Note 1)	**(4,883,723)**	**(14,589,321)**	**(19,473,045)**	**(1,879,158)**	**(9,388,665)**	**(11,267,824)**
Non-Operating Revenues (Expenses)						
Realignment	4,041,119	-	4,041,119	2,436,900	-	2,436,900
Contributions from member cities & donations	24,000	-	24,000	43,675	-	43,675
MHSA funds	-	14,854,572	14,854,572	-	16,693,035	16,693,035
Grants and Contracts	1,035,804	-	1,035,804	742,196	-	742,196
Rent Income from the new Admin Building		35,427	35,427		-	-
Interest Income net with FMV	406,581	1,319,728	1,726,309	293,108	1,394,012	1,687,120
Total Non-Operating Revenues (Expense)	5,507,503	16,209,727	21,717,230	3,515,879	17,451,274	20,967,153
INCOME (LOSS)	**623,780**	**1,620,406**	**2,244,186**	**1,636,720**	**8,062,609**	**9,699,329**
INCREASE (DECREASE) IN NET POSITION	**623,780**	**1,620,406**	**2,244,186**	**1,636,720**	**8,062,609**	**9,699,329**
NET POSITION, BEGINNING OF YEAR	13,832,173	38,199,232	52,031,405	10,020,298	32,339,182	42,359,480
NET POSITION, END OF MONTH	**$ 14,455,953**	**$ 39,819,638**	**$ 54,275,591**	**$ 11,657,019**	**$ 40,401,791**	**$ 52,058,810**

(**Note 1)** "Operating Loss" reflects loss before realignment funding and MHSA funding which is included in non-operating revenues.

Definitions:
Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF CASH FLOWS
EIGHT MONTHS ENDED FEBRUARY 28, 2026 AND 2025

	PERIOD ENDED 2/28/26			PERIOD ENDED 2/28/25		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
Cash Flows from Operating Activities						
Cash received from and on behalf of patients	$ 1,731,134	$ 3,169,702	$ 4,900,836	$ 6,282,930	$ 7,458,563	$ 13,741,493
Cash payments to suppliers and contractors	(1,776,930)	(6,022,999)	(7,799,929)	(1,706,781)	(3,691,187)	(5,397,968)
Payments to employees	(6,324,632)	(13,527,570)	(19,852,202)	(5,290,341)	(12,131,151)	(17,421,492)
	(6,370,428)	(16,380,867)	(22,751,295)	(714,191)	(8,363,775)	(9,077,967)
Cash Flows from Noncapital Financing Activities						
MHSA Funding	-	11,618,989	11,618,989	-	17,725,439	17,725,439
CalHFA-State Administered Projects	-	-	-	-	532	532
Realignment	5,719,495	-	5,719,495	2,436,900	-	2,436,900
Grants and Contracts	699,530	-	699,530	1,755,437	-	1,755,437
	6,443,025	11,618,989	18,062,013	4,236,012	17,725,971	21,961,983
Cash Flows from Capital and Related Financing Activities						
Purchase of capital assets	(30,865)	(3,344,118)	(3,374,983)	(38,400)	(178,136)	(216,536)
Intercompany-MHSA & TCMH	1,400,426	(1,400,426)	-	237,743	(237,743)	-
	1,369,561	(4,813,082)	(3,443,521)	199,344	(415,879)	(216,536)
Cash Flows from Investing Activities						
Interest received	428,085	1,530,255	1,958,340	281,358	1,357,789	1,639,147
	428,085	1,530,255	1,958,340	281,358	1,357,789	1,639,147
Net Increase (Decrease) in Cash and Cash Equivalents	1,870,242	(8,044,705)	(6,174,463)	4,002,522	10,304,105	14,306,628
Cash Equivalents at Beginning of Year	17,961,366	51,687,939	69,649,305	11,061,930	36,745,684	47,807,614
Cash Equivalents at End of Month	**$ 19,831,609**	**$ 43,643,233**	**$ 63,474,842**	**$ 15,064,452**	**$ 47,049,790**	**$ 62,114,242**
Cash from the Balance Sheet	**19,846,768**	**43,676,100**	**63,522,867**	**15,084,531**	**47,160,982**	**62,245,513**
YTD Gain/(Loss) from GASB 31 Fair Market Value	**$ 15,159**	**$ 32,867**	**$ 48,026**	**20,079**	**111,192**	**131,271**

Definitions:

TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
ACTUAL TO BUDGET COMPARISON
EIGHT MONTHS ENDING FEBRUARY 28, 2026
(UNAUDITED)

	TRI-CITY MENTAL HEALTH OUTPATIENT CLINIC (TCMH)			TRI-CITY MENTAL HEALTH SERVICES ACT (MHSA)			TRI-CITY MENTAL HEALTH AUTHORITY CONSOLIDATED		
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
OPERATING REVENUES									
Medi-Cal FFP	$ 2,923,271	$ 5,926,559	$ (3,003,288)	$ 4,050,146	$ 6,998,665	$ (2,948,519)	$ 6,973,418	$ 12,925,225	$ (5,951,807)
Medi-Cal FFP Prior Year	215	-	215	10,084	-	10,084	10,299	-	10,299
Medi-Cal SGF-EPSDT	428,072	604,449	(176,377)	1,319,843	1,516,259	(196,416)	1,747,914	2,120,708	(372,794)
Medi-Cal SGF-EPSDT Prior Year	-	-	-	420	-	420	420	-	420
Medicare	9,796	6,333	3,463	6,210	3,333	2,877	16,006	9,667	6,339
Patient fees and insurance	-	-	-	261	-	261	261	-	261
Contracts	-	-	-	47,464	-	47,464	47,464	-	47,464
Rent income - TCMH & MHSA Housing	8,624	9,024	(400)	37,847	61,747	(23,900)	46,471	70,771	(24,299)
Other income	585	-	585	622	-	622	1,207	-	1,207
Provision for contractual disallowances	(278,162)	(530,885)	252,723	(445,709)	(851,493)	405,784	(723,871)	(1,382,377)	658,507
Provision for contractual disallowances prior year	(18)	-	(18)	(872)	-	(872)	(890)	-	(890)
Net Operating Revenues	**3,092,384**	**6,015,481**	**(2,923,097)**	**5,026,315**	**7,728,511**	**(2,702,196)**	**8,118,699**	**13,743,993**	**(5,625,293)**
OPERATING EXPENSES									
Salaries, wages and benefits	6,588,779	7,821,435	(1,232,656)	13,946,261	17,403,088	(3,456,827)	20,535,040	25,224,523	(4,689,484)
Facility and equipment operating cost	412,868	402,223	10,646	1,326,942	1,130,604	196,338	1,739,810	1,532,827	206,984
Client program costs	12,232	35,557	(23,326)	2,060,131	408,984	1,651,147	2,072,363	444,541	1,627,822
Grants	134,022	878,843	(744,821)	126,845	89,099	37,746	260,867	967,942	(707,075)
MHSA training/learning costs	-	-	-	51,698	64,647	(12,950)	51,698	64,647	(12,950)
Depreciation & amortization	212,204	120,947	91,258	447,151	406,204	40,947	659,355	527,151	132,204
Other operating expenses	616,003	475,591	140,411	1,656,608	1,589,581	67,027	2,272,611	2,065,173	207,438
Total Operating Expenses	**7,976,107**	**9,734,596**	**(1,758,488)**	**19,615,637**	**21,092,208**	**(1,476,572)**	**27,591,744**	**30,826,804**	**(3,235,060)**
OPERATING INCOME (LOSS)	**(4,883,723)**	**(3,719,114)**	**(1,164,609)**	**(14,589,321)**	**(13,363,697)**	**(1,225,624)**	**(19,473,045)**	**(17,082,811)**	**(2,390,233)**
Non-Operating Revenues (Expenses)									
Realignment	4,041,119	2,436,900	1,604,219	-	-	-	4,041,119	2,436,900	1,604,219
Contributions from member cities & donations	24,000	70,236	(46,236)	-	-	-	24,000	70,236	(46,236)
MHSA Funding	-	-	-	14,854,572	14,854,572	-	14,854,572	14,854,572	-
Grants and contracts	1,035,804	1,739,469	(703,666)	-	-	-	1,035,804	1,739,469	(703,666)
Rent Income from the new Admin Building	-	-	-	35,427	-	35,427	35,427	-	35,427
Interest (expense) income, net	406,581	316,121	90,460	1,319,728	1,481,080	(161,352)	1,726,309	1,797,201	(70,892)
Total Non-Operating Revenues (Expense)	**5,507,503**	**4,562,726**	**944,777**	**16,209,727**	**16,335,652**	**(125,925)**	**21,717,230**	**20,898,378**	**818,852**
INCREASE(DECREASE) IN NET POSITION	**$ 623,780**	**$ 843,612**	**$ (219,832)**	**$ 1,620,406**	**$ 2,971,955**	**$ (1,351,549)**	**$ 2,244,186**	**$ 3,815,567**	**$ (1,571,381)**

Definitions:

Medi-Cal FFP= Federal Financial Participation Reimbursement

Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.

TCMH=Tri-City's Outpatient Clinic

MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
EIGHT MONTHS ENDING FEBRUARY 28, 2026

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CFTN PROGRAMS)

Net Operating Revenues

Net operating revenues are lower than the budget by approximately $5.6 million for the following reasons:

1 **Medi-Cal FFP revenues for FY 2025-26** were approximately $5.9 million lower than the budget. Medi-Cal FFP revenues were $3.0 million lower for TCMH and approximately $2.9 million lower for MHSA. At TCMH, the adult program revenues were lower than budget by $1.9 million and the children program revenues were lower by $1.1 million. For MHSA, the adult and older adult FSP programs were lower than budget by $2.1 million and the Children and TAY FSP programs were lower by $875 thousand.

2 **Medi-Cal SGF-EPSDT revenues for fiscal year 2025-26** were lower than budget by $373 thousand of which $176 thousand lower were from TCMH and $196 thousand lower were from MHSA. SGF-EPSDT relates to State General Funds (SGF) provided to the agency for provision of qualifying Medi-Cal services for Early Prevention Screening and Diagnostic Testing (EPSDT) to children and youth under 21 years. These funds are in addition to the FFP reimbursed by the federal government.

3 **Medicare revenues** are $6 thousand higher than the budget. Tri-City records revenue when the services are provided and the claims are incurred and submitted.

4 **Contract revenues** are approximately $47 thousand higher than the budget from MHSA.

5 **Rent Incomes** are lower than the budget by approximately $24 thousand. The rental income represents the payments collected from Genoa pharmacy for space leasing at the 2008 N. Garey Avenue and from the tenants staying at the MHSA house on Park Avenue.

6 **Provision for contractual disallowances** for fiscal year 2025-26 was lower than budget by $658 thousand due to lower revenues.

Operating Expenses

Operating expenses were lower than budget by $3.2 million for the following reasons:

1 **Salaries and benefits** are approximately $4.7 million lower than the budget and of that amount, salaries and benefits are $1.2 million lower for TCMH operations and are $3.5 million lower for MHSA operations. These variances are due to the following:

TCMH salaries are lower than the budget by $655 thousand due to vacant positions. Benefits are also lower by $577 thousand.

MHSA salaries are lower than budget by $2.3 million. The direct program salary costs are lower by $1.2 million due to vacant positions and the administrative salary costs are lower than the budget by $1.1 million. Benefits are lower than the budget by $1.1 million due to lower health insurance of $397 thousand, retirement costs of $592 thousand, state unemployment insurance of $93 thousand and medicare tax of $39 thousand. These lower costs are slightly offset by higher workers compensation insurance.

2 **Facility and equipment operating costs** were higher than the budget by $207 thousand mainly due to the Laptop Refresh Project replacing over 230 new laptops for all staff, funded by CFTN plan.

3 **Client program costs** are higher than the budget by $1.6 million due to a payment of $1.9 million to the City of Pomona's Hope for Home Year-Round Emergency Shelter for the exclusive 71 beds to support emergency shelter for TCMHA clients.

4 **Grants for fiscal year 2025-26** are $707 thousand lower than the budget. These are the sub-grants awarded under the TCMH Mental Health Student Services Act program and the community grants under the MHSA PEI Community Wellbeing project.

5 **MHSA learning and training costs** are $13 thousand lower than the budget.

6 **Depreciation and amortization** are approximately $132 thousand higher than the budget.

7 **Other operating expenses** were higher than the budget by $207 thousand of which $140 thousand higher were from TCMH and $67 thousand higher were from MHSA. Overall, the higher costs were due to higher security expense, personnel recruiting costs and liability insurance. These higher costs are offset with lower attorney fees.

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
EIGHT MONTHS ENDING FEBRUARY 28, 2026

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CFTN PROGRAMS)

Non-Operating Revenues (Expenses)

Non-operating revenues, net, are higher than budget by approximately $819 thousand as follows:

1 **TCMH non-operating revenues** are $945 thousand higher than the budget. Of that, realignment fund was higher than the budget by $1.6 million due to the State's reconciliation of Sales Tax and Vehicle License Fee for fiscal years 2023-24 and 2024-25. Contributions from member cities were lower by $46 thousand, grants and contracts were lower by $704 thousand, and lastly, interest income net with fair market value was higher than budget by $90 thousand.

2 **MHSA non-operating revenue** is in line with the budget.
In accordance with Government Accounting Standards Board, MHSA funds received and available to be spent must be recorded as non-operating revenue as soon as the funds are received. Funds are available to be spent when an MHSA plan and related programs have been approved and the proposed expenditures for those programs have been approved through an MHSA plan, MHSA update, or State Oversight and Accountability Commission.

The differences in actual to budget are broken out as follows:

	Actual	Budget	Variance
CSS funds received and available to be spent	$ 10,424,618	$ 10,424,618	$ -
PEI funds received and available to be spent	3,408,921	3,408,921	-
WET funds received and available to be spent	-	-	-
CFTN funds received and available to be spent	-	-	-
INN funds received and available to be spent	1,021,033	1,021,033	-
Non-operating revenues recorded	$ 14,854,572	$ 14,854,572	$ -

CSS, PEI and INN recorded revenues are all in line with the budgets.

Rent Income from the New Admin Building is $35 thousand since the close of escrow of the newly purchased building on 431 W. Baseline Rd., Claremont on January 15, 2026. It was agreed that the tenant continue to occupy the space until end of March.

Interest income for MHSA net with Fair Market Value is lower than budget by approximately $161 thousand.

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
EIGHT MONTHS ENDED FEBRUARY 28, 2026 AND 2025

	PERIOD ENDED 2/28/26			PERIOD ENDED 2/28/25		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
REVENUES						
Medi-Cal FFP, net of reserves	$ 2,680,640	$ 3,713,984	$ 6,394,624	$ 2,815,496	$ 3,904,837	$ 6,720,333
Medi-Cal FFP FYE Prior Year	197	9,247	9,444	1,076,815	1,188,733	2,265,548
Medi-Cal SGF-EPSDT	392,542	1,210,296	1,602,838	704,770	1,306,161	2,010,931
Medi-Cal SGF-EPSDT Prior Year	-	385	385	174,562	174,613	349,175
Medicare	9,796	6,210	16,006	6,447	5,243	11,691
Realignment	4,041,119	-	4,041,119	2,436,900	-	2,436,900
MHSA funds	-	14,854,572	14,854,572	-	16,693,035	16,693,035
Grants and contracts	1,035,804	47,464	1,083,268	742,196	21,550	763,745
Contributions from member cities & donations	24,000	-	24,000	43,675	-	43,675
Patient fees and insurance	-	261	261	-	-	-
Rent income - TCMH & MHSA Housing	8,624	37,847	46,471	8,624	58,115	66,740
Rent Income from the new Admin Building	-	35,427	35,427	-	-	-
Other income	585	622	1,207	490	587	1,077
Interest Income	406,581	1,319,728	1,726,309	293,108	1,394,012	1,687,120
Total Revenues	**8,599,887**	**21,236,042**	**29,835,930**	**8,303,084**	**24,111,113**	**32,414,196**
EXPENSES						
Salaries, wages and benefits	6,588,779	13,946,261	20,535,040	5,358,613	12,448,911	17,807,525
Facility and equipment operating cost	412,868	1,326,942	1,739,810	426,819	1,091,437	1,518,255
Client lodging, transportation, and supply expense	12,232	2,060,131	2,072,363	41,326	460,503	501,828
Depreciation & amortization	212,204	447,151	659,355	199,759	418,924	618,683
Other operating expenses	750,024	1,835,151	2,585,176	639,846	1,628,730	2,268,576
Total Expenses	**7,976,107**	**19,615,637**	**27,591,744**	**6,666,363**	**16,048,504**	**22,714,867**
INCREASE (DECREASE) IN NET POSITION	**623,780**	**1,620,406**	**2,244,186**	**1,636,720**	**8,062,609**	**9,699,329**
NET POSITION, BEGINNING OF YEAR	13,832,173	38,199,232	52,031,405	10,020,298	32,339,182	42,359,480
NET POSITION, END OF MONTH	**$ 14,455,953**	**$ 39,819,638**	**$ 54,275,591**	**$ 11,657,019**	**$ 40,401,791**	**$ 52,058,810**

NOTE: This presentation of the Change in Net Assets is NOT in accordance with GASB, but is presented only for a simple review of Tri-City's revenue sources and expenses.

Definitions:
Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
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Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Elizabeth Renteria, LCSW, Chief Clinical Officer**

SUBJECT: **Monthly Report of Clinical, Housing and Support Systems Department**

I. EXECUTIVE SUMMARY

This report highlights continued Behavioral Health Services Act (BHSA) implementation efforts, with clinical and housing leadership identifying staffing and training requirements to support fidelity and ongoing workflow refinement. It also provides an administrative update on the newly established operational collaboration process between the Medical, Clinical, and Compliance Department to align workstreams and strengthen coordinated decision-making. In addition, the report summarizes interagency collaboration in response to the closure of the Pathway Home interim housing motel, including on-site engagement and coordination with Volunteers of America and Los Angeles County Department of Health Services to support continuity of care and housing transitions.

II. DEPT OPERATIONAL ITEMS / PROGRAMS & SERVICES

Work has continued on Behavioral Health Services Act (BHSA) implementation. As this work moves forward, clinical and housing leadership are specifically identifying the staffing and training requirements needed to meet program fidelity. Leadership also continued refining workflows to support coordinated service delivery and effective implementation across programs.

III. ADMINISTRATIVE UPDATES

An operational collaboration process has been established between the Medical, Clinical, and Compliance departments to align workstreams and support joint decision-making. This structured approach is intended to strengthen cross-department coordination, reduce duplicative efforts, and ensure consistent implementation of operational and regulatory requirements.

IV. INTERAGENCY COLLABORATION / COMMUNITY PARTNERSHIPS

In response to the closure of the Pathway Home interim housing motel in Pomona, Tri-City Mental Health Authority (TCMHA) partnered with the City of Pomona and a network of community providers to support the 43 individuals sheltered at the site. Volunteers of

America (VOA) led on-site transition planning to connect participants to alternative interim housing by April 10. Several individuals were already moving toward Permanent Supportive Housing through the Coordinated Entry System, while others were offered shared-space interim housing options across Los Angeles County. All participants were connected to Intensive Case Management Services (ICMS) through the Los Angeles County Department of Health Services (DHS) and were provided with additional support through the multi-agency response to promote continuity of care.

To minimize service disruption, TCMHA deployed a coordinated on-site outreach effort that included staff from Access to Care, Full-Service Partnership, Peer Support, Housing, and Community Navigator programs. TCMHA prioritized engagement with its seven known clients and coordinated with treatment teams to ensure continuity of services and follow-up planning. Staff also screened and assisted other participants who may have been eligible for TCMHA services and facilitated timely warm handoffs to appropriate providers when other linkages were needed. This collaborative response was coordinated closely with the City of Pomona, VOA, and DHS staff.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Seeyam Teimoori, MD, Medical Director**

SUBJECT: **Monthly Report for the Psychiatry Department**

I. EXECUTIVE SUMMARY

Our department partnered with the Opioid Response Network (ORN) to deliver a Medication-Assisted Treatment (MAT) training for psychiatrists and psychiatric technicians. This training strengthens our capacity to treat opioid use disorder and prepares the clinic for expanded responsibilities under Drug Medi-Cal and the Behavioral Health Services Act (BHSA). The session covered evidence-based MAT practices, harm-reduction principles, and clinical workflows for integrating MAT into routine psychiatric care. This initiative positions the clinic to provide more comprehensive, life-saving treatment for clients with co-occurring mental health and substance use disorders and aligns with BHSA's emphasis on integrated, whole-person care. Our collaboration with ORN is planned to be ongoing on training, support and sharing resources.

II. DEPT OPERATIONAL ITEMS / PROGRAMS & SERVICES

MAT Training Completion and Department Readiness Activities

The department has completed the ORN-led MAT training as part of its broader preparation for the upcoming Drug Medi-Cal program launch. At this stage, operational efforts are focused on building staff competency, increasing familiarity with MAT principles, and ensuring that psychiatrists and psychiatric technicians have a shared clinical foundation prior to implementation. The training provided essential knowledge on identifying opioid use disorder, understanding MAT medications, and applying harm-reduction approaches—skills that will be critical once MAT services are formally integrated into our clinical workflows

III. INTERAGENCY COLLABORATION

- Collaboration with The Best Practices Department on the billing accuracy and client service hours initiatives.
- Collaboration with the Central Scheduling Team on the initial medical evolutions process (as mentioned above).

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Dana Barford Director of MHSA and Ethnic Services**

SUBJECT: **April 2026 Staff Report for MHSA**

I. EXECUTIVE SUMMARY

Tri-City advanced several major initiatives this quarter, including the launch of the Recruitment Video and Digital Age Campaign with VMA Communications, now moving into filming and landing page development. Significant progress was made on PADs implementation: staff and facilitator trainings were completed, the MyPlanMyVoice digital platform launched, and outreach expanded across colleges, partners, and community groups.

Staff development continued through WET trainings and participation in the SCRP Conference on hope and resilience. Outreach efforts strengthened local partnerships, including school district collaborations and the opening of Claremont High School's Zen Den.

A strategic shift to video focused social media content resulted in strong month-over-month growth across platforms. DEI efforts included participation in Trans Day of Visibility and renewed focus on language access in partnership with the Quality Improvement (QI) Department.

The Community Wellbeing Grant program opened applications for the 2026–2027 cycle, with active engagement from grantees and multiple Q&A sessions. Community Navigators conducted outreach and coordinated a successful intervention for a senior resident, resulting in 24/7 in home care and improved safety.

II. DEPT OPERATIONAL ITEMS / PROGRAMS & SERVICES

Recruitment Video Production and Digital Age Campaign Project Update

In February 2026, the Governing Board approved a four-month contract with VMA Communications to produce recruitment videos and launch the Digital Age Campaign. The goal is to attract qualified behavioral health professionals by highlighting TCMHA's mission, values, and workplace culture, while supporting upcoming organizational growth and system changes in California's behavioral health field.

The project began in March with planning and strategy development. VMA Communications met weekly with TCMHA's Communications and HR teams to define priority job roles, target audiences, geographic focus, and recruitment goals. They reviewed existing materials, brand assets, and competitor examples to ensure alignment with TCMHA's hiring needs.

Work progressed into video pre-production and landing page development. VMA conducted site visits and interviews with clinical teams—including mobile crisis, outreach, psychiatry, peer support, and behavioral health staff—to shape the video narrative and select featured employees. Filming began on April 2, 2026. Meanwhile, development continued on the recruitment landing page, which will serve as the campaign's central digital hub.

PADs: Quarterly Report Summary (Jan–Mar 2026)

The first quarter centered on preparing for PADs implementation, training staff and facilitators, and expanding community outreach.

Training & Implementation

- PRPSN completed facilitator training and follow-ups, including an additional March session on conservatorship and facilitation skills. They began scheduling and conducting PAD appointments, offering English/Spanish phone lines and weekly Friday walk-in hours at the Wellness Center.
- Tri-City trained 68 clinical and Mobile Crisis Team staff on PAD basics, local processes, and how to access completed PADs in the field.

MyPlanMyVoice Platform Launch

- The new web-based platform went live, enabling individuals to independently or collaboratively create, store, and share PADs electronically.

Outreach & Engagement

- Over 20 engagements with colleges and universities, plus virtual presentations to five key partners supporting student and community well-being.
- First in person Spanish language PADs presentation held at NAMI's Café y Conversación.
- New outreach materials—flyers, brochures, digital content—highlighted differences between paper and web based PADs.
- Production began on original marketing videos ("What are PADs?" and "How to Sign Up"), scheduled for April release.

Coordination & Next Steps

- Tri-City continued monthly meetings with all six subcontractors to align outreach and priorities.

- Preparations advanced for the April multicounty convening, where Tri-City will showcase its marketing efforts—the only county producing its own social media content.

Overall, the quarter established foundational processes, strengthened training, and launched early outreach and enrollment efforts. Work will continue to broaden awareness, deepen partnerships, and support individuals in completing PADs.

WET Training Highlights

Staff participated in five training courses this month: Managing Change in Changing Times, Suicide Prevention, Eating Disorders, Leadership Skills for New Managers and Supervisors, and First Aid/CPR.

SCRP Conference Participation

Twenty staff attended the SCRP Conference: *Hope and Resilience; Inner Strength, Shared Values, and Collective Healing*. Participants had the opportunity to:

- Define and deepen their understanding of hope and resilience
- Learn strategies to strengthen client resilience
- Explore ways to build organizational and community resilience
- Foster hope and resilience within leadership roles

This month's outreach and engagement efforts included participation in Pomona Unified's College, Career & Workforce Task Group meeting, where staff connected with district partners around student career pathways. The team also attended the Career Fair at Diamond Ranch High School, engaging with students from all grade levels to share information about careers in public behavioral health and encouraging several interested students to apply for the Mental Health Commission. In addition, staff attended the ribbon cutting ceremony for Claremont High School's new Zen Den, which was supported through TriCity's SCRP Pipeline Grant and now serves as a dedicated wellness space for students.

Social Media Update

TriCity's social media staff began supporting agency platforms in December, posting a mix of graphics, reshared content, and videos. After reviewing engagement metrics, especially the significantly higher interaction rates on video posts, the team shifted in late February to focus exclusively on creating and posting video content. Since then, Instagram has shown steady month-over-month growth, reinforcing the value of consistent, active posting. Analytics also show that audiences respond most strongly to authentic, people centered content, with collaborative videos performing particularly well. Building on this momentum, TriCity plans to feature a wider range of staff and highlight board and commission members to strengthen transparency, deepen community connection, and encourage greater engagement.

Social Media: Statistics for December 2025 – March 2026:

Instagram

Metrics	December	January	February	March
Reach	2.6K	760	1.2K	3.9k
Interactions	396	195	376	651
Views	20.9K	9.0K	10.7K	21.0k
Visits	303	218	220	345

Facebook

Metrics	December	January	February	March
Viewers	317	363	1.2K	1.2k
Interactions	24	21	43	56
Views	1.3K	1.3K	3.4K	3.2k
Visits	207	231	229	191

Videos

Metrics	December	January	February	March
Number of Videos	4	5	5	6

Postings

Metrics	Projected	December	January	February	March
Total Postings	7-10	11	9	15	20
CPP	2-3	2	4	4	3
BHSA	2-3	0	0	2	1
PADs	2	0	0	0	1
RAs	1-2	2	2	1	1

III. INTERAGENCY COLLABORATION / COMMUNITY PARTNERSHIPS

Diversity Equity and Inclusion

On March 31st, the RAINBOW Collaborative attended Pomona Valley Pride's Trans Day of Visibility, a welcoming and gender affirming community gathering centered on resource sharing and celebrating self expression. The Center opened its doors to all, offering music, an open mic, and an inclusive space where attendees could connect, share their stories, and feel supported. We are grateful to our partners at Pomona Valley Pride for hosting such a meaningful event, which served as an important reminder of the value of accessible community hubs that uplift and empower everyone.

Language Accessibility

Over the next several weeks, the Diversity, Equity, and Inclusion (DEI) Coordinator will partner with the Quality Improvement (QI) Department to strengthen staff awareness and effective use of TriCity's translation and interpretation resources. This effort will reintroduce staff to available language access tools, reinforce best practices for working with interpreters, and highlight how these services can enhance rapport and connection with clients and participants. The initiative will also support TriCity's compliance with Los Angeles County Department of Mental Health reporting requirements, including the documentation of services delivered through language access resources as required by the California Department of Health Care Services.

Prevention And Early Intervention (PEI)

Community Wellbeing Grants

Grantees attended a cohort meeting where they learned that the Community Wellbeing Grant program has been extended for two years, and that Tri-City MHA is accepting applications for the 2026–2027 fiscal year. The application became available on March 16th.

Program staff and the Program Supervisor hosted two virtual Q&A sessions about the Community Wellbeing Grant—one on March 25 (23 attendees) and another on March 31 (19 attendees).

Applications for the 2026–2027 grant cycle are due April 13 at noon. Applicants must submit one electronic copy to Daisy Martinez at dmartinez@tricitymha.ca.gov. The application and FAQ are available on the Tri-City website: https://www.tricitymhs.org/our-services/community-support-programs/community-wellbeing-program

Community Navigators

Community Navigator Program outreach included tabling at the Wellness PRIDE event in Pomona and distributing flyers for Green Ribbon Week and the Community Wellbeing Grant.

The La Verne Police Department referred a senior resident who appeared unable to manage daily tasks and showed signs of memory issues. During a home visit, the Community Navigator observed expired food and medications, confusion, and possible dementia symptoms. The SGV Crisis Team was brought in to conduct a deeper assessment and successfully contacted family members to build additional support.
The Community Navigator provided senior care resources, and through coordinated efforts, the client was enrolled in 24/7 in-home care. This intervention ensured immediate safety, improved health, and consistent medical follow-up.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Natalie Majors-Stewart, LCSW, Chief Compliance Officer**

SUBJECT: **Monthly Report of Best Practices Department**

I. EXECUTIVE SUMMARY

As reported in the December 2025 Monthly Report of Best Practices Department, the Electronic Health Record (E.H.R.) Team initiated an internal E.H.R. steering committee to identify priorities and needs for our electronic health record.

During the identification of E.H.R. priorities, it was concluded that our existing Electronic Health Record is not adequate to meet our client care and operational needs and goals. Furthermore, it was determined that an exploration of an alternative electronic health record was warranted.

Over the last several months, the steering committee has embarked on an exploration of potential electronic health record products from several reputable vendors. The goal of the exploration was to find a trusted vendor that is committed to:

- Ensuring and keeping up with both the foundational and the ever-expanding regulatory requirements that govern the mental health care industry.
- Ensuring strong technological infrastructure and performance, high level security, and staying on the cutting edge of technological advancement.
- Maintaining a platform that prioritizes efficient and comprehensive access to monitoring tools, data reporting, and analysis.
- Providing a platform where essential internal controls are built into the workflow structure to reduce risk and error.
- Creating and maintaining an interface that is organized and structured in a way to maximize clinical decision making & positive client care outcomes.

More information is forthcoming soon, as we plan to present (in an upcoming Governing Board meeting) a selected Electronic Health Record that has been evaluated to be a viable candidate to meet our agency's Electronic Health Record needs.

II. DEPT OPERATIONAL ITEMS / PROGRAMS & SERVICES

The Best Practices department has continued to provide ongoing compliance and quality oversight of TCMHA programs and services. This includes but is not limited to training, monitoring, auditing, data and outcomes analysis, and E.H.R administration.

Training and In-Service

Agency workforce members with vital privacy and security oversight responsibilities, participated in the Forty-Third National HIPAA Summit. The HIPAA summit provides valuable insights related to health information privacy, healthcare cybersecurity, and HIPAA enforcement. The overall objective of HIPAA summit participation is to ensure that essential workforce members are equipped with the most current information to help ensure our agency maintains compliance with HIPAA and healthcare data privacy and security.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: April 15, 2026

TO: Governing Board of Tri-City Mental Health Authority

FROM: Ontson Placide, LMFT, Executive Director

BY: Kitha Torregano, Human Resources Director

SUBJECT: **Approval of Resolution No. 850 Adopting a Revised Master Classification and Salary Schedule to Update the Job Descriptions for the Behavioral Health Specialist and Senior Behavioral Health Specialist Classifications, Effective July 1, 2026**

Summary:

Staff recommends approval of revisions to the Behavioral Health Specialist and Senior Health Specialist classification to establish a three-level career ladder (Behavioral Health Specialist I/II/III). This action supports workforce development, regulatory compliance, and operational readiness in anticipation of CalAIM requirement and the Behavioral Health Services Act (BHSA) transition.

Background:

As part of ongoing workforce and classification planning, staff reviewed the existing Behavioral Health Specialist and Senior Behavioral Health Specialist classifications to ensure alignment with CalAIM standards, Medi-Cal billing requirements, and industry best practices.

The proposed revisions consolidate the two existing classifications into a single Behavioral Health Specialist I/II/III career ladder. This structure establishes clearly differentiated levels based on scope, complexity, and independence of work while supporting internal advancement and retention. The revised classification maintains compliance with Title 9 regulations and Mental Health Rehabilitation Specialist (MHRS) requirements. The revised Behavioral Health Specialist I/II/III job description will be effective July 1, 2026. Compensation data and recommended salary ranges will be presented to the Governing Board for approval at a later date.

Fiscal Impact:

There is no immediate fiscal impact associated with approval of the revised classification structure. Salary recommendations will be brought forward separately for Governing Board consideration.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 850 revising the Job Descriptions for the Behavioral Health Specialist I/II/III classifications, and updating the Master Classification and Salary Schedule to include these changes effective July 1, 2026.

Attachments

Attachment 8-A: Resolution No. 850 – Draft

Attachment 8-B: Behavioral Health Specialist I/II/III Job Description

RESOLUTION NO. 850

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ADOPTING THE REVISED BEHAVIORAL HEALTH SPECIALIST I/II/III JOB DESCRIPTIONS; AND UPDATING THE AUTHORITY'S MASTER CLASSIFICATION AND SALARY SCHEDULE TO ADD THESE CHANGES

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to consolidate the Behavioral Health Specialist and Senior Health Specialist classifications to establish a single, three-level career ladder as Behavioral Health Specialist I/II/III, to meet workforce development, regulatory compliance, and operational readiness in anticipation of CalAIM requirement and the Behavioral Health Services Act (BHSA), effective July 1, 2026; and update the Authority's Master Classification and Salary Schedule to reflect these changes.

B. The salary ranges will remain the same for the revised Behavioral Health Specialist I/II/III job classification.

C. The Authority's Governing Board has previously approved job descriptions, classifications, salary ranges, and benefits for the Authority's employees through the adoption of Resolutions.

2. Action

The Governing Board adopts Resolution No. 850 approving the Behavioral Health Specialist I/II/III Job Descriptions; and revising the Authority's Master Classification and Salary Schedule to reflect this change.

[Continues on Page 2]

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3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 15, 2026, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

DRAFT

BEHAVIORAL HEALTH SPECIALIST I/II/III

Classification specifications are only intended to present a descriptive summary of the range of duties and responsibilities associated with specified positions. Therefore, specifications *may not include all* duties performed by individuals within a classification. In addition, specifications are intended to outline the *minimum* qualifications necessary for entry into the class and do not necessarily convey the qualifications of incumbents within the position.

FLSA STATUS: Non-Exempt

DEFINITION:

Under general direction, the Behavioral Health Specialist (BHS) I/II/III provides rehabilitative, recovery-oriented, and support services to individuals with mental health, substance abuse and/or co-occurring conditions. Services emphasize skill development, functional improvement, community integration, and linkage to essential resources. Incumbents work collaboratively with multidisciplinary teams to support client recovery goals while maintaining compliance with Medi-Cal, HIPAA, and organizational standards; and performs related duties as assigned.

SUPERVISION RECEIVED AND EXERCISED:

Receives general supervision from assigned supervisory or clinical management personnel. This position exercises no direct supervision over staff.

DISTINGUISHING CHARACTERISTICS:

All levels in this classification perform rehabilitative services consistent with Title 9, California Code of Regulations, Section 630, and Medi-Cal billing requirements to qualify as a billable Mental Health Rehabilitation Specialist (MHRS). The levels are distinguished by increasing independence, complexity, and impact on team and program outcomes.

Behavioral Health Specialist I
Entry-level; performs structured assignments under close to moderate supervision. Focus is on learning, skill development, and implementing established treatment plans.

Behavioral Health Specialist II
Journey-level; performs the full range of duties independently. Handles more complex cases, contributes to treatment planning, and may provide informal guidance to less experienced staff.

Behavioral Health Specialist III
Advanced/senior-level; handles the most complex cases with a high degree of autonomy. Provides mentorship and functional guidance, supports quality improvement efforts, and serves as a resource to the team.

EXAMPLES OF ESSENTIAL DUTIES: Essential duties include, but are not limited to, the following:

Behavioral Health Specialist I

Incumbents perform **entry-to-journey-level work** under close to moderate supervision, focusing on direct service delivery and skill development.

- Deliver rehabilitative services focused on behavior modification, coping skills, daily living skills, and social functioning in individual and group settings.
- Facilitate structured rehabilitation and psychoeducation groups using established curricula and treatment goals.
- Assist in the implementation of treatment plans developed by licensed clinical staff.
- Provide case management and linkage to community resources including housing, food, benefits, transportation, employment, and healthcare.
- Conduct outreach activities to promote engagement and reduce service barriers for underserved populations.
- Advocate for client inclusion in community, educational, and vocational settings, as directed.
- Accurately document billable and non-billable services in accordance with Medi-Cal, HIPAA, and organizational requirements.
- Participate in multidisciplinary team meetings and contribute observational input regarding client progress.
- Support crisis intervention within defined scope and refer concerns to clinical staff.
- Maintain confidentiality and apply trauma-informed and culturally responsive practices.
- Provide transportation to clients as appropriate.
- Perform related duties as assigned.

Behavioral Health Specialist II

Incumbents perform **independent, journey-level work** with increased responsibility, discretion, and clinical coordination. In addition to duties performed above I, BHS II:

- Independently delivers rehabilitative and skill-building services tailored to client treatment goals.
- Participate actively in the development, review, and modification of treatment plans in collaboration with clinical staff and clients.
- Facilitate more complex rehabilitation and psychoeducation groups, adapting materials to meet diverse client needs.
- Provide more comprehensive case management, including proactive follow-up and coordination across multiple systems of care.
- Lead outreach and engagement efforts for harder-to-reach or high-need populations.
- Monitor client progress and identify changes requiring clinical consultation or intervention.
- Support crisis response activities within program protocols and assist in stabilizing situations pending clinical follow-up.
- Serve as a resource to Behavioral Health Specialist I staff through informal guidance, modeling best practices, and workflow support.
- Ensure documentation reflects medical necessity, service accuracy, and regulatory compliance.
- Contribute meaningfully to multidisciplinary team discussions and service planning.
- Perform related duties as assigned.

Behavioral Health Specialist III

Incumbents function as **senior-level practitioners**, providing advanced services, leadership, and programmatic support with a high degree of autonomy. In addition to duties performed at Levels I and II, the BHS III:

- Deliver advanced rehabilitative and recovery services to individuals with complex clinical, social, and functional needs.
- Take a lead role in treatment planning, service coordination, and outcome evaluation in collaboration with licensed clinicians.
- Design, adapt, and facilitate specialized rehabilitation and psychoeducation groups aligned with evidence-informed and recovery-oriented practices.
- Provide advanced case management for high-risk or high-utilization clients, including coordination across behavioral health, medical, housing, and social service systems.
- Lead outreach and engagement strategies to reduce systemic barriers and improve access to care.
- Provide mentorship, functional guidance, and training support to BHS I and II staff.
- Assist with quality improvement efforts, documentation audits, and program workflow enhancement.
- Support crisis response planning and coordination within scope and organizational protocols.
- Serve as a subject-matter resource on rehabilitative services, cultural responsiveness, and community-based care strategies.
- Ensure high standards of documentation, ethical practice, and regulatory compliance.

QUALIFICATIONS:

Education and Experience

Behavioral Health Specialist I: Associate degree in psychology, social work, or related field *and* six (6) years of experience in behavioral health services.

Behavioral Health Specialist II: Bachelor's degree in behavioral science or related field *and* four (4) years of behavioral health experience.

Behavioral Health Specialist III: Master's or Doctorate degree in behavioral health, psychology, social work, or related field *and* two (2) years of experience in behavioral health services.

Licenses and Certifications

For positions assigned to field-based services:
Ability to travel independently within the Tri-City and surrounding service areas to provide community-based services. Possession of a valid California Driver's License, a satisfactory driving record, and proof of a properly registered and insured vehicle, may be required if operating a personal or Authority vehicle.

For office-based assignments:
No driver's license requirement unless reassigned to a field-based role.

Knowledge of:

Level I
- Basic principles of psychosocial rehabilitation and recovery-oriented services
- Common mental health and co-occurring substance use conditions
- Community resources related to housing, benefits, employment, transportation, and healthcare
- Trauma-informed care and cultural responsiveness principles
- Confidentiality requirements, including HIPAA and basic Medi-Cal documentation standards
- Standard group facilitation techniques for skill-based and psychoeducational services

Level II
- Psychosocial rehabilitation practices and evidence-informed recovery interventions
- Functional assessment concepts and treatment planning processes
- Medi-Cal medical necessity standards and documentation requirements
- Engagement strategies for individuals with moderate to complex behavioral health needs
- Community systems of care, including behavioral health, housing, medical, and social services
- Crisis intervention principles within non-licensed scope of practice
- Group facilitation methods adaptable to varying client needs

Level III
- Advanced recovery-oriented and rehabilitative service models
- Complex psychosocial and functional needs associated with serious mental illness and co-occurring conditions
- Integrated systems of care and cross-sector service coordination
- Quality assurance principles related to service delivery and documentation
- Advanced engagement and retention strategies for high-risk or high-utilization populations
- Program operations, workflows, and continuous quality improvement concepts
- Cultural humility and equity-focused service delivery practices

Ability to:

Level I
- Deliver rehabilitative and skill-building services following established treatment plans
- Engage clients respectfully and effectively across diverse cultural and socioeconomic backgrounds
- Facilitate structured individual and group activities using provided curricula
- Accurately document services within required timeframes
- Establish rapport with clients experiencing behavioral health challenges
- Follow clinical direction, policies, and procedures
- Recognize behavioral health crises and appropriately notify clinical staff
- Work cooperatively as a member of a multidisciplinary team

Level II
- Independently deliver rehabilitative services aligned with client treatment goals
- Participate meaningfully in treatment planning and progress evaluation
- Adapt service approaches to meet diverse and complex client needs
- Coordinate services across multiple providers and systems of care

- Identify emerging client risks and consult appropriately with clinical staff
- Maintain accurate, compliant documentation demonstrating medical necessity
- Model best practices and provide informal guidance to junior staff
- Exercise sound judgment within established protocols and scope of practice

Level III
- Deliver advanced rehabilitative services to clients with complex needs and barriers
- Lead service coordination efforts in collaboration with licensed clinicians
- Design, adapt, and facilitate specialized rehabilitative and psychoeducational groups
- Serve as a mentor and functional resource to Behavioral Health Specialist I and II staff
- Identify service gaps and contribute to program improvement initiatives
- Demonstrate high-level judgment, independence, and professionalism
- Support crisis response planning and coordination within scope and protocol
- Ensure exemplary compliance with documentation, ethical, and regulatory standards

PHYSICAL DEMANDS (ADA)

When assigned to an office environment, must possess mobility to work in a standard office setting and use standard office equipment, including a computer; vision to read printed materials and a computer screen; and hearing and speech to communicate in person and over the telephone; ability to stand and walk between work areas may be required. Finger dexterity is needed to access, enter, and retrieve data using a computer keyboard or calculator and to operate standard office equipment. Positions in this classification occasionally bend, stoop, kneel, reach, push, and pull drawers open and closed to retrieve and file information.

When performing field work, must possess mobility to work in changing site conditions; to sit, stand, and walk on level, uneven, or slippery surfaces; to reach, twist, turn, kneel, and bend; and to operate a motor vehicle and visit various sites throughout the Tri-Cities; vision to observe client behavior, signs of illness, and potential hazards. The job involves frequent walking to locate, assist, and deliver services to clients, with exposure to hazardous materials and waste in some locations. Employees must possess the ability to lift, carry, push, and pull materials and objects averaging a weight of 15 pounds, or heavier weights, in all cases with the use of proper equipment and/or assistance from other staff.

ENVIRONMENTAL CONDITIONS

Employees work in an office environment with moderate noise levels, controlled temperature conditions, and no direct exposure to hazardous physical substances. Employees also work in the field and are exposed to loud noise levels, cold and hot temperatures, inclement weather conditions, and may be exposed to blood and bodily fluids, and other hazardous physical substances and fumes. Employees may be exposed to clients experiencing crisis, homelessness, or severe mental illness, including those with behavioral disorders who may exhibit erratic, assaultive, or emergency-level behaviors requiring intervention. Employees may also interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

WORKING CONDITIONS

In accordance with California Government Code Section 3100, Tri-City Mental Health Authority employees, in the event of a disaster, are considered disaster service workers and may be asked to protect the health, safety, lives, and property of the people of the State.

Employees serve as members of the Authority's on-call crisis intervention team and may be required to be available and respond to crisis situation 24/7 during on-call rotation.

Receive satisfactory results from a background investigation, which includes fingerprinting; a pre-employment physical examination, which includes a drug/alcohol test; and an administrative review.

BEHAVIORAL HEALTH SPECIALIST I/II/III

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- Provide case management and linkage to community resources including housing, food, benefits, transportation, employment, and healthcare.
- Conduct outreach activities to promote engagement and reduce service barriers for underserved populations.
- Advocate for client inclusion in community, educational, and vocational settings, as directed.
- Accurately document billable and non-billable services in accordance with Medi-Cal, HIPAA, and organizational requirements.
- Participate in multidisciplinary team meetings and contribute observational input regarding client progress.
- Support crisis intervention within defined scope and refer concerns to clinical staff.
- Maintain confidentiality and apply trauma-informed and culturally responsive practices.
- Provide transportation to clients as appropriate.
- Perform related duties as assigned.

Behavioral Health Specialist II

Incumbents perform **independent, journey-level work** with increased responsibility, discretion, and clinical coordination. In addition to duties performed above I, BHS II:

- Independently delivers rehabilitative and skill-building services tailored to client treatment goals.
- Participate actively in the development, review, and modification of treatment plans in collaboration with clinical staff and clients.
- Facilitate more complex rehabilitation and psychoeducation groups, adapting materials to meet diverse client needs.
- Provide more comprehensive case management, including proactive follow-up and coordination across multiple systems of care.
- Lead outreach and engagement efforts for harder-to-reach or high-need populations.
- Monitor client progress and identify changes requiring clinical consultation or intervention.
- Support crisis response activities within program protocols and assist in stabilizing situations pending clinical follow-up.
- Serve as a resource to Behavioral Health Specialist I staff through informal guidance, modeling best practices, and workflow support.
- Ensure documentation reflects medical necessity, service accuracy, and regulatory compliance.
- Contribute meaningfully to multidisciplinary team discussions and service planning.

- Perform related duties as assigned.

Behavioral Health Specialist III

Incumbents function as **senior-level practitioners**, providing advanced services, leadership, and programmatic support with a high degree of autonomy. In addition to duties performed at Levels I and II, the BHS III:

- Deliver advanced rehabilitative and recovery services to individuals with complex clinical, social, and functional needs.
- Take a lead role in treatment planning, service coordination, and outcome evaluation in collaboration with licensed clinicians.
- Design, adapt, and facilitate specialized rehabilitation and psychoeducation groups aligned with evidence-informed and recovery-oriented practices.
- Provide advanced case management for high-risk or high-utilization clients, including coordination across behavioral health, medical, housing, and social service systems.
- Lead outreach and engagement strategies to reduce systemic barriers and improve access to care.
- Provide mentorship, functional guidance, and training support to BHS I and II staff.
- Assist with quality improvement efforts, documentation audits, and program workflow enhancement.
- Support crisis response planning and coordination within scope and organizational protocols.
- Serve as a subject-matter resource on rehabilitative services, cultural responsiveness, and community-based care strategies.
- Ensure high standards of documentation, ethical practice, and regulatory compliance.

QUALIFICATIONS:

Education and Experience

Behavioral Health Specialist I: Associate degree in psychology, social work, or related field *and* six (6) years of experience in behavioral health services.

Behavioral Health Specialist II: Bachelor's degree in behavioral science or related field *and* four (4) years of behavioral health experience.

Behavioral Health Specialist III: Master's or Doctorate degree in behavioral health, psychology, social work, or related field *and* two (2) years of experience in behavioral health services.

Licenses and Certifications

For positions assigned to field-based services:

Ability to travel independently within the Tri-City and surrounding service areas to provide community-based services. Possession of a valid California Driver's License, a satisfactory

driving record, and proof of a properly registered and insured vehicle, may be required if operating a personal or Authority vehicle.

For office-based assignments:

No driver's license requirement unless reassigned to a field-based role.

Knowledge of:

Level I
- Basic principles of psychosocial rehabilitation and recovery-oriented services
- Common mental health and co-occurring substance use conditions
- Community resources related to housing, benefits, employment, transportation, and healthcare
- Trauma-informed care and cultural responsiveness principles
- Confidentiality requirements, including HIPAA and basic Medi-Cal documentation standards
- Standard group facilitation techniques for skill-based and psychoeducational services

Level II
- Psychosocial rehabilitation practices and evidence-informed recovery interventions
- Functional assessment concepts and treatment planning processes
- Medi-Cal medical necessity standards and documentation requirements
- Engagement strategies for individuals with moderate to complex behavioral health needs
- Community systems of care, including behavioral health, housing, medical, and social services
- Crisis intervention principles within non-licensed scope of practice
- Group facilitation methods adaptable to varying client needs

Level III
- Advanced recovery-oriented and rehabilitative service models
- Complex psychosocial and functional needs associated with serious mental illness and co-occurring conditions
- Integrated systems of care and cross-sector service coordination
- Quality assurance principles related to service delivery and documentation
- Advanced engagement and retention strategies for high-risk or high-utilization populations
- Program operations, workflows, and continuous quality improvement concepts
- Cultural humility and equity-focused service delivery practices

Ability to:

Level I
- Deliver rehabilitative and skill-building services following established treatment plans
- Engage clients respectfully and effectively across diverse cultural and socioeconomic backgrounds
- Facilitate structured individual and group activities using provided curricula
- Accurately document services within required timeframes
- Establish rapport with clients experiencing behavioral health challenges

- Follow clinical direction, policies, and procedures
- Recognize behavioral health crises and appropriately notify clinical staff
- Work cooperatively as a member of a multidisciplinary team

Level II
- Independently deliver rehabilitative services aligned with client treatment goals
- Participate meaningfully in treatment planning and progress evaluation
- Adapt service approaches to meet diverse and complex client needs
- Coordinate services across multiple providers and systems of care
- Identify emerging client risks and consult appropriately with clinical staff
- Maintain accurate, compliant documentation demonstrating medical necessity
- Model best practices and provide informal guidance to junior staff
- Exercise sound judgment within established protocols and scope of practice

Level III
- Deliver advanced rehabilitative services to clients with complex needs and barriers
- Lead service coordination efforts in collaboration with licensed clinicians
- Design, adapt, and facilitate specialized rehabilitative and psychoeducational groups
- Serve as a mentor and functional resource to Behavioral Health Specialist I and II staff
- Identify service gaps and contribute to program improvement initiatives
- Demonstrate high-level judgment, independence, and professionalism
- Support crisis response planning and coordination within scope and protocol
- Ensure exemplary compliance with documentation, ethical, and regulatory standards

PHYSICAL DEMANDS (ADA)

When assigned to an office environment, must possess mobility to work in a standard office setting and use standard office equipment, including a computer; vision to read printed materials and a computer screen; and hearing and speech to communicate in person and over the telephone; ability to stand and walk between work areas may be required. Finger dexterity is needed to access, enter, and retrieve data using a computer keyboard or calculator and to operate standard office equipment. Positions in this classification occasionally bend, stoop, kneel, reach, push, and pull drawers open and closed to retrieve and file information.

When performing field work, must possess mobility to work in changing site conditions; to sit, stand, and walk on level, uneven, or slippery surfaces; to reach, twist, turn, kneel, and bend; and to operate a motor vehicle and visit various sites throughout the Tri-Cities; vision to observe client behavior, signs of illness, and potential hazards. The job involves frequent walking to locate, assist, and deliver services to clients, with exposure to hazardous materials and waste in some locations. Employees must possess the ability to lift, carry, push, and pull materials and objects averaging a weight of 15 pounds, or heavier weights, in all cases with the use of proper equipment and/or assistance from other staff.

ENVIRONMENTAL CONDITIONS

Employees work in an office environment with moderate noise levels, controlled temperature conditions, and no direct exposure to hazardous physical substances. Employees also work in the field and are exposed to loud noise levels, cold and hot temperatures, inclement weather conditions, and may be exposed to blood and bodily fluids, and other hazardous physical substances and fumes. Employees may be exposed to clients experiencing crisis, homelessness, or severe mental illness, including those with behavioral disorders who may exhibit erratic, assaultive, or emergency-level behaviors requiring intervention. Employees may also interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

WORKING CONDITIONS

In accordance with California Government Code Section 3100, Tri-City Mental Health Authority employees, in the event of a disaster, are considered disaster service workers and may be asked to protect the health, safety, lives, and property of the people of the State.

Employees serve as members of the Authority's on-call crisis intervention team and may be required to be available and respond to crisis situation 24/7 during on-call rotation.

Receive satisfactory results from a background investigation, which includes fingerprinting; a pre-employment physical examination, which includes a drug/alcohol test; and an administrative review.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Elizabeth Renteria, LCSW, Chief Clinical Officer**

SUBJECT: **Consideration of Resolution No. 851 Approving a Memorandum Of Understanding (MOU) with the City of Claremont for Mobile Crisis Care Services, and Authorizing the Executive Director to Execute Said MOU**

Summary:

Approval is requested for the Tri-City Mental Health Authority Governing Board to enter into an updated Memorandum of Understanding (MOU) with the City of Claremont for Mobile Crisis Care response and coordination with the City of Claremont Police Department. This update to the MOU previously approved by the Governing Board in November 2025 incorporates revisions requested by both parties and will support a timely, clinically informed crisis response within the community. Board action is requested to authorize the Executive Director to finalize and execute the MOU.

Background:

Tri-City Mental Health Authority's Mobile Crisis Care program is operational and has identified a growing need for coordinated crisis intervention services in partnership with local law enforcement. The Claremont Police Department frequently encounters individuals experiencing mental health crises, and formal collaboration will allow for rapid, compassionate, and clinically informed responses. This initiative aligns with best practices for community-based crisis care and supports the Authority's mission to improve mental health outcomes and public safety.

Fiscal Impact:

Funding for the Mobile Crisis Care Program will be provided through Behavioral Health Services Act (BHSA) funds for services delivered to community members. For clients who are currently open with Tri-City Mental Health Authority, costs will be covered through MediCal billing.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 851 approving the Memorandum of Understanding with the City of Claremont for Mobile Crisis Care services effective April 15, 2026 through June 30, 2027, and authorizing the Executive Director to execute the MOU.

Attachments:

Attachment 9-A: Resolution No. 851- Draft

Attachment 9-B: MOU between TCMHA and the City of Claremont for MCC services, effective

RESOLUTION NO. 825

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AUTHORIZING A MEMORANDUM OF UNDERSTANDING WITH THE CITY OF CLAREMONT TO ESTABLISH A RESPONSE WORKFLOW BETWEEN TCMHA's MOBILE CRISIS CARE TEAM AND THE CLAREMONT POLICE DEPARTMENT

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to approve a Memorandum of Understanding (MOU) with the City of Claremont to outline the roles and responsibilities of TCMHA and the City of Claremont for Mobile Crisis Care Services to provide an effective, efficient, timely, and a clinically appropriate collaborative response process to Claremont residents and/or visitors during a mental health crisis intervention and ongoing care.

B. The Authority affirms that there is no agency relationship between TCMHA and the City of Claremont; and no payments, compensation, or fees shall be made between TCMHA and the City of Claremont in connection with the MOU.

2. Action

The Governing Board approves the MOU with the City of Claremont, in substantially the same form as presented at its meeting on April 15, 2025, and authorizes the Authority's Executive Director to enter into and execute the MOU effective April 1, 2026 through June 30, 2027; and any Amendments or extensions of such MOU,

[Continued on page 2]

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3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 15, 2026, by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

DRAFT

TRI·CITY Mental Health

Founded in 1960
by the residents

of Pomona, Claremont
and La Verne.

www.tricitymha.ca.gov

MEMORANDUM OF UNDERSTANDING

BETWEEN

TRI-CITY MENTAL HEALTH AUTHORITY

AND

CITY OF CLAREMONT

DATED

_____, 2026

Administrative Office
1717 North Indian Hill
Boulevard, Suite B
Claremont, CA 91711
Phone (909) 623-6131
Fax (909) 623-4073

Clinical Office / Adult
2008 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 865-9281

Clinical Office / Child & Family
1900 Royalty Drive, Suite 180
Pomona, CA 91767

Phone (909) 766-7340

Fax (909) 865-0730

MHSA Administrative Office
2001 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 326-4690

Wellness Center
1403 North Garey Avenue
Pomona, CA 91767
Phone (909) 242-7600
Fax (909) 242-7691

ATTACHMENT 9-B

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MEMORANDUM OF UNDERSTANDING

BY AND BETWEEN TRI-CITY MENTAL HEALTH AUTHORITY AND THE CITY OF CLAREMONT TO ESTABLISH THE RESPONSE WORKFLOW BETWEEN TCMHA MOBILE CRISIS CARE (MCC) TEAM AND THE CLAREMONT POLICE DEPARTMENT

1. PARTIES AND AGREEMENT DATE

This Memorandum of Understanding (hereinafter "MOU") is made and entered into as of _____, 2026 ("MOU Date") by and between the TRI-CITY MENTAL HEALTH AUTHORITY, a joint powers agency organized under the laws of the State of California with its administrative office at 1717 N. Indian Hill Boulevard, Suite B, Claremont, California 91711 (hereinafter "TCMHA") and the CITY OF CLAREMONT, a municipal government, with its principal place of business at 207 Harvard Avenue, Claremont, CA 91711 (hereinafter "City"). TCMHA and City are sometimes individually referred to as a "Party" and collectively as "Parties."

2. PURPOSE OF MOU

2.1 TCMHA, by and through its Mobile Crisis Care Team ("MCC Team"), provides mobile behavioral health crisis services (including linkages to necessary care and support) within its service area, including to persons in the City of Claremont. This MOU represents good faith commitments, which are being made by each of the Parties to provide an effective, efficient, timely, and a clinically appropriate collaborative response process to Claremont residents and/or visitors during a mental health crisis intervention and ongoing care.

2.2 A further purpose of this MOU is to outline the roles and responsibilities of the Parties.

3. TERM OF MOU

The term of this MOU shall commence April 1, 2026, and shall be in full force and effect through June 30, 2027, or until it is amended or terminated. This MOU may be terminated, in whole or in part, by either Party at any time, without cause, upon thirty (30) calendar days prior written notice to the other Party. This MOU may be amended only by the mutual written agreement of both Parties. The Parties agree to cooperate fully in the event of any amendment or termination of this MOU.

4. GUIDING PRINCIPALS

4.1 Client-Centered Care: Prioritize compassionate, culturally competent responses.

4.2 Clear Communication: Ensure all City law enforcement ("Police Department" or "CPD"), the office of the City Manager, City's Recreation and Human Services Department, and TCMHA (collectively, "Partners") are informed of the appropriate contact points and response roles.

4.3 Coordinated Response: Align responsibilities and referral pathways across Partners.

5. ROLES AND RESPONSIBILITIES

5.1 Responsibilities of TCMHA

5.1.1 Primary Mobile Crisis Provider

5.1.1.1 Serve as the primary mobile behavioral health crisis response involving individuals experiencing behavioral health crises, including TCMHA clients and community members.

5.1.1.2 TCMHA will respond to calls initiated by the Claremont Police Department and the City's Recreation and Human Services Department, ensuring coordinated support and timely intervention across City operations.

5.1.2 Crisis Screening and Triage

5.1.2.1 TCMHA will utilize the California Department of Health Care Services (DHCS) Mobile Crisis – MTAC screening tool, or successor tool, to evaluate acuity, safety risk, and appropriate level of response.

5.1.2.2 TCMHA will determine whether response will be telephonic or in-person, based on clinical judgment, staffing availability, and safety considerations.

5.1.3 Clinical Assessment and Determination

5.1.3.1 The MCC Team will conduct behavioral health assessments within scope of practice when responding telephonically or in the field.

5.1.3.2 The MCC Team will make the clinical determination of appropriate intervention, which may include:

5.1.3.2.1 involuntary detention for evaluation pursuant to Welfare and Institutions Code Sections 5150 (adults) or 5585 (youth) when criteria are met; and/or

5.1.3.2.2 referral to voluntary or community-based services;

5.1.3.2.3 crisis stabilization interventions, safety planning, or

5.1.3.2.4 linkage to urgent care; or other clinically appropriate stabilization processes.

5.1.4 In-Person Mobile Crisis Response

5.1.4.1 MCC Team will respond in the field when clinically indicated and when CPD confirms the scene is stable and safe for clinician engagement.

5.1.4.2 MCC Team will follow established field safety protocols, including staged arrival, situational awareness, withdrawal criteria, and coordination with CPD.

5.1.5 Communication and Coordination with CPD and/or City

5.1.5.1 The MCC Team will participate in structured information exchange with CPD prior to and during response.

5.1.5.2 The MCC Team will communicate triage outcomes, clinical determinations, and recommended dispositions necessary for coordination and safety.

5.1.6 Jurisdictional Coordination and Continuity of Care

5.1.6.1 TCMHA will coordinate with Los Angeles County Department of Mental Health (LACDMH) to align response protocols and prevent duplication of services.

5.1.6.2 The MCC Team will provide crisis screening and stabilization regardless of client residence when clinically appropriate.

5.1.6.3 The MCC Team will coordinate with LACDMH to ensure referrals, service linkage, and follow-up for individuals who:

5.1.6.3.1 Reside outside the Tri-City Mental Health Authority jurisdiction;

5.1.6.3.2 Are not eligible for Tri-City services; or

5.1.6.3.3 Request or require services outside of the Tri-City jurisdiction. The MCC Team will facilitate warm handoffs when feasible.

5.1.7 Unavailability and Back-Up Notification

5.1.7.1 Tri-City Mental Health Authority shall serve as the primary mobile behavioral health crisis responder within its service area when resources are available. LACDMH, as the County Mental Health Plan, retains overall statutory responsibility for crisis response services within Los Angeles County and shall serve as the secondary or backup responder when Tri-City is unable to

respond. Nothing herein transfers County Mental Health Plan responsibilities to Tri-City.

5.1.7.2 The MCC Team will notify CPD/City promptly when TCMHA is unable to respond due to staffing limitations or concurrent crisis activity.

5.1.7.3 The MCC Team will support CPD's activation of LACDMH Psychiatric Mobile Response Team (PRMT) as the designated secondary/back-up crisis response provider.

5.1.8 Information Sharing and Documentation

5.1.8.1 TCMHA may share limited contact and behavioral health information to support immediate safety, care coordination, and disposition decisions. Information shall be shared only with the individual's informed consent, or without consent solely when permitted by law, including when necessary to prevent or lessen a serious and imminent threat to the health or safety of the individual or others, or to facilitate lawful emergency intervention. Any information disclosed shall be limited to the minimum necessary to support a direct, person-to-person transfer of care, clinical determination, or law-enforcement assistance with safety and transportation. All disclosures shall comply with applicable federal, state, and local confidentiality and privacy laws, including HIPAA and relevant California statutes, and shall be used exclusively for authorized crisis response and coordination purposes.

5.1.8.2 The MCC Team will document clinical activities consistent with TCMHA policies and applicable law.

5.2 Responsibilities of Claremont Police Department (CPD)

5.2.1 Public Safety and Initial Response

5.2.1.1 CPD will serve as the primary public safety responder to incidents involving potential behavioral health crises.

5.2.1.2 CPD will address immediate threats, criminal activity, or medical emergencies consistent with law and departmental policy.

5.2.2 Request for Mobile Crisis Support

5.2.2.1 CPD will utilize a best-practice communication process to request TCMHA Mobile Crisis Care support. Police Department or City

staff will directly call or utilize a centralized City dispatch to contact the TCMHA 24/7 crisis line. This includes sharing known safety, behavioral, and situational information necessary for triage and response planning.

5.2.3 Scene Stabilization Prior to Clinical Engagement

5.2.3.1 CPD will take reasonable steps to stabilize the scene prior to in-person clinical assessment, including:

5.2.3.1.1 Assessing and mitigating weapon risks;

5.2.3.1.2 Controlling active threats or unsafe environments;

5.2.3.1.3 Managing bystanders and reducing environmental hazards; and

5.2.3.1.4 Confirming when the scene is safe for clinician approach.

5.2.4 Coordination During On-Scene Response

5.2.4.1 CPD will maintain safety presence as appropriate while TCMHA conducts clinical engagement and assessment.

5.2.4.2 CPD will support a coordinated, non-duplicative approach to interaction with the person in crisis.

5.2.5 Transportation Assistance When Safety Is a Concern

5.2.5.1 When clinical determination results in hospitalization or involuntary evaluation and safety concerns are present, provide reasonable assistance consistent with law and departmental policy, including:

5.2.5.1.1 Assisting with transport to a designated hospital or facility when law enforcement transport is necessary for safety; and

5.2.5.1.2 Supporting transfer to EMS or other transport resources as appropriate.

5.2.6 Activation of Back-Up Mobile Crisis Services

5.2.6.1 CPD will contact LACDMH Psychiatric Mobile Response Team (PRMT) as the secondary mobile crisis provider when TCMHA is unavailable or unable to respond.

5.2.7 Information Sharing

5.2.7.1 CPD may share relevant, lawfully obtained information with the MCC Team as necessary to support safe and effective crisis assessment, response, and care coordination. Information shared shall be limited to observations, safety concerns, and other operational details reasonably necessary for the MCC Team to assess risk and determine appropriate intervention and shall be disclosed and used solely in accordance with applicable federal, state, and local privacy and confidentiality laws.

5.2.8 TCMHA will provide periodic training in crisis response techniques and MCC program or other resource updates to the Police Department and City staff to aid with identifying and referring individuals in mental health crisis.

5.2.9 MCC Team will assist as appropriate with crisis coverage on Wednesdays, evenings, weekends, when City's crisis team is unavailable, and during periods of high need or when staffing is limited.

5.2.10 MCC Team will coordinate referrals for treatment services directly from the City's crisis team to ensure timely support and continuity of care.

5.2.11 TMCHA will participate in ongoing collaborative meetings in accordance with a mutually agreed upon schedule between City, public safety officials, and service providers to ensure an integrated crisis response.

5.2.12 TCMHA will offer additional consultation and training sessions for City based teams to support effective service delivery.

5.2.13 The MCC Team will perform administrative and case related duties in a mutually agreed upon workspace to be provided by the City and location confirmed in writing by both Parties.

5.2.14 MCC Team will comply with all applicable City safety, security, and confidentiality requirements while on site at the workspace.

5.3 Responsibilities of the City

5.3.1 The City will provide access to a workspace appropriate for MCC Team to perform administrative and case-related duties.

5.3.2 The City will provide MCC Team with reasonable access to the workspace and parking consistent with the terms of this MOU.

5.3.3 The City will orient MCC Team to relevant facility procedures, including emergency protocols and security measures.

5.3.4 The City will retain ownership and control of the workspace and may reassign it with reasonable advance notice to TCMHA.

5.3.5 **Health Insurance Portability and Accountability Act.** The City and its officers, employees, agents, or police officers providing services pursuant to this MOU shall adhere to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 and 164, 42 CFR, Part 2, and Welfare Institutions Code (WIC) Sections 5328 through 5330, inclusive, and all other applicable County, State, and federal laws, ordinances, rules, regulations, manuals, guidelines, and directives, relating to confidentiality and privacy. The City shall require all its officers, employees, and agents providing services under this MOU to acknowledge understanding of, and agree to fully comply with, such confidentiality and privacy provisions.

5.3.6 **Business Associate Agreement.** To the extent necessary, TCMHA will furnish Protected Health Information (PHI) to the City (Business Associate) in accordance with all applicable legal requirements to allow law enforcement to perform community response services under this MOU. The City is required to appropriately safeguard the PHI disclosed to it. Accordingly, the City will sign a *Business Associate Agreement*, incorporated herein as 'Exhibit A', accepting liability for any breach of ePHI or PHI.

5.4 Mutual Responsibilities of the Parties

5.4.1 Each Party will designate a representative for the purpose of day-to-day mutual coordination of timely and appropriate community response under this MOU.

5.4.2 The Parties will meet regularly upon a mutually agreed schedule to coordinate and review response data, identify system gaps, and enhance joint protocols.

5.4.3 Neither Party will discriminate against any person because race, color, creed, religion, sex, marital status, national origin, ancestry, age, physical or mental handicap, medical condition, sexual orientation or gender identity, or any other basis protected by law.

6. NO FINANCIAL AGREEMENT

No payments, compensation, or fees shall be made between the Parties in connection with this MOU.

7. NO AGENCY RELATIONSHIP BETWEEN THE PARTIES

7.1 Nothing in this MOU is intended to or shall be construed to constitute or establish an agency, employer/employee, partnership, franchise, or fiduciary relationship between the Parties; and neither party shall have the right or authority nor shall hold itself out to have the right or authority to bind the other Party, nor shall either Party be responsible for the acts or omissions of the other except as provided specifically to the contrary herein.

7.2 TCMHA employees providing services under this MOU will not be considered employees or agents of the City for any purpose. TCMHA employees will not be entitled to receive any compensation or any benefits of employment from the City, including but not limited to, health care or workers' compensation benefits, vacation, sick time, or any other benefit of employment, direct or indirect.

7.3 City employees providing services under this MOU will not be considered employees or agents of TCMHA for any purpose. City employees will not be entitled to receive any compensation or any benefits of employment from TCMHA, including but not limited to, health care or workers' compensation benefits, vacation, sick time, or any other benefit of employment, direct or indirect.

8. NO THIRD-PARTY BENEFICIARIES

Except as expressly set forth herein, there are no intended third-party beneficiaries to this MOU, nor shall anything herein confer upon any person other than the Parties, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

9. INDEMNIFICATION

Each Party shall indemnify, defend and hold harmless the other Party, their elected and appointed officers, employees, representatives, volunteers, and contractors who serve as officers, officials, or staff, from and against any and all liability, including but not limited to demands, claims, actions, suits, accidents, injuries, fees, costs, expenses, liability, and/or proceedings (including attorney and expert witness fees), arising from or connected with each Party's respective acts and/or omissions arising from and/or relating to this MOU. Notwithstanding the foregoing, neither Party shall be obligated to indemnify the other Party for that Party's own negligence or willful misconduct.

Tort Liability. Government Code Section 895.2 imposes certain tort liability jointly upon public agencies solely by reason of such public agencies being parties to an agreement as defined in Government Code Section 895. Therefore, the Parties hereto, as between themselves, pursuant to the authorization contained in Government Code Sections 895.4 and 895.6, each assumes the full liability imposed upon it or any of its officers, agents, representatives or employees by law for injury caused by a negligent or wrongful act or omission occurring in the performance of this MOU, to the same extent that such liability would be imposed in the absence of Government Code Section 895.2. To achieve this purpose, each Party indemnifies and holds harmless the other Party for any loss, cost, or expense,

including reasonable attorneys' fees that may be imposed upon or incurred by such other Party solely by virtue of Government Code Section 895.2.

Survival. All duties of the Parties under this Section 9 shall survive termination of this MOU.

10. GENERAL TERMS AND CONDITIONS

10.1 Governing Law, Jurisdiction and Venue. This MOU will be governed by, and construed in accordance with, the laws of the State of California. Parties agree and consent to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this MOU and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles, California.

10.2 Representative and Notice

10.2.1 TCMHA's Representative. Tri-City Mental Health Authority hereby designates its Executive Director to act as its representative for the performance of this MOU and shall have the power to act on behalf of TCMHA for all purposes under this Agreement.

10.2.2 City's Representative. City warrants that the individual who has signed the MOU has the legal power, right, and authority to make this MOU and to act on behalf of City for all purposes under this MOU.

10.2.3 Delivery of Notices. All notices permitted or required under this MOU shall be given to the respective parties in writing, and will be deemed to have been duly given when delivered personally or when deposited in the United States Mail, First Class, at the following address and addressed as indicated:

If to TCMHA:
Tri-City Mental Health Authority
1717 N. Indian Hill Boulevard, #B
Claremont, CA 91711-2788
Attn: Executive Director

If to the City:
City of Claremont
207 Harvard Avenue
Claremont, CA 91711
Attn: City Manager

11. ENTIRE AGREEMENT

This MOU and any other documents incorporated herein by specific reference, represents the entire and integrated agreement between the Parties. This MOU supersedes all prior agreements, written or oral, between TCMHA and the City relating to the subject matter of this MOU. This MOU may not be modified, changed or discharged in whole or in part, except by an agreement in writing signed by TCMHA and the City. The validity or unenforceability of any provision of this

MOU declared by a valid judgment or decree of a court of competent jurisdiction, shall not affect the validity or enforceability of any other provision of this MOU. No delay or omission by either Party in exercising any right under this MOU will operate as a waiver of that or any other right. A waiver or consent given by either Party on any one occasion is effective only in that instance and will not be construed as a bar to or waiver of any right on any other occasion or a waiver of any other condition of performance under this MOU.

12. EXECUTION

IN WITNESS WHEREOF, the Parties have executed this Memorandum of Understanding as of the Agreement Date.

TRI-CITY MENTAL HEALTH AUTHORITY

By:_____
Ontson Placide, Executive Director

Attest:

By:_____
Micaela P. Olmos
JPA Administrator/Clerk

Approved as to Form
RICHARDS WATSON & GERSHON

By:_____
Steven L. Flower, General Counsel

CITY OF CLAREMONT

By: _____
Adam Pirrie, City Manager

Attest:

By: _____
Shelley Desautels
City Clerk

Approved as to Form:
RUTAN & TUCKER, LLP

By: _____
Alisha Patterson, City Attorney

EXHIBIT A

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT ("**BAA**") is made as of this ___ day of _____, 2026 (the "**Effective Date**") by and between TRI-CITY MENTAL HEALTH AUTHORITY, a Covered Entity ("**Covered Entity**" or "**CE**") and CITY OF CLAREMONT ("**Business Associate**" or "**BA**") (each a "**Party**" and, collectively, the "**Parties**").

RECITALS

A. CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain consumer medical information.

B. Pursuant to the terms of one or more agreements between the Parties, whether oral or in writing, (collectively, the "**Agreement**"), BA shall provide certain services to CE. To facilitate BA's provision of such services, CE wishes to disclose certain information to BA, some of which may constitute Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation state patient privacy laws (including the Lanterman-Petris-Short Act), as such laws may be amended from time to time. This BAA shall be governed by and construed in accordance with the laws of the State of California.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

I. Definitions.

A. Breach shall have the meaning given to such term under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

B. Business Associate shall have the meaning given to such term under 42 U.S.C. § 17921 and 45 C.F.R. § 16.103.

C. Consumer is an individual who is requesting or receiving mental health services

and/or has received services in the past. Any consumer certified as eligible under the Medi-Cal program according to Title 22, Section 51001 is also known as a beneficiary.

D. **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

E. **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

F. **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

G. **Electronic Protected Health Information** or **EPHI** means Protected Health Information that is maintained in or transmitted by electronic media.

H. **Electronic Health Record** shall have the meaning given to such term under 42 U.S.C. § 17921(5).

I. **Health Care Operations** shall have the meaning given to such term under 45 C.F.R. § 164.501.

J. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

K. **Protected Health Information** or **PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under 45 C.F.R. § 160.103. Protected Health Information includes Electronic Protected Health Information.

L. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

M. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

N. **Subcontractor** shall mean a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

O. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

II. Obligations of Business Associate.

A. Permitted Access, Use or Disclosure. BA shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the Agreement, this BAA, or as required by law, including but not limited to the Privacy Rule. To the extent that BA carries out CE's obligations under the Privacy Rule, BA shall comply with the requirements of the Privacy Rule that apply to CE in the performance of such obligations. Except as otherwise limited in the Agreement, this BAA, or the Privacy Rule or Security Rule, BA may access, use, or disclose PHI (i) to perform its services as specified in the Agreement; and (ii) for the proper administration of BA, provided that such access, use, or disclosure would not violate HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law if done or maintained by CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) agreement from such third party to promptly notify BA of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

B. Prohibited Uses and Disclosures. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of the HITECH Act, the HIPAA Regulations, and applicable state law, including but not limited to 42 U.S.C. § 17936, 45 C.F.R. § 164.508, and 45 C.F.R. § 164.514(f); (ii) BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); 45 C.F.R. § 164.522(a); (iii) BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); 45 C.F.R. § 164.502(a)(5); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

C. Appropriate Safeguards. BA shall comply, where applicable, with the HIPAA Security Rule, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements set forth in 45 C.F.R. § 164.316, and shall implement appropriate safeguards designed to prevent the access, use or disclosure of Protected Information other than as permitted by the Agreement or this BAA. BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

D. Reporting of Improper Access, Use, or Disclosure.

1. Generally. BA shall provide an initial telephone report to CE's Compliance Contact within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized access, use, or disclosure of PHI of which BA becomes aware and/or any actual or suspected access, use, or disclosure of data in violation of the Agreement, this BAA, or any applicable federal or state laws or regulations, including, for the avoidance of doubt, any

Security Incident (as defined in 45 C.F.R. § 164.304). BA shall take (i) prompt corrective action to cure any deficiencies in its policies and procedures that may have led to the incident, and (ii) any action pertaining to such unauthorized access, use, or disclosure required of BA by applicable federal and state laws and regulations.

2. Breaches of Unsecured PHI. Without limiting the generality of the reporting requirements set forth in Section D(1), BA shall report to CE any use or disclosure of the information not permitted by this BAA, including any Breach of Unsecured PHI pursuant to 45 C.F.R. § 164.410. Following the discovery of any Breach of Unsecured PHI, BA shall notify CE in writing of such Breach without unreasonable delay and in no case later than three (3) days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what the BA has done or is doing to investigate the Breach and to mitigate harm to the individuals impacted by the Breach; (v) any other available information that CE is required to include in notification to the individual under 45 C.F.R. § 164.404.

3. Mitigation. BA shall establish and maintain safeguards to mitigate, to the extent practicable, any deleterious effects known to BA of any unauthorized or unlawful access or use or disclosure of PHI not authorized by the Agreement, this BAA, or applicable federal or state laws or regulations; provided, however, that such mitigation efforts by BA shall not require BA to bear the costs of notifying individuals impacted by such unauthorized or unlawful access, use, or disclosure of PHI, unless (i) otherwise agreed in writing by the Parties, (2) BA bears responsibility for the unauthorized or unlawful access or use or disclosure of PHI, or (3) required by applicable federal or state laws or regulations; provided, further, however, that BA shall remain fully responsible for all aspects of its reporting duties to CE under Section D(1) and Section D(2).

E. Business Associate's Subcontractors and Agents. BA shall ensure that any agents or Subcontractors to whom it provides Protected Information agree to the same restrictions and conditions that apply to BA with respect to such PHI. To the extent that BA creates, maintains, receives or transmits EPHI on behalf of the CE, BA shall ensure that any of BA's agents or Subcontractors to whom it provides Protected Information agree to implement the safeguards required by Section C above with respect to such EPHI.

F. Access to Protected Information. To the extent BA maintains a Designated Record Set on behalf of the CE, BA shall make Protected Information maintained by BA or its agents or Subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

G. Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from the CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or Subcontractors shall make PHI available to CE so that CE may make any amendments that CE directs or agrees to in accordance with the Privacy Rule.

H. Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or Subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or Subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for three (3) years prior to the request, and only to the extent BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include, to the extent known to BA: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting Party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or Party requesting the accounting a reasonable cost-based fee in responding to the request, to the extent permitted by applicable law, so long as BA informs the individual or requesting Party in advance of the fee and the individual or requesting Party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting Party for an accounting of disclosures. The provisions of this Section H shall survive the termination of this BAA.

I. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining BA's compliance with the Privacy Rule. BA shall immediately notify CE of any requests made by the Secretary and provide CE with copies of any documents produced in response to such request.

J. Minimum Necessary. BA (and its agents or Subcontractors) shall request, use, and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary." Notwithstanding the foregoing, BA must limit its (and its agents or Subcontractors) uses and disclosures of Protected Information to be consistent with CE's minimum necessary policies and procedures as furnished to BA.

K. Permissible Requests by Covered Entity. CE shall not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA or the HITECH Act if done by CE or BA. CE shall not direct BA to act in a manner that would not be compliant with the Security Rule, the Privacy Rule, or the HITECH Act.

L. Breach Pattern or Practice. If CE knows of a pattern of activity or practice of the BA that constitutes a material breach or violation of BA's obligations under this BAA or other arrangement, CE must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, CE must terminate the applicable Agreement to which the breach and/or violation relates if feasible. If BA knows of a pattern of activity or practice of an agent or Subcontractor that constitutes a material breach or violation of the agent or Subcontractor's obligations under its BAA or other arrangement with BA, BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, BA must terminate the applicable agreement to which the breach and/or violation relates if feasible.

III. Indemnification; Limitation of Liability. To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of BA or its agents, Subcontractors or employees in connection with the representations, duties and obligations of BA under this Agreement. To the extent permitted by law, CE shall indemnify, defend and hold harmless BA from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of CE or its agents, Subcontractors or employees in connection with the representations, duties and obligations of CE under this Agreement. Any limitation of liability contained in the applicable Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of this BAA.

IV. Business Associate's Insurance. BA shall obtain insurance, including self-insurance or participation in an insurance pool, for itself and all its employees, agents and independent contractors in an amount not less than Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Commercial General Liability insurance, and One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. If the general liability or the errors and omissions insurance do not cover, among other things, Breaches, Business Associate should also carry One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Cyber/Privacy insurance that covers, among other things, Breaches. BA may satisfy its insurance requirements through self-insurance or participation in an insurance pool providing equivalent coverage. BA shall provide CE with certificates of insurance or other written evidence of the insurance policy, policies, or self-insurance required herein prior to execution of this BAA (or as shortly thereafter as is practicable) and as of each annual renewal of such insurance policies during the period of such coverage. Further, in the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, BA shall give written notice thereof to CE not more than ten (10) days following BA's receipt of such notification. If BA fails to procure, maintain or pay for the insurance required under this section, CE shall have the right, but not the obligation, to obtain such insurance. In such event, BA shall promptly reimburse CE for the cost thereof upon written request, and failure to repay the same upon demand by CE shall constitute a material breach of this BAA.

V. Term and Termination.

A. Term. The term of this BAA shall be effective as of the Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

B. Termination.

1. Material Breach by BA. Upon any material breach of this BAA by either Party, the non-breaching Party shall provide the breaching Party with written notice of such breach and such breach shall be cured by the breaching Party within thirty (30) business days of such notice. If such breach is not cured within such time period, the non-breaching Party may immediately terminate this BAA and the applicable Agreement.

2. Effect of Termination. Upon termination of any of the agreements comprising the Agreement for any reason, BA shall, if feasible, return or destroy all PHI relating to such agreements that BA or its agents or Subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, BA shall continue to extend the protections of this BAA to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

VI. Assistance in Litigation. BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreements or this BAA available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its shareholders, directors, officers, agents or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse Party.

VII. Compliance with State Law. Nothing in this BAA shall be construed to require BA to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

VIII. Compliance with 42 C.F.R. Part 2. CE is also subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 C.F.R. Part 2, which requires certain programs to enter into contracts with qualified service organizations (as defined in 42 C.F.R. § 2.11) that may have access to certain patient medical information. BA acknowledges that in receiving, storing, processing, or otherwise dealing with any Records (as defined in 42 C.F.R. Part 2) from CE, BA is fully bound by 42 C.F.R. Part 2. BA agrees to resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 C.F.R. Part 2. To the extent any provisions of 42 C.F.R. Part 2 restricting disclosure of Records are more protective of privacy rights than the provisions of this BAA, HIPAA, the HITECH Act, or other applicable laws, 42 C.F.R. Part 2 controls.

IX. Amendment to Comply with Law. Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE

shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either Party, the other Party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the applicable Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this Section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its reasonable discretion, deems sufficient to satisfy the standards and requirements of applicable laws, within thirty (30) days following receipt of a written request for such amendment from CE.

X. No Third-Party Beneficiaries. Nothing express or implied in the Agreement or this BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

XI. Notices. All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to CE:	Tri-City Mental Health Authority 1717 N. Indian Hill Blvd., Suite B Claremont, CA 91711 Attn: Privacy Officer
With a copy to:	Hooper, Lundy & Bookman, P.C. 1875 Century Park East, Suite 1600 Los Angeles, CA 90067 Attn: Linda Kollar, Esq. Fax: 310-551-8181
If to BA:	City of Claremont 207 Harvard Avenue Claremont, CA 91711 Attn: City Manager
With a copy to:	Rutan and Tucker 18575 Jamboree Rd., 9th Floor Irvine , CA 92612 Attn: Alisha Patterson

or to such other persons or places as either Party may from time to time designate by written notice to the other.

XII. Interpretation. The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

XIII. Entire Agreement of the Parties. This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the Parties and constitutes the final and entire agreement between the Parties hereto with respect to the subject matter hereof. Each Party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either Party, or by anyone acting on behalf of either Party, which are not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

XIV. Regulatory References. A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

XV. Counterparts. This BAA may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties hereto have duly executed this BAA as of the BAA Effective Date.

AGREED AND ACCEPTED:

TRI-CITY MENTAL HEALTH AUTHORITY	CITY OF CLAREMONT
Name of Covered Entity	**Name of Business Associate**
Authorized Signature	**Authorized Signature**
ONTSON PLACIDE	ADAM PIRRIE
Print Name	**Print Name**
EXECUTIVE DIRECTOR	CITY MANAGER
Print Title	**Print Title**
Date	**Date**

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson, Placide, LMFT, Executive Director**

SUBJECT: **Consideration of Resolution No. 852 Approving the California Department of Health Care Services (DHCS) Behavioral Health Services Act (BHSA) Performance Contract No. 26-60076 Effective July 1, 2026; and Authorizing the Executive Director to Execute the Contract**

Summary:

The California Department of Health Care Services (DHCS) administers and oversees multiple state and federal behavioral health funding programs, including those authorized under the Behavioral Health Services Act (BHSA), the Lanterman-Petris-Short (LPS) Act, Projects for Assistance in Transition from Homelessness (PATH), the Community Mental Health Services Block Grant (MHBG), the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), the Crisis Counseling Assistance and Training Program (CCP), and community mental health services pursuant to the Bronzan-McCorquodale Act.

DHCS requires each county mental health authority to enter an annual County Performance Contract that establishes the conditions, requirements, and compliance obligations necessary to receive and maintain funding for these programs, as authorized under Welfare and Institutions Code sections 5650(a), 5651, and 5897.

As a Joint Powers Authority recognized by the State, Tri-City Mental Health Authority contracts directly with DHCS and is subject to all statutory, regulatory, fiscal, and performance requirements outlined in the DHCS County Performance Contract. The proposed BHSA Performance Contract is a three-year agreement covering the period from July 1, 2026 through June 30, 2029, and through the execution of this agreement, Tri-City affirms compliance with all applicable state and federal requirements governing BHSA and related behavioral health funding, ensuring continued eligibility, accountability, and alignment with statewide behavioral health policy and oversight expectations.

Background:

Tri-City Mental Health Authority has operated Mental Health Services Act (MHSA)-funded programs since the inception of MHSA in the State of California and has long contracted

directly with the California Department of Health Care Services (DHCS) as a recognized Joint Powers Authority serving Claremont, La Verne, and Pomona.
Through these contracts, Tri-City has administered and delivered a comprehensive continuum of public mental health services in compliance with state and federal requirements.

Pursuant to the enactment of Proposition 1, MHSA is now transitioning to the Behavioral Health Services Act (BHSA), resulting in a restructuring of planning, reporting, and accountability requirements statewide. The new DHCS Performance Contract reflects this transformation from MHSA to BHSA. While the overall behavioral health funding source remains substantially the same, BHSA reorganizes funding into three primary funding categories, replacing the previous five MHSA program components. This change represents a structural and policy-driven reorganization rather than a reduction in Tri-City's role or responsibility as a direct contractor with DHCS.

Execution of the DHCS BHSA Performance Contract ensures Tri-City's continued authority to receive and administer behavioral health funding, aligns the agency with updated statutory requirements, and supports the ongoing delivery of essential mental health and substance use disorder services under the BHSA framework.

Fiscal Impact:

Execution of the new DHCS BHSA Performance Contract does not change the total amount of funding received by Tri-City Mental Health Authority; therefore, the overall funding level remains unchanged. However, due to the transition from MHSA to BHSA, funding categories have been restructured and redistributed, resulting in significant shifts in service expectations, activity types, and delivery models. While the total funding allocation is maintained, these categorical changes may impact Tri-City's ability to fully utilize funds as designed without corresponding adjustments to program operations and service mix.

The BHSA Integrated Plan serves as the foundational planning and design document that outlines the programmatic approach, service delivery strategies, and associated budget allocations under the new funding framework. This Integrated Plan, including the related budgeting assumptions, has will be presented to the Governing Board for approval and subsequently submitted to DHCS for final approval and implementation. The potential financial risks, compliance considerations, and opportunities associated with the BHSA funding structure are detailed within the Integrated Plan, which provides the primary mechanism for monitoring fiscal alignment and performance under the new contract.

Recommendation:

It is recommended that the Governing Board adopt Resolution No. 852 approving Performance Contract No. 26-60076 with the California Department of Health Care Services BHSA, effective July 1, 2026, and authorizing the Executive Director to execute the contract and any amendments thereafter. Approval of this contract is required by DHCS for all counties and Joint Powers Authorities no later than April 30, 2026 to continue receipt of behavioral health funding necessary to operate mandated and essential services.

While Tri-City Mental Health Authority will continue to identify and raise concerns regarding certain provisions of the contract that may be conflictual, unclear, or inconsistent with existing statutory or programmatic requirements, execution of the contract is necessary to maintain ongoing operations and funding continuity. Tri-City will continue to engage in active dialogue and advocacy with DHCS, both independently and in coordination with statewide partners, to seek clarification and refinement of specific legal, fiscal, and programmatic language as implementation proceeds.

Adoption of the contract currently ensures uninterrupted funding, preserves TCMHA's status as a direct contractor with DHCS, and allows continued participation in the BHSA framework while pursuing necessary clarifications and improvements through established state processes.

Attachments:

Attachment 10-A: Resolution No. 852 - Draft

Attachment 10-B: CA Dept of Health Care Services (DHCS) Behavioral Health Services Act (BHSA) Performance Contract No. 26-60076 with Tri-City Mental Health Authority

RESOLUTION NO. 852

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY APPROVING THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS) BEHAVIORAL HEALTH SERVICES ACT (BHSA) PERFORMANCE CONTRACT NO. 26-60076 EFFECTIVE JULY 1, 2026; AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE CONTRACT AND ANY AMENDMENTS THEREAFTER

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to enter into and execute Performance Contract No. 26-60076 with the California Department of Health Care Services (DHCS) Behavioral Health Services Act (BHSA), as required by Welfare and Institutions Code (W&I) sections 5650(a), 5651, and 5897.

B. The DHCS administers the Behavioral Health Services Act, Lanterman-Petris-Short (LPS) Act, Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), and Crisis Counseling Assistance and Training Program (CCP), and oversees county provision of community mental health services pursuant to the Bronzan-McCorquodale Act.

2. Action

The Governing Board approves Performance Contract No. 26-60076 with the California Department of Health Care Services (DHCS) Behavioral Health Services Act (BHSA), in substantially the same form as presented at its meeting on April 15, 2025, and authorizes the Authority's Executive Director to enter into and execute the contract effective July 1, 2026 through June 30, 2029, and any Amendments or extensions of such Contract.

[Continued on page 2]

DRAFT

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 15, 2026, by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

DRAFT

SCO ID: 4260-2660076

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
26-60076	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
Department of Health Care Services

CONTRACTOR NAME
Tri-City Mental Health Authority

2. The term of this Agreement is:

START DATE
July 1, 2026

THROUGH END DATE
June 30, 2029

3. The maximum amount of this Agreement is:
$0 (Zero Dollars)

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of the Agreement.

Exhibits	Title	Pages
Exhibit A	Scope of Work	4
Exhibit A, Attachment I	Behavioral Health Services Act	34
Exhibit A, Attachment II	Additional Terms and Conditions	6
Exhibit A, Attachment III	Request for Waiver	1
Exhibit B	Budget Detail Provisions	1
Exhibit C *	General Terms and Conditions (GTC 02/2025)	Online
Exhibit D	Special Terms and Conditions	40
Exhibit E	Additional Provisions	5
Exhibit F	Business Associate Addendum (HIPAA)	6

Items shown with an asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at https://www.dgs.ca.gov/OLS/Resources

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
Tri-City Mental Health Authority

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
1717 N. Indian Hill Blvd. Suite B	Claremont	CA	91711

PRINTED NAME OF PERSON SIGNING	TITLE

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

ATTACHMENT 10-B

SCO ID: 4260-2660076

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
26-60076	

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME			
Department of Health Care Services			
CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
1501 Capitol Avenue, MS 4200	Sacramento	CA	95814
PRINTED NAME OF PERSON SIGNING	TITLE		
CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED		
CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable) Exempt per Budget Act 2025, Assembly Bill 227, Item 4260-116-0890; Welfare and Institution Code, Sections 5402(i), 5706, and 5814(g).		

Exhibit A
SCOPE OF WORK

I. Service Overview

The California Department of Health Care Services (hereafter referred to as DHCS) administers the Behavioral Health Services Act, Lanterman-Petris-Short (LPS) Act, Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), and Crisis Counseling Assistance and Training Program (CCP), and oversees county provision of community mental health services pursuant to the Bronzan-McCorquodale Act.

Contractor (hereafter referred to as County) must meet certain conditions and requirements to receive funding for these programs and services, as set forth in this County Performance Contract (hereafter referred to as the Contract or Agreement), as required by Welfare and Institutions Code (W&I) sections 5650(a), 5651, and 5897. County agrees to comply with all of the conditions and requirements described herein.

DHCS will monitor this Contract to ensure compliance with applicable federal and State law and applicable regulations. (California Government Code (GC), §§ 11180-11182; W&I §§ 5614, 5717(b), 5651(b)(10), 5897(d), 5963.04, 14124.2(a), and 14197.7.)

County must submit all deliverables required in this Contract in the schedule, form, and manner specified by DHCS.

II. Service Location

The services must be performed at the Contractor's work site unless specified via writing to the DHCS Contract Manager.

III. Service Hours

The services must be provided during the Contractor's normal working hours, 8:00AM – 5:00PM, Monday through Friday, unless specified via writing to the DHCS Contract Manager.

IV. Contract Representatives

A. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**Tri-City Mental Health Authority**
Contract Manager: Waheeda Sabah Telephone: 916-345-7462 Email: waheeda.sabah@dhcs.ca.gov	Ontson Placide, Executive Director Telephone: (909) 762-7861 Fax: (909) 623-4073 Email: oplacide@tricitymhs.org

B. Direct all inquiries to:

Department of Health Care Services	**Tri-City Mental Health Authority**
Behavioral Health – Community Services Division/Federal Grants Branch Attention: Waheeda Sabah 1501 Capitol Avenue P.O. Box Number 997413, Mail Stop 2624 Sacramento, CA 95899-7413 Telephone: (916) 345-7462 Email: waheeda.sabah@dhcs.ca.gov	Attention: Ontson Placide 1717 N. Indian Hill Blvd., Suite B Claremont, CA 91711 Telephone: (909) 762-7861 Fax: (909) 623-4073 Email: oplacide@tricitymhs.org

C. Either party may make changes to the information in provision 4 of this Exhibit A by giving written notice to the other party. Said changes will not require an amendment to this Contract.

V. General Requirements for Agreement

W&I section 5651(b) sets forth specific assurances that must be incorporated into this Contract. County must:

A. Comply with the expenditure requirements of W&I section 17608.05;

B. Provide services to persons receiving involuntary treatment as required by the LPS Act (commencing with W&I section 5000) and the Children's Civil Commitment and Mental Health Treatment Act of 1988 (commencing with W&I section 5585);

C. Comply with all of the requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 of the Bronzan-McCorquodale Act (commencing with W&I section 5700) , and submit cost reports and other data to DHCS in the form and manner determined by DHCS;

D. Ensure that the Behavioral Health Advisory Board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to W&I section 5604.2;

E. Comply with all provisions and requirements in law pertaining to patient rights;

F. Comply with all requirements in federal law and regulation, and all agreements, certifications, assurances, and policy letters, pertaining to federally funded mental/behavioral health programs, including, but not limited to, the PATH, MHBG, and SUBG programs;

G. Provide all data and information set forth in W&I sections 5610 and 5664 ;

H. If County elects to provide the services described in Chapter 2.5 of the Bronzan-McCorquodale Act (commencing with W&I section 5670), comply with guidelines established for program initiatives outlined in this chapter; and

I. Comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Behavioral Health Services Act.

VI. County Behavioral Health Director

A. County must comply with the organizational requirements of W&I sections 5604 (Behavioral Health Board), 5607, and 5608 (County Behavioral Health Director).

B. County agrees to notify DHCS immediately if there is any change in the position of the County Behavioral Health Director. County must provide DHCS the contact information for any new County Behavioral Health Director appointed.

VII. Americans with Disabilities Act

County agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 as amended (29 United States Code (USC) § 794d), the Americans with Disabilities Act of 1990 (42 USC § 12101 *et seq.*), and the implementing regulations, including 36 Code of Federal Regulations (CFR) Part 1194 and 28 CFR Part 36, as applicable. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California GC section 7405 codifies section 508 of the Rehabilitation Act of 1973 and its implementing regulations requiring accessibility of electronic and information technology.

VIII. Executive Order N-6-22 – Russia Sanctions

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. “Economic Sanctions” refers to sanctions imposed by the U.S. government in response to Russia’s actions in Ukraine, as well as any sanctions imposed under State law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should the State determine County is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that will be grounds for termination of this Contract. The State must provide County advance written notice of such termination, allowing County at least 30 calendar days to provide a written response. Termination will be at the sole discretion of the State.

IX. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neutral genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Exhibit A, Attachment I

Table of Contents

1.0 Behavioral Health Services Act

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1.2 Integrated Plan, Annual Updates, and Intermittent Updates
1.3 Behavioral Health Outcomes, Accountability, and Transparency Report
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1.10 BHSA Oversight and Enforcement

2.0 Additional State and Federal Programs

2.1 Bronzan-McCorquodale Act
2.2 Lanterman-Petris-Short Act
2.3 Laura's Law
2.4 Projects For Assistance In Transition From Homelessness Program
2.5 Community Mental Health Services Block Grant
2.6 Substance Use Prevention, Treatment, and Recovery Services Block Grant
2.7 Crisis Counseling Assistance and Training Program

1.0 Behavioral Health Services Act

This Article enumerates key County requirements for implementing the Behavioral Health Services Act (BHSA). These requirements are set forth in greater detail in the BHSA County Policy Manual and other applicable DHCS guidance. This Article is executed pursuant to Welfare and Institutions Code (W&I) section 5897.

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The primary goals of the BHSA are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California.

This Article details County's obligations under the BHSA, including reporting requirements, fiscal policies, and programmatic requirements for BHSA-funded Behavioral Health Services and Supports (BHSS), Housing Interventions, and Full Service Partnership (FSP) programs.

1.1 BHSA: Overview and General Requirements

1.1.1 Overview

A. County must implement the BHSA consistent with this Contract (which is executed pursuant to W&I section 5897), applicable law and regulations, the BHSA County Policy Manual (hereafter referred to as the BHSA Policy Manual), and other applicable DHCS guidance.

B. The defined terms enumerated in the BHSA Policy Manual apply to this Contract, except as otherwise provided.

C. To the extent there is a conflict between the terms of this Contract and any federal or state statute or regulation or DHCS guidance issued pursuant to W&I section 5963.05 (or other applicable bulletin authority), County must comply with the statute, regulation, or guidance, and the conflicting Contract provision will no longer be in effect.

D. Where a requirement provided or referenced herein has an effective date that differs from the effective date of this Contract, County is required to comply with the requirement as of its applicable effective date (not the effective date of this Contract) unless DHCS guidance provides otherwise.

E. All terms and conditions set forth in the BHSA Policy Manual are hereby incorporated by reference and made a part of this Contract as if fully set forth herein.

1.1.2 Eligible and Priority Populations

County must comply with BHSA requirements concerning eligibility for and prioritization of services, as described in BHSA Policy Manual section 2.B.3 and any other applicable DHCS guidance.

A. Eligible Populations

1) County must limit BHSA services to eligible children and youth and eligible adults and older adults, as defined in W&I section 5892(k). BHSA eligible populations are not required to be enrolled in the Medi-Cal program. (W&I § 5892(k)(7)-(8).)

B. Priority Populations

1) County must prioritize BHSA services to the populations enumerated in W&I section 5892(d).

2) County is permitted to offer BHSA services to eligible individuals outside these priority populations.

1.2 Integrated Plan, Annual Updates, and Intermittent Updates

County must develop and submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes and Annual Updates as described in this section. Counties may submit intermittent updates as needed at any time during the IP cycle consistent with BHSA Policy Manual section 3, and any other applicable DHCS guidance. (W&I §§ 5963–5963.03.)

1.2.1 IP Purpose & Contents

A. Using the IP and budget templates developed by DHCS, County must comply with the requirements in this section and the BHSA Policy Manual chapter 3:

1) Describe its planned BHSA services and programming in accordance with:

a. Local data, including using local mental health and substance use disorder (SUD) prevalence data, unmet behavioral health treatment needs data, as well as identifying local health disparities, homelessness point-in-time counts and considering community health improvement plans (W&I § 5963.02(b)(2), (b)(4)); and

b. Statewide behavioral health goals and performance measures as described in BHSA Policy Manual section 3.E.6 (W&I § 5963.02(c)(3); BHSA Policy Manual §§ 2.C, 3.D);

2) Report County's planned activities and projected expenditures for all County Behavioral Health System services within the Behavioral Health Care Continuum for all funding sources (W&I § 5963.02(c)(1-2); BHSA Policy Manual § 3.C); and

3) Ensure County Board of Supervisors approves the IP and certifies that County will meet its realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth W&I section 14197 without utilizing waitlists. (W&I §§ 5963.02(a), (c), 14197; 14197.71(c)(2).)

B. Joint IP Submissions

1) Counties submitting a joint IP must comply with the requirements in this subsection and the BHSA Policy Manual section 3.E.5. A joint IP means an IP that covers:

a. Two or more county behavioral health departments; or

b. One or more city-operated programs or departments acting jointly with another city-operated program or department or county behavioral health department.

2) Special circumstances for joint IPs

a. Counties that submitted joint three-year plans under the MHSA may continue to submit joint IPs under BHSA.

b. The two city-operated mental health authorities receiving funds pursuant to W&I section 5701.5 must submit IPs independently from their counties under BHSA.

c. Counties with separate mental health and substance use disorder departments must collaborate on development on the IP and submit one joint IP to their County Board of Supervisors.

3) Counties must ensure joint IP is (BHSA Policy Manual § 3.E.5.3):

a. Approved by the Board of Supervisors for each county represented in the joint IP or other local governing body prior to submission to the Behavioral health Services Oversight and Accountability Commission and DHCS; and

b. Includes certification from the joint entity's behavioral health director as described in subsection 1.2.7.D. of this Attachment I.

1.2.2 IP Submission

A. County must submit a draft IP no later than March 31 and final IP no later than June 30 to DHCS the fiscal year prior to the effective date of the IP in accordance with BHSA Policy Manual sections 3.A.1 and 3.E.

1) If County fails to submit a complete draft or final IP by the required deadlines, County will be out of compliance and may be subject to corrective action. (BHSA Policy Manual § 3.E.4.)

2) County must submit draft and final IPs through the DHCS' web-based county portal. (BHSA Policy Manual §§ 3.A, 3.E.4.1.)

a. If DHCS requires County to revise the IP, County will have 15 calendar days from the revision notice to address the issues raised by DHCS and resubmit the IP through the county portal. IPs are effective beginning July 1 of the fiscal year the IP covers. DHCS will post County's IP on DHCS' website. (BHSA Policy Manual § 3.E.4.2.)

1.2.3 Exemptions Submissions & Approval

A. If County seeks an exemption (as described in subsections 1.7.4 (FSP) and 1.8.2 (Housing Interventions) of this Attachment I), County must comply with the requirements in this subsection 1.2.3 and in BHSA Policy Manual section 3.E.3.

B. County must submit any exemption requests as part of the draft IP, as outlined in subsection 1.2.2, above. To determine local priorities and make the exemption requests responsive to local needs, counties must begin their community planning process, as described in subsection 1.2.6 of this Attachment I, prior to submitting a draft IP with an exemption request. (BHSA Policy Manual § 3.E.3.2.)

C. DHCS must approve or deny County's exemption request 30 calendar days from receipt of the request. If DHCS does not respond within 30 calendar days, the exemption request will be considered approved. (BHSA Policy Manual § 3.E.3.4.)

D. If DHCS denies County's exemption request, County may appeal the denial within 30 calendar days of receiving DHCS' denial as described in BHSA Policy Manual section 3.E.3.5.

E. An approved exemption will only be valid for the duration of the three-year plan. For each subsequent three-year plan submission, County must submit an updated exemption request for DHCS approval. (BHSA Policy Manual § 3.E.3.2.)

1.2.4 Funding Allocation Percentage Changes

A. Approved funding allocation percentage changes are final and cannot be adjusted again for the duration of the three-year plan, unless an annual change is approved by DHCS due to a state or local emergency. To be granted an annual change, County must demonstrate to DHCS that (BHSA Policy Manual § 6.B.5.1):

1) It is experiencing a state (Government Code (GC), § 8625) or local (GC § 8630) emergency, and

2) The change is necessary because of the emergency.

B. County may only request an annual change in funding allocation percentages for previously approved funding allocation percentage changes. (W&I § 5892(c)(4)(C).)

C. County must submit the funding allocation percentage change request in the county portal.

1.2.5 Annual Updates and Intermittent Updates

A. County must submit annual updates to the IP in the second and third years of the IP cycle. (W&I § 5963.02(a); BHSA Policy Manual § 3.A.3.)

B. County may prepare intermittent updates to the IP at any time during the IP cycle, although County must notify DHCS prior to submitting intermittent updates. (BHSA Policy Manual § 3.A.3.)

C. County must include a summary and justification of the changes made by the annual updates and intermittent updates for a 30-day comment period prior to the effective date of the updates. (W&I § 5963.03(c)(2)(B); BHSA Policy Manual § 3.A.3.)

D. Annual updates and intermittent updates are not subject to the stakeholder engagement requirements outlined in subsection 1.2.6 of this Attachment I. (W&I § 5963.03(a).) However (BHSA Policy Manual § 3.A.3):

   1) DHCS encourages stakeholder engagement; and

   2) If County chooses to elicit local stakeholder engagement in developing annual updates or intermittent updates, County must comply with the local behavioral health public hearing requirements outlined in subsection 1.2.7 of this Attachment I. (W&I § 5963.03(b)(1).)

E. Submission and DHCS Review

   1) County must submit annual updates and intermittent updates using the DHCS' templates and web-based portal.

   2) Annual updates and intermittent updates are subject to the same process for submission and DHCS review as the IP, as described above in subsection 1.2.1 of this Attachment I.

1.2.6 Community Planning Process

A. In developing the IP, County must conduct the following Community Planning Process activities (W&I § 5963.03(a); BHSA Policy Manual § 3.B):

   1) Engage local stakeholders in developing each element of the IP, as described in BHSA Policy Manual section 3.B.1 (W&I § 5963.02(b)); and

   2) Collaborate and engage with Medi-Cal Managed Care Plans (MCPs) and Local Health Jurisdictions (LHJs) as described in BHSA Policy Manual section 3.B.2, including by:

a. Working with its LHJ on the development of the Community Health Improvement Plan (CHIP) (W&I § 5963.01(b));

b. Considering the CHIP of each LHJ that covers residents of the County in preparing County's IP and annual update (W&I § 5963.02(b)(4));

c. Working with each MCP that covers residents of the County on the development of the MCP's Population Needs Assessment (PNA) (W&I § 5963.01(a)); and

d. Considering the PNA of each MCP that covers residents of the County in preparing County's IP and annual update. (W&I § 5963.02(b)(3).)

B. In implementing this subsection 1.2.6, County must:

1) Engage with LHJs and MCPs on Community Health Assessments (CHAs) and CHIPs through collaboration, data-sharing, and stakeholder engagement as described in BHSA Policy Manual section 3.B.2.3.

2) Refer to the statewide behavioral health goals and associated performance measures during the community planning process, as described in BHSA Policy Manual section E.6.

1.2.7 Public Comment

For each draft IP, County must comply with the public comment and update processes outlined in this section, as applicable, and the requirements specified in BHSA Policy Manual sections 3.B.3 and 3.E.2.1.2 (W&I § 5963.03(a)-(b)):

A. Provide 30 days for stakeholder comment, which may be conducted before or after County submits its draft IP to DHCS (W&I § 5963.03(a)(2)(B));

B. After the 30-day comment period, require the local behavioral health board to (W&I § 5963.03(b), (d)):

1) Review the draft plan and make recommendations to the local behavioral health agency for revisions (W&I § 5963.03(b).); and

2) Provide an annual report to the local governing body (the local Board of Supervisors or city council) and to DHCS that includes written explanations in response to any substantive recommendations made by the local behavioral health board that are not included in the final IP or annual or intermittent updates. (W&I § 5963.03(d), (b)(5).)

C. After the 30-day comment period and public hearing are complete, County must revise the IP to include (W&I § 5963.03(b)((2)-(3)):

1) A summary of substantive written recommendations; and

2) A summary and analysis of the revisions made as a result of stakeholder feedback.

D. County must receive approval from County's Board of Supervisors and certification from County's Behavioral Health Director prior to submitting the final IP. (BHSA Policy Manual § 3.E.2.1.2.)

1.2.8 County Planning Funds

A. County may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs, pursuant to the requirements set forth in subsection 1.4 of this Attachment I. (W&I § 5892(e)(1)(B)-(C); BHSA Policy Manual § 3.B.4; Behavioral Health Information Notice (BHIN) 25-016.) Eligible planning costs do not include costs incurred as administrative costs or program expenditures.

1.3 Behavioral Health Outcomes, Accountability, and Transparency Report

County must develop and submit an annual Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to DHCS, consistent with BHSA Policy Manual section 4 and any other applicable DHCS guidance. (W&I § 5963.04.)

1.3.1 BHOATR Purpose, Contents and Submission

A. Using the BHOATR and expenditure templates developed by DHCS, County must:

1) Report on behavioral health spending, service utilization, and achievement of goals and outcomes outlined for the reporting period (W&I § 5963.04(a); BHSA Policy Manual §§ 3.C, 4); and

2) Ensure County Board of Supervisors approves the BHOATR and certifies that County will meet its realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth W&I section 14197 without utilizing waitlists. (W&I § 5963.04(b)-(c), 14197.71(c)(2).)

B. County must submit the BHOATR through DHCS' web-based county portal.

C. DHCS must post County's BHOATR and an aggregated statewide BHOATR on DHCS' website. (W&I § 5964.04(d); BHSA Policy Manual § 4.A.)

1.4 BHSA Fiscal Policies

County must establish a local BHSF, appropriately allocate funding, and comply with related reporting requirements consistent with BHSA Policy Manual section 6.B and any other applicable DHCS guidance. (W&I § 5892.)

1.4.1 Allocation Methodology

A. County must establish a local BHSF for the monthly distribution of funds from the State Controller's Office. (W&I §§ 5892(g), 5891(c); BHSA Policy Manual § 6.B.1.)

B. County must establish and maintain sub-accounts for each BHSA component (Housing Intervention Programs, FSP Program, and BHSS). County is encouraged to maintain sub-accounts for each suballocation under each BHSA component, as described in BHSA Policy Manual section 6.B.1.1.

C. County must allocate and spend funds consistent with the proposed activities and projected expenditures approved in County's IP, intermittent updates, and/or annual update. (W&I § 5892(h); BHSA Policy Manual § 6.B.1.1.)

1.4.2 Local Prudent Reserve

County must (BHSA Policy Manual § 6.B.3):

A. Establish and maintain a local Prudent Reserve (PR) to ensure BHSA components are not significantly impacted during years where revenues for the BHSF are below recent averages adjusted by changes in the state population and the California Consumer Price Index, as determined by DHCS. During such periods, County may transfer funds out of the PR in accordance with this Attachment I and BHSA Policy Manual section 6.B.3. (W&I § 5892(b)(1).) County may draw down PR funds only during periods in which DHCS has determined that state-level BHSF revenues are below recent trends.

B. Assess PR funding levels at least once every three years. County must report PR assessments in the IP and must ensure each PR assessment is certified by County's Behavioral Health Director in the county portal. (W&I § 5892(b)(5).)

C. Not exceed the maximum PR levels calculated by DHCS.

D. Spend excess funds on BHSA components as outlined in subsection 1.4.1.A if County exceeds the PR allowable maximum. (W&I § 5892(b)(1), (b)(3)-(5).)

E. Not count funds placed in the PR toward its required BHSA component allocations. Counties may transfer funds from their monthly disbursement to their local PR after allocating the required amount of funds to each component. (W&I § 5892.)

F. Report all PR transfers and expenditures in the BHOATR.

1.4.3 Funding Component Allowances

County must comply with the following funding allocation and suballocation requirements, unless County receives approval for a funding transfer (in accordance with subsection 1.4.4, below) or exemption (in accordance with subsections 1.7.4 (FSP) and 1.8.2 (Housing), below). (W&I § 5892(a); BHSA Policy Manual § 6.B.5.)

A. County must allocate funding for BHSA components and suballocations according to the following requirements:

1) Thirty percent for Housing Intervention Programs. Within this thirty percent (W&I § 5892(a)(1)(A)):

a. A minimum of fifty percent must be spent on housing interventions for persons who are chronically homeless with a focus on those in encampments; and

b. A maximum of twenty-five percent may be spent on Capital Development Projects.

2) Thirty-five percent for the FSP Program (W&I § 5892(a)(2)(A)); and

3) Thirty-five percent for BHSS, including (W&I § 5892(a)(3)(A), (a)(3)(B)(i)-(ii)):

a. A minimum of fifty-one percent exclusively for early intervention programs, of which at least fifty-one percent must be used to serve individuals 25 years of age and younger. Services provided as part of an early intervention evidence-based practices (EBPs) or community-defined evidence-based practices (CDEPs) that supports parents and caregivers may count towards the percentage to be used to service individuals 25 years of age and younger when they are provided for the benefit of that child/youth. (BHSA Policy Manual § 7.A.7.)

1.4.4 Funding Transfer Requests

County may request permission from DHCS to change required funding allocation percentages by transferring BHSA funds between BHSA components, in accordance with BHSA Policy Manual section 6.B.4. (W&I § 5892(c).)

A. County's approved funds transfers between BHSA components are final and cannot be adjusted for the three-year duration of the IP, unless an annual change is approved by DHCS due to a state or local emergency pursuant to W&I section 5892(c)(4)(C).

   1) County may modify its budgeted projected expenditures for the suballocations within a component without advance DHCS approval as part of an annual or intermittent update, in accordance with subsection 1.2.5.E, above. However, County must continue to abide by the suballocation requirements described in subsection 1.4.3, above.

B. County must report approved transfers and updated BHSA allocations on the BHOATR, consistent with the transfers and exemptions approved as part of the IP. (W&I § 5963.04(a).)

C. Transferring funds between BHSA components, pursuant to an approved funding transfer request under this subsection 1.4.4, does not reset or extend the original reversion period. All transferred funds remain subject to the same reversion period that applied based on the fiscal year in which the funds were originally allocated.

D. County's funding transfer requests are not exempt from:

   1) Suballocation requirements or any other additional applicable laws, including as described in subsection 1.4.3 of this Attachment I (W&I § 5892(c)(2));

   2) Local stakeholder consultation requirements (W&I § 5892(c)(3)); and

   3) Reversion requirements, including the reversion period associated with the funds prior to the transfer. (W&I § 5892(i).)

E. County must submit transfer requests to DHCS prior to or at the same time as County's IP submission using DHCS' web-based county portal and must report all approved transfer requests on the IP. (W&I § 5892(c)(4).) Transfer requests must be approved by DHCS prior to the beginning of the fiscal year in which the requested changes would take effect.

1.4.5 Reversion Policy

County must spend BHSA funds allocated to BHSA components within three years for large counties, or within five years for small counties, as described in

BHSA Policy Manual section 6.B.6.2. Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) funds must be spent within ten years, regardless of county size. (BHSA Policy Manual § 6.B.6.)

A. For purposes of this Attachment I, a small county is defined as a county with a population of less than 200,000, and a large county is defined as a county with a population of 200,000 or more.

B. Any BHSA funds remaining after the reversion period must revert to the State. DHCS will offset the amount of reverted funds from the County's future monthly BHSA distribution. (W&I § 5892(i); BHSA Policy Manual § 6.B.6.)

C. DHCS will provide notice of funds subject to reversion. County may submit an appeal to DHCS if County disagrees with DHCS' determination of the reversion amount. For details, see BHSA Policy Manual sections B.6.5-9. (W&I § 5892.1(b)(2).)

1.4.6 Mental Health Services Act to Behavioral Health Services Act Transition

A. County must only use BHSF dollars for permissible BHSA purposes. County must not allocate BHSF funds to any of the following activities, notwithstanding that these activities represented permissible uses of funds under the MHSA (W&I § 5892(a)(1)-(3); BHSA Policy Manual § 6.B.7):

1) Community Services and Supports

2) Prevention and Early Intervention

3) Innovation (INN) funds (BHSA Policy Manual § 6.B.7.2)

a. If County has INN funds that were encumbered prior to July 1, 2026, and the INN project is operational, meaning that County has spent any funds on the INN project prior to July 1, 2026, those INN funds will remain encumbered for the duration of the FY 2026-29 IP.

b. If County's INN funds are encumbered in a previously approved INN project, but that project is not operational as of July 1, 2026, those funds will be disencumbered and may be subject to reversion.

c. County must report all INN projects, including which INN projects are operational, in the IP and expenditures in the BHOATR.

B. If County has unspent MHSA funds as of July 1, 2026, County may allocate those funds to BHSA components, subject to compliance with applicable BHSA requirements, including:

1) Allocation and suballocation requirements for each BHSA component as outlined in subsection 1.4.3 of this Attachment I;

2) BHSA component requirements as outlined in subsections 1.6, 1.7, and 1.8 of this Attachment I; and

3) Reversion requirements as outlined in subsection 1.4.5 of this Attachment I except for INN Funds.

C. County's MHSA funds for WET and CFTN must remain available for WET and CFTN expenditures within the BHSS component. (BHSA Policy Manual §§ 6.B.7.3, 6.B.7.6.)

1) MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to BHSA suballocation requirements.

2) All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN.

D. Any unspent MHSA funds transferred to the BHSF remain subject to their original revision periods. (BHSA Policy Manual §§ 6.B.7.3, 6.B.7.6.)

1.4.7 Administrative Cost Principles

County may claim reimbursement for administrative costs in accordance with BHSA Policy Manual section 6.B.8 and BHIN 25-016.

A. Administrative costs are costs that support the operations and overhead of County's behavioral health programs. Administrative costs for BHSA do not include costs incurred as planning costs (outlined in subsection 1.2.8 of this Attachment I and BHSA Policy Manual section 3.B.4) or service expenditures.

B. County may use a portion of local BHSA revenue towards direct and indirect administrative costs.

1) Administrative costs include expenses related to improving planning, quality outcomes, data reporting, and subcontract oversight for County's behavioral health programs, including programs other than BHSA. Administrative costs are capped at two percent for large counties and four percent for small counties. (W&I § 5892(e)(2)(B).)

2) Administrative costs do not include expenditures incurred as direct service costs or as planning costs related to development of the IP. Planning costs for the IP are subject to a separate five percent cap, as outlined in subsection 1.2.8 of this Attachment I. (W&I § 5892(e)(1)(B)-(C); BHSA Policy Manual § 3.B.4.)

3) Counties may submit claims for reimbursement of certain direct administrative costs in excess of these caps pertaining to preparing and submitting the IP or BHOATR, or to information technology system enhancements, as described in BHIN 25-016.

C. County must report all administrative costs in the IP and BHOATR, and must report such costs consistent with 2 Code of Federal Regulations (CFR) section 200. (W&I § 5963.04(a)(2)(F); BHSA Policy Manual § 6.B.8.1.)

D. For indirect administrative costs, County must charge indirect costs to a BHSA program through an acceptable allocation method that allocates the costs of support and administrative services to the benefiting programs, in accordance with 2 CFR part 200 and BHSA Policy Manual section 6.B.8.2.2.

1.5 Promoting Access to Care through Efficient Use of State and County Resources

1.5.1 Overview

Effective July 1, 2027, County must comply with the requirements set forth in this subsection 1.5, BHSA Policy Manual section 6.C, and any other applicable DHCS guidance. These requirements apply with respect to all BHSA-funded providers (including contracted providers as well as providers employed, owned, or operated by County) delivering a BHSA-funded service that is also covered by, as applicable (W&I § 5891(a)(2)-(3)):

A. County's Medi-Cal Behavioral Health Delivery System (BHDS) (i.e., the county's administration of Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and/or DMC Organized Delivery System (DMC- ODS) services);

B. An MCP; or

C. Commercial health insurance.

1.5.2 Medi-Cal BHDSs

For any provider receiving BHSA funding for services that are covered by County's BHDS, County must require the provider to (W&I § 5891(a)(3); BHSA Policy Manual § 6.C.2):

A. Enroll in Medi-Cal, seek SMHS and/or DMC certification, and participate in County's BHDS, as applicable;

B. For an individual receiving BHSA-funded services that are also covered by County's BHDS, check whether the individual is enrolled in Medi-Cal, and

if not, refer the individual for eligibility screening and enrollment support; and

C. Submit claims to the BHDS for all covered services for all Medi-Cal members.

1.5.3 Medi-Cal MCPs

For any provider receiving BHSA funding for services that are non-specialty mental health services (NSMHS) or SUD services covered by Medi-Cal MCPs, County must require the provider to (W&I § 5891(a)(3)-(4); BHSA Policy Manual § 6.C.2):

A. Enroll in Medi-Cal;

B. For an individual receiving BHSA-funded services that are also covered by MCPs, check whether the individual is enrolled in Medi-Cal, and if not, refer the individual for eligibility screening and enrollment support; and

C. Make a good faith effort to submit claims to MCPs for all covered services for all Medi-Cal members in accordance with each MCP's billing requirements, including obtaining prior authorization, when applicable.

1.5.4 Commercial Health Insurance

For any provider receiving BHSA funding for services that are covered by commercial health insurance, County must require provider to make a good faith effort to meet the following requirements in this subsection 1.5.4. For County-contracted providers, County will meet these requirements if it contractually requires BHSA-funded providers to take the following steps (W&I § 5891(a)(3)-(4); BHSA Policy Manual § 6.C.3):

A. Check whether individuals receiving BHSA-funded services are enrolled in a commercial health plan at the time the individuals request and receive BHSA-funded service; and if so,

B. Make a good faith effort to submit claims to commercial health plans for all covered services in accordance with each health plan's billing requirements, including obtaining prior authorization, when applicable.

C. Report complaints about commercial health plan conduct for failure to contract, enter into agreements, or timely reimburse the county for services.

1.5.5 Appropriate Use of Other Non-Behavioral Health Services Act Funds

County must not use BHSA funds to supplant existing State or County funds that have been used to provide mental health services or SUD treatment services, in accordance with W&I section 5891(a)(1)(B). (BHSA Policy Manual § 6.C.4.)

1.6 Behavioral Health Services and Supports

County must implement BHSA BHSS consistent with BHSA Policy Manual section 7.A and any other applicable DHCS guidance. (W&I § 5892, (a)(3)(A).) BHSS categories include:

1.6.1 Children's Adult, and Older Adult Systems of Care

County may use a portion of BHSS funds to provide services pursuant to W&I Division 5, Part 4 (commencing with section 5850) for the Children's System of Care and Part 3 (commencing with section 5800) for the Adult Systems of Care. Children's, Adult, and Older Adult Systems of Care services funded under BHSS may not include Housing Interventions or services for individuals enrolled in an FSP. (BHSA Policy Manual § 7.A.2.)

1.6.2 Outreach and Engagement

County may use a portion of BHSS funds for Outreach and Engagement. BHSS funds may be used for activities intended to reach, identify, and engage individuals, families, and communities in the behavioral health system and reduce disparities. (BHSA Policy Manual § 7.A.3.)

1.6.3 WET

A. County may use a portion of BHSS funds for County-operated and County-contracted behavioral health workforce recruitment, development, training, and retention activities. BHSS funds for WET activities must be spent within ten years, after which unspent funds will be subject to reversion. (BHSA Policy Manual § 7.A.4.)

B. WET activities must supplement, but must not duplicate, funding available through other State-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). (BHSA Policy Manual § 7.A.4.1.)

1.6.4 CFTN

County may use a portion of BHSS funds for CFTN. BHSS CFTN projects include the acquisition and development of land, the construction or renovation of buildings, or the development, maintenance, or improvement of information technology to support behavioral health administration and services. Counties can also use BHSS funds as the required match for Behavioral Health Infrastructure Bond Act of 2023 Program Behavioral Health Continuum Infrastructure Program (BHCIP) awards. BHSS funds for CFTN projects must be spent within ten years, after which unspent funds will be subject to reversion. (BHSA Policy Manual § 7.A.5.)

1.6.5 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. County is encouraged to pilot and test innovative behavioral health pilots and projects in all BHSA funding components (Housing Interventions, FSP, and BHSS). County should fund innovative behavioral health pilots and projects under each of those separate funding components. (BHSA Policy Manual § 7.A.6.)

1.6.6 Early Intervention Programs

County must implement Early Intervention Programs designed to prevent mental illness and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health. (W&I §§ 5840(a)(1), 5892(a)(3)(A)(ii); BHSA Policy Manual § 7.A.7)

A. County's Early Intervention Program must, as described in BHSA Policy Manual section 7.A.7:

   1) Emphasize the reduction of the likelihood of suicide and self-harm, incarcerations, homelessness, and the other adverse outcomes enumerated in BHSA Policy Manual section 7.A.7 (W&I § 5840(d));

   2) Include culturally responsive and linguistically appropriate interventions;

   3) Create critical linkages with community-based organizations;

   4) Prioritize funds according to BHSA Policy Manual section 7.A.7.2, including specific interventions focused on childhood trauma (W&I §§ 5840.7; 5840.6(c));

   5) Include the following components, as described in BHSA Policy Manual section 7.A.3: outreach, access and linkage to care, and mental health and SUD services and supports (W&I § 5840(b)); and

   6) Provide an Early Psychosis Intervention (EPI) Plus Program, which must include a Coordinated Specialty Care for First Episode Psychosis (CSC for FEP) program with fidelity and consistent with the requirements established for BH-CONNECT, as described in BHSA Policy Manual section 7.A.7.5.2. This BHSA requirement applies regardless of whether the County has elected to offer CSC for FEP as a bundled Medi-Cal service.

B. In addition to CSC for FEP, DHCS may, in the future, identify other EBPs or CDEPs that County is required to implement. (W&I § 5840(c)(5).) County may, in addition, describe in their IP County-specific CDEPs that are not included on DHCS' list of EBPs and CDEPs. (BHSA Policy Manual § 7.A.6.)

1.7 Full Service Partnership

County must implement a BHSA FSP program consistent with BHSA Policy Manual section 7.B and any other applicable DHCS guidance. (W&I § 5887.)

1.7.1 Eligible and Priority Populations

A. FSP eligible populations include (W&I § 5892(k); BHSA Policy Manual § 7.B.3.1):

1) BHSA eligible adults and older adults who meet the priority population criteria specified in W&I section 5892(d); and

2) BHSA eligible children and youth, including transitional age youth (TAY) ages 16-25.

B. County must comply with presumptive eligibility requirements set forth in W&I section 5887(d)(2) and any other applicable DHCS guidance.

1.7.2 FSP Levels of Care

County must, as described in BHSA Policy Manual section 7.B.4, ensure that FSP programs have a standard of care, with levels of care using the appropriate EBP to treat individuals based on acuity, based on clinical judgment and discretion reflecting individualized needs. (W&I § 5887(e).)

1.7.3 Program Requirements

A. County must provide the following BHSA services to FSP participants in accordance with demonstrated clinical need and in alignment with the required FSP levels of care, regardless of whether County's BHDS has opted to provide these services under a Medi-Cal bundled rate (W&I § 5887; BHSA Policy Manual § 7.B):

1) Mental health services, supportive services, and SUD services as described in BHSA Policy Manual section 7.B.3.2;

2) Assertive Community Treatment (ACT) as described in BHSA Policy Manual section 7.B.4.1;

3) Forensic ACT (FACT) as described in BHSA Policy Manual section 7.B.4.1;

4) FSP Intensive Case Management (ICM) under a team-based approach with an identified team lead, as described in BHSA Policy Manual section 7.B.4.2;

5) High Fidelity Wraparound (HFW) as described in BHSA Policy Manual section 7.B.4.3;

6) Individual Placement and Support (IPS) model of Supported Employment as described in BHSA Policy Manual section 7.B.5;

7) Assertive field-based initiation for SUD as described in BHSA Policy Manual section 7.B.6;

8) Outpatient behavioral health services for evaluation and stabilization as described in BHSA Policy Manual section 7.B.3.2;

9) Ongoing engagement services as described in BHSA Policy Manual section 7.B.3.2;

10) Service Planning in accordance with the processes in W&I sections 5806 and 5868; County's FSP Program is not required to maintain documentation in a "standalone" treatment plan or service plan; and

11) Housing Interventions, funded under the Housing Interventions category as outlined in subsection 1.8 of this Attachment I.

B. County FSP teams must be capable of supporting FSP participants living with co-occurring mental health and SUD conditions, as described in BHSA Policy Manual sections 7.B.3.2 and 7.B.3.5.

C. County may include additional behavioral health services County determines are beneficial to an eligible individual's treatment, if not already covered by ACT, FACT, FSP ICM, or HFW, in collaboration with the individual and, when appropriate, the individual's family. (BHSA Policy Manual § 7.B.3.3.)

D. County may use FSP funding for outreach activities if the activities relate to enrolling individuals living with significant behavioral health needs in an FSP (W&I § 5887(d).) General outreach to individuals living with significant behavioral health needs who are not FSP eligible should be funded under other appropriate funding sources including BHSS and Housing Interventions. (BHSA Policy Manual § 7.B.3.3.)

1.7.4 FSP Exemptions

A. For the first IP (covering July 1, 2026, to June 30, 2029), all counties are exempt from the EBP fidelity requirements for ACT, FACT, IPS Model of Supported Employment, and HFW. Counties are still required to begin offering the required FSP EBPs by July 1, 2026, unless a small county receives an exemption under subsection 1.7.4.C, below. (BHSA Policy Manual § 7.B.3.4.)

B. To meet FSP EBP requirements (between fiscal years 2026-2029), County must (BHSA Policy Manual § 7.B.3.4):

1) Participate in ongoing training and technical assistance for all FSP EBPs;

2) Understand gaps to fidelity for each FSP EBP by December 31, 2027; and

3) Meet other requirements and implementation milestones as described in BHSA Policy Manual section 7.B.6.

C. Small counties as defined under subsection 1.4.5.A.1 of this Attachment I and cities submitting an IP independently may request an exemption from the EBP requirements for ACT, FACT, and/or IPS. (W&I § 5887(a)(2); BHSA Policy Manual § 7.B.3.4.) County must request exemptions from each EBP (ACT, FACT, and/or IPS) individually and provide corresponding documentation. Criteria for FSP exemption requests include (BHSA Policy Manual § 7.B.3.4):

1) Limited workforce (e.g., qualified providers)

2) Limited need (e.g., the estimated population with a clinical need for an EBP)

3) Other hardships, subject to DHCS' review

1.7.5 FSP EBP Service Capacity and Fidelity Standards

A. Absent a DHCS-approved exemption, County is required to adhere to EBP requirements and to establish teams of behavioral health practitioners to deliver each FSP EBP, regardless of whether County's Medi-Cal BHDS has opted to cover these services as bundled Medi-Cal services. (BHSA Policy Manual § 7.B.)

B. County must use the IP and annual update to project the number of full-time equivalent (FTE) practitioners and multidisciplinary teams to provide ACT, FACT, IPS, and HFW between 2026 and 2029. (BHSA Policy § 7.B.6.1.) County must ensure that the projected teams identified comply with the FSP EBP fidelity standards as described in BHSA Policy Manual section 7.B.6.2.

1.8 Housing Interventions

County must implement BHSA Housing Interventions consistent with BHSA Policy Manual section 7.C and any other applicable DHCS guidance. (W&I § 5830.)

1.8.1 Eligible and Priority Populations

A. County must limit BHSA Housing Interventions component to individuals who (W&I § 5830(a)):

1) Meet BHSA eligibility criteria as defined in subsection 1.1.2 of this Attachment I; and

2) Are either at risk of homelessness, experiencing homelessness, or chronically homeless as defined in W&I section 5892(k)(2)-(3) and BHSA Policy Manual section 7.C.4.

B. Housing Interventions must not (W&I § 5830(a)(2)-(4); BHSA Policy Manual § 7.C.5):

1) Be limited to individuals enrolled in FSP;

2) Be limited to individuals enrolled in Medi-Cal; and

3) Discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications, or individuals who are justice-involved.

C. County must prioritize BHSA Housing Interventions to the populations enumerated in BHSA Policy Manual section 7.C.4.2.

D. For individuals housed under the MHSA as of June 30, 2026, County must comply with the BHSA transition policies outlined in BHSA Policy Manual section 7.C.4.3.

E. County must ensure that all BHSA Housing Intervention settings are combined with access to clinical and supportive behavioral health care and housing services that will promote the individual's health and functioning and long-term stability. (BHSA Policy Manual § 7.C.5.)

1.8.2 Housing Interventions Exemptions

In accordance with the procedures in BHSA Policy Manual section 7.C.6.2 (W&I § 5892(a)(1)(B)-(C)):

A. Beginning with the IP covering fiscal years 2026-2029, counties with a population of less than 200,000 and cities submitting an IP independently may request an exemption from the Housing Interventions component allocation and suballocation funding allowances described in subsection 1.4.3 of this Attachment I; and

B. Beginning with the IP covering fiscal years 2032-2035, all counties regardless of size may request such exemptions.

1.8.3 Relationship to Medi-Cal Funded Housing Services

BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCPs. (W&I § 5830(c)(2); BHSA Policy Manual § 7.C.7.) County must coordinate with MCPs as described in BHSA Policy Manual section 7.C.7 to:

A. Ensure Housing Interventions are not used for services covered by MCPs;

B. Support seamless connections from the county to MCPs for coverage of housing services and vice versa; and

C. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet eligibility criteria for BHSA.

1.8.4 Allowable Expenditures and Related Requirements

BHSA Housing Interventions may include the following types of expenditures, subject to the program requirements and limitations outlined in this section and BHSA Policy Manual sections 7.C.9 and 7.C.10:

A. Rental subsidies (BHSA Policy Manual § 7.C.9.1.)

B. Operating subsidies (BHSA Policy Manual § 7.C.9.2.)

C. Allowable settings (BHSA Policy Manual § 7.C.9.3.)

1) Non-time-limited permanent settings, including Permanent Supportive Housing (PSH)

2) Time limited interim settings

D. Other housing supports (BHSA Policy Manual § 7.C.9.4.)

1) Landlord Outreach and Mitigation Funds

2) Participant Assistance Funds

3) Housing Transition Navigation Services and Tenancy and Sustaining Services

4) Outreach and Engagement, up to a limit of seven percent of Housing Interventions

E. Other Housing Interventions requirements and policies (BHSA Policy Manual § 7.C.9.5)

1) County must ensure Housing Interventions are:

a. Operated in compliance with the core components of Housing First (W&I §§ 8255(b), 5830(a)(5));

b. Available to support Family Housing, as appropriate; and

c. Only used in connection with housing settings that meet minimum standards for habitability and quality.

2) County must operate the Housing Interventions component in accordance with Homeless Management Information System (HMIS) reporting requirements. (W&I § 8256(d)(3)(A).)

F. Capital development projects, up to a limit of 25 percent of Housing Interventions funding (W&I § 5892(a)(1)(A)(iii); BHSA Policy Manual § 7.C.10.)

1.9 Documentation Requirements for BHSA Services

A. County must ensure all mental health and SUD services funded under BHSA (with the exception of hospital inpatient and Narcotic Treatment Program services) comply with documentation requirements established in BHIN 23-068. (BHSA Policy Manual § 8.)

B. Documentation requirements do not apply to services and supports where this approach to clinical documentation requirements may be unsuitable, such as (BHSA Policy Manual § 8):

1) BHSA housing services;

2) Outreach programs, including BHSS Outreach and Engagement and outreach funded under FSP, where gathering identifying information is not feasible (e.g., outreach to homeless individuals and others who are not yet comfortable providing their information);

3) Warm lines and hotlines; and

4) Food support provided under FSP.

1.10 BHSA Oversight and Enforcement

1.10.1 DHCS Oversight and Enforcement

A. DHCS will conduct compliance reviews to assess County's compliance with BHSA program requirements as required under W&I section 5897(d). The reviews will be conducted as described in BHSA Policy Manual section 9.C.

1) County must comply with DHCS requests for documents and information needed to conduct compliance reviews, including (BHSA Policy Manual §§ 9.C.1-2.):

a. Submitting requested documents to DHCS prior to and during the review; and

b. Making personnel, including personnel employed by or under contract with County and BHSA-funded providers (including contracted providers and providers employed, owned, or operated by County) available for DHCS to interview.

B. If DHCS determines that County is out of compliance with BHSA requirements as set forth in State law, applicable DHCS guidance, and this Contract, DHCS may conduct enforcement actions, such as (W&I §§ 5897(e), 5963.04(e), 14197.7; BHSA Policy Manual § 9.D):

1) Administrative sanctions, including (W&I § 5963.04(e); BHSA Policy Manual § 9.D.1):

a. Imposing a corrective action plan (CAP) as described in BHSA Policy Manual section 9.D.1.1 or requiring County to revise its IP or annual update as described in BHSA Policy Manual section 9.D.1.2.

i. Administrative sanctions may be imposed for, among other reasons, failure to make adequate progress in meeting performance measures established by DHCS pursuant to W&I section 5963.04(b). DHCS can exercise this authority outside the standard IP and annual update submission timeline, including after County's BHOATR submission. (BHSA Policy Manual § 9.D.1.2.)

2) Temporary monetary withholds and monetary sanctions. (W&I §§ 5963.04(e)(3), 14197.7(n)(5); BHSA Policy Manual § 9.D.2.)

a. DHCS may impose temporary monetary withholds and monetary sanctions, as outlined in BHSA Policy Manual section 9.D.2, if County (W&I § 5963.04(e)(3)):

i. Fails to follow stakeholder engagement requirements for the IP or the 30-day comment period for the annual update and intermittent update, as described in W&I section 5963.03 and BHSA Policy Manual section 3.B;

i. Fails to allocate BHSA funds in accordance with statutory requirements, as set forth at W&I section 5892 and BHSA Policy Manual section 6.B;

ii. Fails to submit a complete, accurate, and timely BHOATR in accordance with W&I section 5963.04 and BHSA Policy Manual chapter 4; or

iii. Spends BHSA funds in a manner that significantly varies from its budget in the IP, annual update, or intermittent update.

C. County may appeal a temporary withhold or monetary sanction imposed pursuant to this subsection 1.10.1.A.2, above. County's appeal will be conducted in accordance with the requirements specified in BHSA Policy Manual section 9.D.2.5 and pursuant to procedures outlined in DHCS guidance. (W&I 14197.7(h), (k)-(m); BHIN 25-023.)

1.10.2 County Oversight

County must comply with BHSA Policy Manual Section 9.E and any other applicable DHCS guidance regarding oversight of BHSA-funded providers (including contracted providers as well as providers employed, owned, or operated by County).

A. County must ensure its behavioral health workforce, including all BHSA-funded providers (contracted providers and providers employed, owned, or operated by County) are well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures as described in W&I section 5963.02(c)(8). (BHSA Policy Manual § 9.E.)

B. County must describe in the IP how County will conduct oversight of BHSA providers to ensure compliance with federal and state laws and regulations and requirements specified in the Policy Manual, as described in BHSA Policy Manual section 9.E.3. (W&I § 5963.02(c)(8)(I).)

C. County must execute a contract with each non-County provider (i.e., providers that are not owned or operated by County) receiving BHSA funds that meets the requirements in BHSA Policy Manual section 9.E.1.1. County must make a good-faith effort to execute the contract before the provider begins delivering BHSA-funded services.

   1) If County is unable to execute a contract before the delivery of BHSA-funded services, County must execute the contract within 120 calendar days from the commencement of BHSA-funded services, consistent with the time limit for provisional SMHS provider contracts. (BHSA Policy Manual § 9.E.1.1.)

   2) County must codify the applicable standards outlined in this subsection 1.10.2.D of this Attachment I in each County-contracted provider contract. (BHSA Policy Manual § 9.E.2.)

D. County must monitor each provider's compliance (including contracted providers, and providers employed, owned, or operated by County) with the following requirements as described in BHSA Policy Manual section 9.E.1.1:

   1) All program requirements applicable to the provider's BHSA-funded services;

2) Any requests for records, information, or onsite access by the county, DHCS or their designees for purposes of BHSA oversight;

3) BHSA fiscal policies, as set forth in subsection 1.5 of this Attachment I and BHSA Policy Manual section 6.C;

4) General standards for BHSA providers, which include ensuring providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner, as specified in W&I section 5963.02(c)(8)(C)-(F) and BHSA Policy Manual section 9.E.2; and

5) County monitoring activities resulting from County's oversight of BHSA providers, as described in this subsection 1.10.2.F, below (BHSA Policy Manual § 9.E.3.)

E. For all providers (contracted providers, and providers employed, owned, or operated by County), County must: (BHSA Policy Manual § 9.E.1.2):

1) Maintain records of expenditures sufficient to comply with BHOATR requirements; and

2) Maintain policies and procedures to ensure compliance with the requirements described in this subsection 1.10.2.D, above.

F. Effective July 1, 2027, County must describe how they will conduct oversight of BHSA providers in the IP, and must conduct the following monitoring activities (W&I § 5963.02(c)(8)(I); BHSA Policy Manual § 9.E.3):

1) Adopt a monitoring schedule for BHSA-funded providers that includes periodic site visits;

2) Preserve provider monitoring records, including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and

3) Provide monitoring records to DHCS at any time, upon DHCS' request.

2.1 Bronzan-McCorquodale Act

2.1.1 Overview

A. The Bronzan-McCorquodale Act realigned responsibility for administration of community mental health services, for the indigent population, to counties and provided a dedicated funding source. (Welfare and Institutions Code (W&I), § 5600.)

B. County's primary goal in using the funds is to provide an array of treatment options to seriously emotionally disturbed children and adults who have a serious mental disorder, in every geographic area, to the extent resources are available to County. (W&I §§ 5600.3, 5600.35, 5600.4.)

C. The mission of California's mental health system is to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings. (W&I § 5600.1.)

2.1.2 County Obligations

County must comply with all requirements in the Bronzan-McCorquodale Act (W&I § 5600 *et. seq*.), including the following:

A. County must comply with Chapter 3 of Part 2 of Division 5 of W&I (commencing with section 5700), including that County must fund children's services pursuant to the requirements of W&I sections 5704.5 and 5704.6.

B. County must comply with all reporting requirements pursuant to W&I sections 5610, 5664, and 5614(b)(4).

C. To the extent resources are available, County must maintain the program principles and array of treatment options required under W&I sections 5600.2 to 5600.9, inclusive. (W&I § 5614(b)(5).)

D. County must report data to the State required by the performance outcome systems for adults and children in accordance with W&I sections 5612 and 5613. (W&I §§ 5610, 5664, 5614(b)(6).)

2.2 Lanterman-Petris-Short Act

2.2.1 Overview

A. The Lanterman-Petris-Short (LPS) Act was enacted to end indefinite involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism; to provide prompt evaluation and treatment, to establish consistent personal rights standards, and to provide services in the least restrictive setting for individuals served under the Act. (W&I § 5001.)

B. Pursuant to W&I section 5400, DHCS administers the LPS Act and may adopt standards as necessary.

2.2.2 Designating Facilities for Involuntary Treatment

A. County must comply with applicable statutes, regulations, and DHCS standards and guidance pertaining to designating and monitoring facilities to provide involuntary evaluation and treatment services under the LPS Act and the Children's Civil Commitment and Mental Health Treatment Act. (W&I §§ 5008, 5120, 5121, 5150–5349.5, 5350–5372, 5585–5599, 5651(b)(2).)

2.2.3 Reporting and Data Submission Requirements

A. County must maintain data on the following (W&I § 5402):

1) The number of persons admitted for 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day post-certification intensive treatment and the conditions for which they are held, including danger to self, danger to others, grave disability due to mental health disorder, grave disability due to severe substance use disorder, grave disability due to both a mental health disorder and a severe substance use disorder;

2) The number of persons transferred to mental health facilities pursuant to section 4011.6 of the Penal Code;

3) The number of persons for whom temporary conservatorships are established, and the number of persons for whom conservatorships are established in the County;

4) Services provided, including payer information, and clinical outcomes for the individuals identified in paragraphs (1) through (3) of this subsection 2.2.3.A, above;

5) Demographic data for the individuals identified in paragraphs (1) through (3) of this subsection 2.2.3.A, above. Demographic data must include age, sex, gender identity, race, ethnicity, primary language, sexual orientation, veteran status, and housing status, to the extent those data are available;

6) The number of persons admitted or detained once, between two and five times, between six and eight times, and greater than eight times for each type of admission or detention including 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day postcertification intensive treatment;

7) The waiting periods for individuals prior to receiving an evaluation in a designated and approved facility pursuant to W&I sections 5150 or 5151 and waiting periods for individuals prior to receiving treatment services in a designated facility, including the reasons for waiting periods;

8) Number of all County-contracted beds; and

9) Number and outcomes for the following:

a. The certification review hearings (W&I § 5256);

b. The petitions for writs of habeas corpus filed (W&I § 5275);

c. The judicial review hearings held (W&I § 5276);

d. The petitions for capacity hearings filed (W&I § 5332); and

e. The capacity hearings held (W&I § 5334).

B. County must provide data as required in this subsection 2.2.3.A, above, or other information, records, and reports, which DHCS deems necessary for the purposes of W&I section 5402 on a quarterly basis, or more frequently as required by DHCS.

C. County must maintain data on the number of persons whose rights under W&I section 5325 were denied and the right or rights which were denied. Quarterly, County must provide DHCS with a report of this information (W&I § 5326.1.)

D. County must collect information regarding the number of patients receiving treatment for each patient type, total treatments given, complications attributed to treatment, excessive treatment, and payment source of patients, and report this information quarterly to DHCS (W&I § 5326.15(a).)

2.3 Laura's Law

2.3.1 County Obligations

A. County must comply with Article 9 of Part 1 of Division 5 of W&I (Laura's Law), unless its governing body has passed a resolution in compliance with W&I section 5349.

B. County either individually or pursuant to its memorandum of understanding with a group of Counties to which County has joined for participation in Laura's Law, must:

1) Maintain and provide data to DHCS regarding the services County provides under Laura's Law. (W&I § 5348.) The report must include an evaluation of the effectiveness of the strategies employed by each program in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. County must maintain and include in the report to DHCS all of the information enumerated in W&I section 5348(d).

2) Pay for the provision of services under W&I sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund when included in County plans pursuant to W&I sections 5847 or 5963.02 and any other funds from which the Controller makes distributions to the counties for those purposes. (W&I § 5349.)

2.4 Projects For Assistance In Transition From Homelessness Program

2.4.1 Overview

A. Pursuant to Title 42 of the United States Code (USC), sections 290cc-21 through 290cc-35, inclusive, the State of California has been awarded federal homeless funds through the federal McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant.

B. The PATH grant funds community-based outreach, mental health and substance abuse referral/treatment, case management and other support services, as well as a limited set of housing services for the homeless mentally ill.

2.4.2 Application for Funds and Compliance with Requirements

A. County must submit its Request for Application (RFA) responses and required documentation specified in DHCS' RFA to receive PATH funds. County must complete its RFA responses in accordance with the instructions, enclosures and attachments distributed annually from DHCS by email.

B. If County applied for and DHCS approved its request to receive PATH grant funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:

1) The Notice of Funding Opportunity (NOFO) issued by Substance Abuse and Mental Health Services Administration (SAMHSA) for the PATH program;

2) The State's approved application to SAMHSA for PATH funding;

3) The federal Notice of Award issued to DHCS;

4) DHCS's RFA;

5) County's RFA responses, including the proposed scope of work and budget details.

2.4.3 Federal Authorities

The PATH grant is a federal award within the meaning of Title 2 Code of Federal Regulations (CFR) parts 200 and 300. County's receipt of PATH funds is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR parts 200 and 300, including, but not limited to, the County requirement to have a single audit performed for PATH funds in accordance with the audit requirements therein.

2.5 Community Mental Health Services Block Grant

2.5.1 Overview

A. Pursuant to Title 42 USC section 300x *et seq.*, the State of California has been awarded the federal Community Mental Health Services Block Grant funds, known as Mental Health Block Grant (MHBG).

B. County mental health agencies utilize MHBG funding to provide a broad array of mental health services within their mental health system of care programs. These programs provide services to the following target populations: children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses.

2.6 Application for Funds and Compliance with Requirements

A. County must submit its RFA responses and required documentation specified in DHCS' RFA to receive MHBG funding. County must complete its RFA responses in accordance with the instructions, enclosures and attachments.

B. If County applied for and DHCS approved its request to receive MHBG grant funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:

1) The NOFO issued by SAMHSA for the MHBG program;

2) The State's approved application to SAMHSA for MHBG funding;

3) The federal Notice of Award issued to DHCS;

4) DHCS's RFA;

5) County's RFA responses, including the proposed scope of work and budget details.

2.6.1 Federal Authorities

A. The MHBG grant is a federal award within the meaning of 2 CFR parts 200 and 300. County's receipt of MHBG funds is a subaward to County. County is a subrecipient and subject to all applicable

requirements in 2 CFR parts 200 and 300, and 45 CFR part 96 including, but not limited to, the County requirement to have a single audit performed for MHBG funds in accordance with the audit requirements therein.

B. MHBG Funding must not be used to supplant existing resources. County expenditure of MHBG Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (42 USC § 300x-4(b); 42 CFR § 200.503.)

2.7 Substance Use Prevention, Treatment, and Recovery Services Block Grant

2.7.1 Overview

A. Pursuant to Title 42 USC section 300x *et seq.*, the State of California has been awarded the federal Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).

B. County Alcohol and Other Drug Programs utilize SUBG funding to provide a broad array of alcohol and other drug treatment and prevention services within their system of care programs.

2.7.2 Application for Funds and Compliance with Requirements

A. County must submit its RFA responses and required documentation specified in DHCS' RFA to receive SUBG funding. County must complete its RFA responses in accordance with the instructions, enclosures and attachments.

B. If County applied for, and DHCS approved its request to receive SUBG funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:

1) The NOFO issued by SAMHSA for the SUBG program;

2) The State's approved application to SAMHSA for SUBG funding;

3) The federal Notice of Award issued to DHCS;

4) DHCS's RFA; and

5) County's RFA responses, including the proposed scope of work and budget details.

2.7.3 Federal Authorities

A. The SUBG is a federal award within the meaning of 2 CFR parts 200 and 300. County's receipt of SUBG funds is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR parts 200 and 300, and Title 45 CFR part 96, including, but not limited to, the County

requirement to have a single audit performed for SUBG funds in accordance with the audit requirements therein.

B. SUBG Funding must not be used to supplant existing resources. County expenditure of SUBG Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (45 CFR § 96.134(a), 42 CFR § 200.503.)

2.8 Crisis Counseling Assistance and Training Program

2.8.1 Overview

A. Pursuant to Title 42 USC section 5183, and upon the issuance of a Presidential declaration of a major disaster, the State of California may be awarded Federal Emergency Management Agency (FEMA) funding for the Crisis Counseling Assistance and Training Program (CCP) pursuant to 44 CFR section 206.171.

B. The CCP supports short-term interventions that involve assisting disaster survivors in understanding their current situation and reactions, mitigating stress, developing coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that help survivors in their recovery process. These funds are used to provide services to all individuals affected during a disaster.

2.8.2 Request for Funds and Compliance with Requirements

A. Participation in the CCP is optional.

B. If County participates in the CCP, it must comply with all applicable federal and State requirements, including:

1) FEMA or SAMHSA approved funding application and budget;

2) Applicable requirements in the Notice of Award (from FEMA or SAMHSA) to the State, including special and standard program conditions or terms, supplemental grant information, and the federal Health and Human Services Grants Policy Statement; and

3) 44 CFR section 206.171, 42 CFR part 38, and FEMA or SAMHSA CCP secondary guidance.

2.8.3 Federal Authorities

A. The CCP is a federal award within the meaning of 2 CFR part 200. County's receipt of CCP funding is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR part 200 and 44 CFR section 206.207(c), including, but not limited to, the County

requirement to have a single audit performed for CCP funds in accordance with the audit requirements therein.

B. CCP Funding must not be used to supplant existing resources. County expenditure of CCP Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (44 CFR § 206.171(k), 42 CFR § 38.9.)

C. For reference, FEMA Crisis Counseling Assistance and Training Program (FEMA secondary guidance), is accessible at the following link: https://www.samhsa.gov/technical-assistance/dtac/ccp.

Exhibit A, ATTACHMENT II

Table of Contents

1.0 Additional Terms and Conditions

1.1 Dispute Resolution Process for Projects For Assistance In Transition From Homelessness, Community Mental Health Services Block Grant, and Substance Use Prevention, Treatment, and Recovery Services Block Grant
1.2 Welfare and Institutions Code section 5751.7 Waiver
1.3 Reporting, Data Submission, and Data Sharing Requirements

1.1 Dispute Resolution Process for Projects For Assistance In Transition From Homelessness, Community Mental Health Services Block Grant, and Substance Use Prevention, Treatment, and Recovery Services Block Grant

1.1.1 Dispute Resolution Process

A. Notwithstanding Exhibit D, if a dispute arises between County and DHCS regarding County's compliance with subsection 2.4 (Projects For Assistance In Transition From Homelessness), subsection 2.5 (Community Mental Health Services Block Grant), or subsection 2.6 (Substance Use Prevention, Treatment and Recovery Services Block Grant) of Attachment I, the County must seek resolution using the process outlined in this subsection 1.1.1.D, below.

B. County must first informally discuss the problem with the DHCS Project Representative listed in subsection 1.1.1.D, below. If County and DHCS are unable to resolve the problem informally, County must mail a written Statement of Dispute, with supporting evidence, to DHCS at the address listed in subsection 1.1.1.D, below. The Statement of Dispute must describe the issues in dispute, the legal authority or other basis for County's position, and the remedy sought.

C. The Branch Chief of DHCS' Federal Grants Branch will decide the dispute and mail a written decision to the County within twenty (20) working days of receiving the Statement of Dispute from County. The decision will be in writing, and include a statement of the reasons for the decision that addresses each issue raised by County. If applicable, the decision will also indicate any action County must take to comply with the decision. The Branch Chief's decision will be the final administrative determination of DHCS.

D. Unless otherwise agreed to in writing by DHCS, the Statement of Dispute, supporting documentation, and all correspondence and documents related to the dispute resolution process must be directed to the following:

California Department of Health Care Services
Community Services Division/Federal Grants Branch
Attention: Waheeda Sabah
1501 Capitol Avenue
P.O. Box Number 997413, Mail Stop 2624
Sacramento, CA, 95899-7413

1.2 Welfare and Institutions Code section 5751.7 Waiver

1.2.1 Overview

A. County must comply with Welfare and Institutions Code (W&I) section 5751.7 and ensure that minors are not admitted into inpatient psychiatric treatment with adults. If this requirement creates undue hardship to County due to inadequate or unavailable alternative resources, County may request a waiver of this requirement. County must submit the waiver request on Exhibit A, Attachment III of this Contract to DHCS.

B. DHCS must review County's waiver request and provide a written notice of approval or denial of the waiver. If County's waiver request is denied, County must prohibit health facilities from admitting minors into psychiatric treatment with adults.

C. County must submit the waiver request to DHCS at the time County submits this Contract, signed by County, to DHCS for execution. County must complete Exhibit A, Attachment III and attach it to this Contract.

D. Execution of this Contract by DHCS will not constitute approval of a waiver submitted pursuant to this section.

E. Any waiver granted in the prior fiscal year's Contract will be deemed to continue until either party chooses to discontinue it, as specified in Exhibit A, Attachment III. Execution of this Contract will continue independently of the waiver review and approval process.

F. In unusual or emergency circumstances, when County needs to request waivers after this Contract has been executed, these requests should be e-mailed, with the subject line "Performance Contract: Unusual or Emergency Circumstances", immediately to the contact listed in this subsection 1.2.1.G, below.

G. County must submit waiver requests for designated facilities by e-mail to:

California Department of Health Care Services
Licensing and Certification Division
Mental Health Licensing and Certification Branch
e-mail: LPSinfo@dhcs.ca.gov.

H. Each admission of a minor to a facility that has an approved waiver must be reported to the Local Behavioral Health Director.

1.3 Reporting, Data Submission, and Data Sharing Requirements

1.3.1 Data Requirements

A. County must comply with all data and information submission requirements specified in State and federal law, this Contract, and all applicable DHCS guidance. (W&I §§ 5610(a)(1), 5664(a), 5963.04(a)(2).) Applicable laws include:

1) Title 42 of the United States Code (USC), sections 290cc-21 through 290ee-10 and 300x through 300x-68, inclusive;

2) W&I sections 5000 through 5987; and

3) All corresponding regulations that implement, interpret or make specific, these federal and State laws.

B. County must provide data and information regarding the following programs as required by, and in accordance with, federal and State laws and DHCS guidance:

1) The Behavioral Health Services Act (BHSA), as outlined in Exhibit A, Attachment I, Article 1.0;

2) Projects for Assistance in Transition from Homelessness (PATH), as outlined in Article 2.0, subsection 2.4 of Attachment I;

3) Community Mental Health Services Block Grant (MHBG), as outlined in Article 2.0, subsection 2.5 of Attachment I;

4) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), as outlined in Article 2.0, subsection 2.6 of Attachment I; and

5) County provision of community behavioral health services provided with 1991 and 2011 realignment funds (other than Medi-Cal).

1.3.2 Reporting Requirements

A. County must comply with all reporting requirements as specified in DHCS guidance and State and federal law. (W&I §§ 5610(a)(1), 5664(a), 5651(b)(7), 5963.04(e)(3)(A); Health & Safety Code §§ 11754(a),11755(q)(1).)

B. County must submit complete and accurate information to DHCS, and as applicable to the Behavioral Health Services Oversight and Accountability Commission, including, but not limited, to the following (W&I §§ 5610(a)(1), 5963.04(a)(1)-(2)):

1) Client and Service Information (CSI) System Data, as specified in Title 9 of the California Code of Regulations (CCR) section 3530.10 and according to the specifications set forth in DHCS' CSI Data Dictionary. County must:

   a. Report complete and accurate monthly CSI data to DHCS within 60 calendar days after the end of the month in which services were provided.

   b. If complete and accurate data are not reported within 60 calendar days, County must be in compliance with an approved plan of correction.

   c. Make diligent efforts to minimize errors on the CSI error file.

   d. Correct all errors on the CSI error file.

   e. Notify DHCS 90 calendar days prior to any change in reporting system or change of automated system vendor.

2) Full Service Partnership Performance Outcome data (9 CCR § 3530.30)

3) Consumer Perception Survey (9 CCR § 3530.40)

4) Substance use disorder treatment services data in accordance with W&I section 5891.5(b).

C. Effective January 1, 2027, County must capture and submit all behavioral health individual service-level (ISL) encounter data to DHCS pursuant to applicable DHCS guidance. (W&I §§ 5610(b), (d), 5664(a).)

D. In the event that DHCS or County determines that, due to federal or State law changes or business requirements, an amendment is needed of either County's or DHCS' obligations under this contract relating to either DHCS' or County's information needs, both DHCS and County agree to provide notice to the other party as soon as feasible prior to implementation. This notice must include information and comments regarding the anticipated requirements and impacts of the projected changes. DHCS and County agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.

E. County must submit complete, accurate, reasonable, and timely data as mandated by State and federal law and DHCS guidance, and in a form and manner specified by DHCS.

F. If applicable to a specific federal or State funding source covered by this Contract, County must require each of its subcontractors to submit a fiscal year-end cost report to DHCS no later than December 31 following the close of the fiscal year, in accordance with applicable federal and State laws, regulations, and DHCS guidance.

1.3.3 Data Sharing Requirements

A. County must comply with all data sharing requirements as mandated by and in accordance with applicable federal and State law and applicable Data Exchange Framework Policies and Procedures and DHCS guidance. (W&I §§ 14197.71(d)(1), 14184.102(j).)

B. County must implement data sharing policies and procedures and adhere to required state and federal care coordination rules and regulations, including bidirectionally sharing the minimum necessary individual data in real time with other counties, Managed Care Plans (MCPs), County-contracted providers, and other delivery systems and partners that support service delivery, care coordination, referrals, closed loop referrals, and care transitions. (W&I § 14197.71(d)(1).)

Exhibit A, Attachment III
Request for Waiver

Request for Waiver Pursuant To Section 5751.7 of the Welfare and Institutions Code

_____ hereby requests a waiver for the following public or private health facilities pursuant to section 5751.7 of the Welfare and Institutions Code for the term of this contract. These are facilities where minors may be provided psychiatric treatment with nonspecific separate housing arrangements, treatment staff, and treatment programs designed to serve minors. However, no minor shall be admitted for psychiatric treatment into the same treatment ward as an adult receiving treatment who is in the custody of any jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate sexual or other violent behavior which would present a threat to the physical safety of others.

The request for waiver must include, as an attachment, the following:

1. A description of the hardship to the County/City due to inadequate or unavailable alternative resources that would be caused by compliance with the State policy regarding the provision of psychiatric treatment to minors.
2. The specific treatment protocols and administrative procedures established by the County/City for identifying and providing appropriate treatment to minors admitted with adults.
3. The specific plan and administrative procedures established by the County ensuring that a designated facility admitting both adults and minors will house them in specific and separate housing arrangements.
4. Name, address and telephone number of the facility:
   - Number of the facility's beds designated for involuntary treatment
   - Type of facility, license(s), certification(s) or accreditation(s) held (including licensing, certifying, or accrediting agency and license, certificate, or accreditation number)
   - A copy of the facility's current license, certificate or accreditation and a description of the program, including target population and age range, and genders to be admitted to the designated facility.
5. If applicable, include a copy of the County's approval letter indicating the County has designated a facility to house both minors and adults.

To rescind the waiver, either party shall send a letter to the other party on official letterhead signed by their respective County Behavioral Health Director or his or her designee indicating that the party no longer grants or requests a waiver. If not otherwise specified by the party in the letter to the respective party, the discontinuance shall be effective the date the letter to the party is postmarked and the facility shall no longer be waivered as of this date. When DHCS denies or rescinds a waiver issued to a County, the facility and the County Behavioral Health Director or designee shall receive written notification from DHCS, by certified mail or e-mail. The notice shall include the decision, the basis for the decision, and any supporting documentation. DHCS' denial or rescission is the final administrative decision and there is no further review or appeal.

Exhibit B – Budget Detail Provisions

1.0 Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, this Contract will be of no further force and effect. In this event, DHCS will have no liability to pay any funds whatsoever to County or to furnish any other considerations under this Contract and County will not be obligated to perform any provisions of this Contract.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS will have the option to either cancel this Contract with no liability occurring to DHCS, or offer an agreement amendment to County to reflect the reduced amount.

Exhibit D
Special Terms and Conditions

The provisions herein apply to this Agreement **unless** the applicable conditions do not exist, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the provisions are removed by reference on the face of this Agreement.

The use of headings or titles throughout this exhibit is for convenience only and will not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" will also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” will all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.).

Index of Special Terms and Conditions

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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action will include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212). Such notices will state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and will post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 Code of Federal Regulations (C.F.R.) Part 60, “Office of the Federal Contract Compliance

Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. § 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement will, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for non-represented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates will apply upon their effective date and no amendment to this Agreement will be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California will be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. **Equipment/Property definitions**

Wherever the term equipment and/or property is used, the following definitions will apply:

1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities (including state colleges/universities and auxiliary organizations),** whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 will also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses,** whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

1) Equipment/property purchases must not exceed $50,000 annually.

   To secure equipment/property above the annual maximum limit of $50,000, the Contractor must make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS will be deducted from the funds available in this Agreement. Contractor will submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 will also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.

3) Nonprofit organizations and commercial businesses must use a procurement system that meets the following standards:

   a) Maintain a code or standard of conduct that will govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent will participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

   b) Procurements must be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

   c) Procurements must be conducted in a manner that provides for all of the following:

      i. Avoid purchasing unnecessary or duplicate items.

      ii. Equipment/property solicitations must be based upon a clear and accurate description of the technical requirements of the goods to be procured.

      iii. Take positive steps to utilize small and veteran owned businesses.

d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or

desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) must also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment / Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 will apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement will be considered state equipment and the property of DHCS.

1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor must report the

receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor must use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor must request a copy from the DHCS Program Contract Manager.

2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor must submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor must request a copy from the DHCS Program Contract Manager. Contractor must:

a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property will not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS will be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.

d. The Contractor and/or Subcontractor must maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.

1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor must immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor must promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment

and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, must only be used for performance of this Agreement or another DHCS agreement.

f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor must provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and must, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property will be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions will be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor must return such vehicles to DHCS and must deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California will be the legal owner of said motor vehicles and the Contractor will be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, must hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator must also hold a State of California Class B driver's license.

4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, must provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

b) The Contractor and/or Subcontractor must, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance must identify the DHCS contract or agreement number for which the insurance applies.

c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, will remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

   I. The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

   II. The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

   III. The insurance carrier must notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices will contain a reference to each agreement number for which the insurance was obtained.

f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance

Management. The Contractor will be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services will be performed prior to obtaining said approval.

g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor must obtain at least three bids or justify a sole source award.

1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

2) DHCS may identify the information needed to fulfill this requirement.

3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

a) A local governmental entity or the federal government,

b) A State college or State university from any State,

c) A Joint Powers Authority,

d) An auxiliary organization of a California State University or a California community college,

e) A foundation organized to support the Board of Governors of the California Community Colleges,

f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

g) Firms or individuals proposed for use and approved by DHCS' funding program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Volume 1 Chapter 5 Section 5.80 Subsection B.

i) Entities whose name and budgeted costs have been submitted to DHCS in response to a competitive Invitation for Bid or Request for Proposal.

b. Agreements with governmental or public entities and their auxiliaries, or a Joint Powers Authority

1) If the total amount of all subcontracts exceeds twenty-five percent (25%) of the total agreement amount or $50,000, whichever is less and each subcontract is not with an entity or of a service type described in paragraph a(3) herein, DHCS will:

a) Obtain approval from DGS to use said subcontracts, or

b) If applicable, obtain a certification from the prime Contractor indicating that each subcontractor was selected pursuant to a competitive bidding process requiring at least three bids from responsible bidders, or

c) Obtain attestation from the Secretary of the California Health and Human Services Agency attesting that the selection of the particular subcontractor(s) without competitive bidding was necessary to promote DHCS' program needs and was not done for the purpose of circumventing competitive bidding requirements.

2) When the conditions of b(1) apply, each subcontract that is not with a type of entity or of a service type described in paragraph a(3) herein, must not commence work before DHCS has obtained applicable prior approval to use said subcontractor. DHCS will inform the Contractor when DHCS has obtained appropriate approval to use said subcontractors.

c. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor must take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

2) The requirements specified in Provision 28 entitled, "Use of Disabled Veteran Business Enterprises (DVBEs)" will apply to the use and substitution of DVBE subcontractors.

3) The requirements specified in Provision 30 entitled, "Use of Small Business Subcontractors" will apply to the use and substitution of small business subcontractors.

d. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers must be confirmed in writing by DHCS.

e. Contractor must maintain a copy of each subcontract entered into in support of this Agreement and must, upon request by DHCS, make copies available for approval, inspection, or audit.

f. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

g. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

h. When entering into a consulting agreement with DHCS, the contract must include detailed criteria and a mandatory progress schedule for the performance of the contract, and must require Contractor to provide a detailed analysis of the costs of performing the contract.

i. The Contractor must ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

j. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

k. Unless otherwise stipulated in writing by DHCS, the Contractor will be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

l. Contractor must, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 18, 19, 20, 32, 37, 38 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement must be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor must maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or Subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records must be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, DGS, the California State Auditor, or their designated representatives including, but not limited to, the Comptroller General of the United States will have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code (Gov. Code) § 8546.7, Title 2 Code of California Regulations (C.C.R.), § 1896.77 and other applicable State laws.) The Contractor must comply with the above and be aware of the penalties for violations of fraud and for obstruction of an investigation under applicable State laws.

d. The Contractor and/or Subcontractor must preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code (Mil. & Vet. Code) § 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

   1) If this Agreement is completely or partially terminated, the records relating to the work terminated must be preserved and made available for a period of three years from the date of any resulting final settlement.

   2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other

data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. For agreements with non-profit entities funded in part or whole with federal funds in the amount of $750,000 or more, the Contractor must, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 et seq.

g. For Direct Service Contracts as defined in Health & Saf. Code § 38040 in the amount of $25,000 or more, the Contract must comply with the audit requirements set forth in Health & Saf. Code § 38040.

8. Site Inspection

The 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 Contractor or Subcontractor, the Contractor must provide and must require 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 will be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days

advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State will be deducted from any sum due the Contractor under this Agreement and the balance, if any, will be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State will pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least thirty (30) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the Contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

(Applicable to all agreements that may be fund, in whole or part, the creation and development Intellectual Property.)

a. The State will be the owner of all rights, title, and interest in any and all intellectual property or other products or materials created or developed pursuant to this Agreement, whether or not published, produced, manufactured or distributed. The copyright, patent and/or other intellectual property rights to any and all products created, provided or developed, in whole or part, under this Agreement, whether or not published, produced, manufactured or distributed belongs to the State from the moment of creation.

b. The State retains all rights to use, reproduce, distribute, or display any products or materials created, provided, developed, or produced under this Agreement and any derivative products based on Agreement products or materials, as well as all other rights, privileges, and remedies granted or reserved to a copyright, patent, service mark or trademark owner under statutory and common law.

c. Contractor agrees to cooperate with State and to execute any document(s) that may be necessary to give the foregoing provisions full force and effect, including but not limited to, an assignment of trademark, copyright or patent rights. Contractor, subject to reasonable availability, agrees to give testimony and take all further acts necessary to acquire, transfer, maintain, and enforce the State's intellectual property rights and interest.

d. Contractor agrees to cooperate with the State in assuring the State's sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor must require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to the State all rights, title and interest in Intellectual Property conceived, developed, derived from, or reduced to practice by the subcontractor, Contractor or the State and which result from this Agreement or any subcontract.

e. Contractor agrees not to incorporate into or make the works developed, dependent upon any original works of authorship or Intellectual Property Rights of third parties without first (a) obtaining State's prior written permission, and (b) granting to or obtaining for State, without additional compensation, a nonexclusive, royalty-free, paid-up, irrevocable, perpetual, world-wide license, to use, reproduce, sell, modify, publicly and privately display and distribute, for any purpose whatsoever, any such prior works.

f. Contractor will retain title to all of its Intellectual Property to the extent such intellectual Property is in existence prior to the effective date of this Agreement. **Unless otherwise specified in the Statement of Work in contracts other than those funded, in part or whole, by federal funds (see paragraph k below)**, Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in

the Intellectual Property resulting from this Agreement. Proprietary software packages that are provided at established catalog or market prices and sold or leased to the general public will not be subject to this license provision.

g. In the case of copyrighted materials, all materials distributed under the terms of this Agreement, and any reproductions or derivative works thereof, must include a notice of copyright in a place that can be visually perceived at the direction of the State. This notice must be placed prominently on products or materials and set apart from other matter on the page or medium where it appears. The notice "Copyright" or "©", the year in which the work was first created, and the Department of Health Care Services DHCS", or other appropriate mark as directed by DHCS, must be included on any such products or materials.

h. Contractor represents and warrants that:

1) It is free to enter into and fully perform this Agreement.

2) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

3) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or the State and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any State, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

4) Neither Contractor's performance nor any part of its performance will violate the right of privacy of or constitute a libel or slander against any person or entity.

5) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real property, sites, locations, property or props that may be used or shown.

6) It has not granted and will not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the State in this Agreement.

7) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition,

operation or maintenance of computer software in violation of copyright laws.

8) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

i. THE STATE MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

j. INTELLECTUAL PROPERTY INDEMNITY

1) Contractor must indemnify, defend and hold harmless the State and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of the State's use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or the State and which result directly or indirectly from this Agreement. This indemnity obligation will apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. The State reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against the State.

2) Should any Intellectual Property licensed by the Contractor to the State under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve the State's right to use the licensed Intellectual Property in accordance with this Agreement at no expense to the State. The State will have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for the State to continue using the licensed Intellectual Property; or replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, the State will be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in

equity.

3) Contractor agrees that damages alone would be inadequate to compensate the State for breach of any term of this Intellectual Property attachment by Contractor. Contractor acknowledges the State would suffer irreparable harm in the event of such breach and agrees the State will be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

k. If this Agreement is funded in whole or part by federal funds, the State will retain all Intellectual Property rights, title, and ownership, which result directly or indirectly from the Agreement pursuant to applicable federal law including, but not limited to, 45 C.F.R. § 75.322 and 45 C.F.R. § 95.617, except as provided in 37 C.F.R. Part 401.14. However, the federal government will have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

l. The provisions set forth herein will survive any termination or expiration of this Agreement.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. § 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. § 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor must obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor must acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors must protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors must not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors must promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor must not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

e. For purposes of this provision, identity will include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Gov. Code § 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement must contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance

between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor must direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance must state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief will render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief will respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor must include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal must be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee will meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee will be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal. The decision rendered by the Deputy Director or his/her designee will be the final administrative determination by the Department.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code (Health & Saf. Code) § 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence will be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor will be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

e. Notwithstanding any dispute, the Contractor shall diligently continue performance of the Contract (including matters subject to dispute to the maximum extent possible).

17. Subrecipient Compliance

(Applicable to agreements in which a Subrecipient receives federal funding. This does not apply to Medi-Cal programs.)

Per 2 C.F.R. § 200.93, a Subrecipient is a non-federal entity that receives a subaward from a pass-through entity to carry out part of a federal award. Subrecipients must comply with certain requirements, including without limitation, audit requirements, as set forth in 2 C.F.R. Part 200, as applicable to Subrecipients. Subrecipients may be subject to applicable monitoring activities by DHCS as required in 2 C.F.R. § 200.332.

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. § 263a (CLIA) and the regulations thereunder.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 C.F.R. Part 180, 2 C.F.R. Part 376.

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

    1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

    2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) violation of Federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

    3) Are not presently indicted for or otherwise criminally or civilly charged by a

governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 C.F.R. Part 180, Subpart C as supplemented by 2 C.F.R. Part 376.

6) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R .part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor must submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 C.F.R. Part 180 as supplemented by 2 C.F.R. Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), 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 WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

22. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS

will have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

23. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

24. Progress Reports or Meetings

(Applicable to consultant service agreements and, at DHCS' option, other agreements.)

a. Contractor shall submit progress reports or attend meetings with state personnel at intervals determined by DHCS to determine if the Contractor is on the right track, whether the project is on schedule, provide communication of interim findings, and afford occasions for airing difficulties or special problems encountered so that remedies can be developed quickly.

b. At the conclusion of this Agreement and if applicable, Contractor shall hold a final meeting at which Contractor shall present any findings, conclusions, and recommendations. If required by this Agreement, Contractor shall submit a comprehensive final report.

25. Performance Evaluation

a. For all consultant service agreements of $5000 or more:

   1) The Contractor's performance under this Agreement will be evaluated at the conclusion of the term of this Agreement. The evaluation will include, but not be limited to:

      a) Whether the contracted work or services were completed as specified in the Agreement and reasons for and amount of any cost overruns.

      b) Whether the contracted work or services met the quality standards specified in the Agreement.

      c) Whether the Contractor fulfilled all requirements of the Agreement and if not, in what ways the Contractor did not fulfill the contract.

      d) Factors outside the control of the Contractor, which caused difficulties in Contractor performance. Factors outside the control of the Contractor will not include a Subcontractor's poor performance.

      e) Other information the awarding agency may require.

f) How the Contract results and findings will be utilized to meet the agency goals.

2) The evaluation of the Contractor will not be a public record.

b. For all other agreements except grant agreements:

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation will not be a public record and will remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature will be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision will not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

28. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Mil. & Vet. Code § 999 et seq. in that should award of this Contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Mil. & Vet. Code § 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the DGS prior to the commencement of any work by the proposed subcontractor. Changes to the

scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

   1) A written explanation of the reason for the DVBE substitution.

   2) A written description of the business enterprise that will be substituted, including its DVBE certification status and contact information.

   3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

   4) One or more of the permissible justifications for substituting a DVBE subcontractor as found in 2 C.C.R. § 1896.73(g).

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Mil. & Vet. Code§ 999.9 and other applicable State laws.

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), all of the following:

   1) The total amount the prime Contractor received under the Agreement;

   2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

   3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;

   4) That all payments under the Contract have been made to the DVBE(s); and

   5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, the Department will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in § 999 of the Mil. & Vet. Code, including, but not limited to, the requirements of § 999.5(d).

29. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts must be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors must take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

30. Use of Small Business Subcontractors

(Only applicable to agreements awarded in part due to the granting of small business preference where the Contractor committed to use small business subcontractors for at least 25% of the initial contract cost or amount bid.)

a. All Small Business Preference Request attachments and Small Business Subcontractor/Supplier Acknowledgment attachments, however labeled, completed as a condition of bidding, are incorporated herein, and made a part of this Agreement by this reference.

b. Contractor agrees to use each small business subcontractor/supplier, as

identified in previously submitted Small Business Preference Request attachments, unless the Contractor submits a written request for substitution of a like or alternate subcontractor. All requests for substitution must be approved by DHCS, in writing (including email or fax), prior to using a proposed substitute subcontractor.

c. Requests for substitution must be approved by the funding program and must include, at a minimum:

   1) An explanation of the reason for the substitution.

   2) A written description of the business enterprise that will be substituted, including its small business certification status and contact information.

   3) If substitution of an alternate small business does not occur, include a written justification and description of the steps taken to try to acquire a new small business and how that portion of the Contract will be fulfilled.

   4) A written description of the work to be performed by the substituted subcontractor identified by both task (if applicable) and dollar amount or percentage of the overall Contract that the substituted subcontractor will perform. The substituted business, if approved, must perform a commercially useful function in the Contract pursuant to 2 C.C.R. § 1896.15.

d. DHCS may consent to the substitution if allowed by applicable State laws.

e. Prior to the approval of the prime contractor's request for the substitution, the funding program will give notice in writing to the listed subcontractor of the prime contractor's request to substitute and the reasons for the request to substitute. The notice will be served by certified or registered mail to the last known address of the subcontractor. The listed subcontractor that has been so notified will have five (5) working days after the receipt of the notice to submit written objections to the substitution to the funding program. Failure to file these written objections will constitute the listed subcontractor's consent to the substitution. If written objections are filed, DHCS will give notice in writing of at least five (5) working days to the listed subcontractor of a hearing by DHCS on the prime contractor's request for substitution.

f. Failure of the Contractor to subcontract with the small businesses listed in its bid or proposal to DHCS, or failure to follow applicable substitution rules and regulations will be grounds for DGS to impose sanctions pursuant to Gov. Code § 14842.5 and 2 C.C.R. § 1896.92. In the event such sanction are to be imposed, the Contractor be notified in writing and entitled to a hearing pursuant to Gov. Code § 14842. and 2 C.C.R. § 1896.18 and § 1896.20.

g. If requested by DHCS, Contractor agrees to provide documentation/verification, in a form agreed to by DHCS, that small business subcontractor usage under this Agreement complies with the commitments specified during the contractor selection process.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering into federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. § 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Gov. Code §§ 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee must, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee must provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with § 100525) of Chapter 3 of Part 1 of Division 101 of the Health & Saf. Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

   1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

   2) Director's and executive committee member's fees.

3) Incentive awards and/or bonus incentive pay.

4) Allowances for off-site pay.

5) Location allowances.

6) Hardship pay.

7) Cost-of-living differentials.

c. Specific allowable fringe benefits include:

1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

1) Be necessary and reasonable for the performance of the Agreement.

2) Be determined in accordance with generally accepted accounting principles.

3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits must be at actual cost.

f. Earned/Accrued Compensation

1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification will remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

1) Upon receipt of a suspension or stop work notification, the Contractor must immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

2) Within 90 days of the issuance of a suspension or stop work notification, DHCS will either:

a) Cancel, extend, or modify the suspension or stop work notification; or

b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is canceled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification will require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is canceled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS will allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS will not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications must follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Legal Services Contract Requirements

(Applicable only to agreements involving the performance of legal services.)

The Contractor must:

a. Adhere to legal cost and billing guidelines designated by DHCS.

b. Adhere to litigation plans designated by DHCS.

c. Adhere to case phasing of activities designated by DHCS.

d. Submit and adhere to legal budgets as designated by DHCS.

e. Maintain legal malpractice insurance in an amount not less than the amount designated by DHCS. Said amount must be indicated in a separate letter to the Contractor.

f. Submit to legal bill audits and law firm audits if requested by DHCS. Such audits may be conducted by State employees or its designees or by any legal cost control providers retained by DHCS for such purpose.

g. Applicable only to legal agreements of $50,000 or more:

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

37. Compliance with Statutes and Regulations

a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement. This includes any changes to the applicable laws, regulations, and/or published guidelines that arise after the execution of this Agreement.

b. For federally funded agreements, these authorities include, but are not limited to, 2 C.F.R. Part 200, subpart F, Appendix II; 42 C.F.R. Part 431, subpart F; 42 C.F.R. Part 433, subpart D; 42 C.F.R. Part 434; 45 C.F.R. Part 75, subpart D; and 45 C.F.R. Part 95, subpart F. To the extent applicable under federal law, this Agreement will incorporate the contractual provisions in these federal regulations and they will supersede any conflicting provisions in this Agreement.

38. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, must file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

2) Each recipient must file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient 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 grant or any extension or amendment of that

contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient must 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 by such person under Paragraph a(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 individuals(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.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant must file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) must be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person must forward all disclosure forms to DHCS Program Contract Manager.

b. 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 or agreement, 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 or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
CERTIFICATION REGARDING LOBBYING

The recipient 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 must complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" (Attachment 2) in accordance with its instructions.

3. The recipient must 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 must 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 will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By signing or otherwise accepting the Agreement, the recipient certifies and files this Attachment 1. **CERTIFICATION REGARDING LOBBYING,** as required by Section 1352, Title 31, U.S.C., unless the conditions stated in paragraph 2 above exist. In such case, the awardee/contractor must complete and sign Attachment 2. **CERTIFICATION REGARDING LOBBYING and returning it to the Department of Health Care Services.**

Attachment 2
CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ___, if known: Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency	7. Federal Program Name/Description:
	CDFA Number, if applicable: _____
8. Federal Action Number, if known:	9. Award Amount, if known:
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a.* *(Last name, First name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above 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.

Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grant.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001”.

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E
Additional Provisions

1. Amendment Process

A. This provision is in addition to provision 2 of Exhibit C, General Terms and Conditions (GTC 02/2025).

B. Should either party, during the term of this Agreement, desire a change or amendment to the terms of this Agreement, such changes or amendments must be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes must be made through the State's official agreement amendment process, unless otherwise stipulated within this Agreement. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), the Centers for Medicare and Medicaid (CMS), or any other applicable regulatory agencies, is such approval(s) are required.

2. Termination for Convenience

A. This provision replaces and supersedes only Provision 10(b) Termination for Convenience in Exhibit D. **Note**: Provision 10(a) Termination for Cause in Exhibit D remains in force as is.

B. This agreement may be terminated, in whole or in part, without cause, and without penalty, by either party by giving thirty (30) calendar days advance written notice to the other party. Such notification must state the effective date of termination or cancellation and include any final performance and/or payment/invoicing instructions/requirements. Upon receipt of a notice of termination or cancellation from DHCS, Contractor must take immediate steps to stop performance and to cancel or reduce subsequent contract costs.

C. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the Contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims.

Exhibit E
Additional Provisions

D. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

3. Insurance Requirements

Contractor must comply with the following insurance requirements:

A. General Provisions Applying to All Policies

1. Coverage Term

   Coverage needs to be in force for the complete term of the contract. If insurance expires during the term of the contract, a new certificate must be received by the State at least thirty (30) days prior to the expiration of this insurance. Any new insurance must still comply to the original terms of the contract.

2. Policy Cancellation or Termination & Notice of Non-Renewal

   Contractor is responsible to notify the State within thirty (30) days of any cancellation, non-renewal or material change that affects required insurance coverage. In the event Contractor fails to keep in effect at all times the specified insurance coverage, the State may, in addition to any other remedies it may have, terminate this Contract upon the occurrence of such event, subject to the provisions of this Contract.

3. Deductible & Other Costs

   Contractor is responsible for any deductible or self-insured retention contained within their insurance program, or any premiums or assessments.

4. Primary Clause

   Any required insurance contained in this contract must be primary, and not excess or contributory, to any other insurance carried by the State.

5. Insurance Carrier Required Rating

   All insurance companies must carry an A rating or better. If the Contractor is self-insured for a portion or all of its insurance, review of financial information including a letter of credit may be required.

Exhibit E
Additional Provisions

6. Endorsements

   Any required endorsements requested by the State must be physically attached to all requested certificates of insurance and not substituted by referring to such coverage on the certificate of insurance.

7. Inadequate Insurance

   Inadequate or lack of insurance does not negate the Contractor's obligations under the contract.

8. Subcontractors

   If Contractor has identified subcontractors for the work/services identified in the scope of work, the Contractor must include all subcontractors as insureds under Contractor's insurance or supply evidence of subcontractor's insurance to the State equal to policies, coverages and limits required of Contractor.

9. Certificate of Insurance

   The Contractor shall furnish a Certificate of Insurance for in complete compliance with the terms of the applicable insurance requirements in this provision (i.e., coverage type; dollar limit per occurrence; cancellation requires notification to DHCS at least thirty (30) days in advance; and the State of California, its officers, agents, and employees are included as additional insureds with respect to work performed for the State of California under this Agreement).

B. Commercial General Liability

Contractor and any subcontractors must maintain general liability on an occurrence form with limits not less than $1,000,000 per occurrence for bodily injury and property damage liability combined. If Commercial General Liability insurance or other form with a general aggregate limit is used, either the general aggregate limits must apply separately to this project/location, or the general aggregate limit must be twice the required occurrence limit. If the aggregate applies "per project/location" it must so state on the certificate. The policy must include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal & advertising injury, and liability assumed under an insured contract. This insurance must apply separately to each insured against whom claim is made or suit is brought subject to the Contractor's limit of liability. The policy must be endorsed to include the State of California, its officers, agents and employees as additional insured with respect to work performed under the

Exhibit E
Additional Provisions

contract. The additional insured endorsement must be provided with the certificate of insurance.

C. Automobile Liability

Contractor must maintain motor vehicle liability with limits not less than $1,000,000 combined single limit per accident. Such insurance must cover liability arising out of a motor vehicle including owned, hired and non-owned motor vehicles. The policy must be endorsed to include the State of California, its officers, agents and employees as additional insured with respect to work performed under the contract. The additional insured endorsement must be provided with the certificate of insurance.

D. Workers Compensation and Employers Liability

Contractor must maintain statutory worker's compensation and employer's liability coverage for all its employees who will be engaged in the performance of the Contract. Employer's liability limits of $1,000,000 are required. The Workers' Compensation policy must be endorsed with a waiver of subrogation in favor of the State.

E. Errors and Omissions/Professional Liability

Contractor shall maintain Errors and Omissions/Profession liability with limits of not less than $1,000,000 each incident and $2,000,000 aggregate covering damages caused by negligent, acts or omissions. The policy retro date must be shown on a certificate of insurance and must be before the Contract date, or before the date contract work begins. 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 the completion of work.

Contractor must maintain Pollution Liability covering the Contractor's liability for bodily injury, property damage, and environmental damage resulting from pollution and related cleanup costs incurred, all arising out of the work or services to be performed under this agreement. Coverage must be provided for both work performed on site and during transportation as well as proper disposal of hazardous materials. Proof of Pollution during transportation must be provided on an MCS-90 form. Limits of not less than $1,000,000 per incident, and annual aggregate amount of $2,000,000 must be provided. The policy must name The State of California, its officers, agents, and employees as additional insured, but only with respect to work performed under the

Exhibit E
Additional Provisions

agreement.

F. Cyber Liability

Contractor shall maintain Cyber Liability insurance with limits of not less than $2,000,000 for each occurrence and an annual aggregate of $4,000,000 covering claims involving privacy violations, information theft, damage or destruction of electronic information, intentional and/or unintentional release of State and or private information, alteration of electronic information, extortion and network security. The policy must name The State of California, its officers, agents, and employees as additional insured with respect to work performed under the contract.

Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

7.2 **Nondisclosure.** Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 19. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Safeguards and Security.

9.1.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at https://csrc.nist.gov/publications/detail/sp/800-53/rev-5/final; updates will be available online at https://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate shall employ FIPS 140-3 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-3 validation can be determined online at https://csrc.nist.gov/projects/cryptographic-module-validation-program/validated-modules/search. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.1.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.1.7 Remote access to PHI from outside the continental United States, inclusive of remote access to PHI by Business Associate's support staff in identified support centers, is prohibited.

9.1.8 Business Associate shall only store PHI in a data center physically located within the continental United States.

9.2 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Collaboration.** The parties shall collaborate as appropriate and necessary to ensure compliance with this Agreement, including but not limited to Sections 11 – 13 of this Agreement. The parties acknowledge and agree that neither party intends that this Agreement shall create obligations and/or liabilities that do not otherwise exist as appropriate based on the nature of the work performed and applicable law.

15. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

16. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

17. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

18. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

19. Breaches and Security Incidents. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

19.1 Notice to DHCS.

19.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification shall be provided via the DHCS Incident Reporting Portal upon discovery of the breach. If Business Associate is unable to provide notification via the DHCS Incident Reporting Portal, then Business Associate shall provide notice by email or telephone to DHCS.

19.1.2 Business Associate shall notify DHCS **within 24** hours via the online DHCS Incident Reporting Portal (or by email or telephone if Business Associate is unable to use the DHCS Incident Reporting Portal) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

19.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

19.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

19.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

19.1.2.4 Potential loss of confidential information affecting this Agreement.

19.1.3 Notice submitted to the DHCS Incident Reporting Portal will be sent to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office. If providing notice to DHCS via email, use the DHCS contact information at Section 19.6 below (collectively, "DHCS Contacts").

Notice shall be made using the DHCS Incident Reporting Portal via the link on the DHCS Data Privacy Website online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx

Notice via email shall be made using the current DHCS "Privacy Incident Reporting Form" and shall include all information known at the time the incident is reported. The form is available online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

19.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

19.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

19.2 Investigation. Business Associate shall immediately investigate such security incident or breach.

19.3 **Complete Report**. Business Associate shall provide a complete report of the investigation to DHCS within ten (10) working days of the discovery of the security incident or breach. This complete report must include any applicable additional information not included in the initial submission. The complete report shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests additional information, Business Associate shall make reasonable efforts to provide DHCS with such information. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

19.3.1 If Business Associate does not submit a complete report within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the complete report.

19.4 **Notification of Individuals**. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

19.5 **Responsibility for Reporting of Breaches to Entities Other than DHCS.** If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

19.6 **DHCS Contact Information**. To contact the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Data Privacy Unit Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office Department of Health Care Services P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

20. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

21. Audits, Inspection and Enforcement

21.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how

DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

21.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

22. Termination

22.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

22.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

22.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

22.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

23. Miscellaneous Provisions

23.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

23.2. **Amendment**.

23.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

23.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 23.2.1 shall constitute a material violation of this Agreement.

23.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

23.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

23.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

23.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
Tri-City Mental Health Authority	95-3775190

By (Authorized Signature)

Printed Name and Title of Person Signing

Date Executed	Executed in the County of

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;

2) the person's or organization's policy of maintaining a drug-free workplace;

3) any available counseling, rehabilitation and employee assistance programs; and,

4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm’s offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor’s records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Dana Barford, Director of MHSA and Ethnic Services**
Sara Rodriguez, MHSA Projects Manager

SUBJECT: **Consideration of Resolution No. 853 Adopting the Tri-City Mental Health Authority's Behavioral Health Services Act (BHSA) Integrated Plan (IP) for Fiscal Year 2026-29, as Recommended by the TCMHA Mental Health Commission**

Summary:

The Welfare and Institutions Code Section (WIC) 5963 states that county mental health programs shall prepare and submit an Integrated Plan and Expenditure Plan for all Behavioral Health Services Act (BHSA) programs and expenditures. The MHSA Projects Manager presented an overview of the three-year Integrated Plan for Fiscal Year 2026-29 for the Tri-City Mental Health Commission during the Public Hearing held on April 14, 2026.

Background:

This BHSA Integrated Plan for Fiscal Year 2026-29 was posted on February 20th, 2026, and the required minimum 30-day review process ended on March 23rd, 2026. Staff circulated a draft of the Integrated Plan by making electronic copies available on TCMHA's website as well as circulating hard copies throughout the community. The plan was also promoted on social media including Facebook, X, and Instagram. Several methods of collecting feedback were available such as phone, QR codes, links, emails, mail, and comment cards. All comments received regarding this plan will be shared during the Public Hearing on April 14th, 2026.

Stakeholder involvement is a critical component to the success of the BHSA process for Tri-City, and staff continue to value and empower community member participation throughout the community planning process. In preparation of this Integrated Plan under BHSA, community members were invited to participate in several opportunities to leave a comment, including but not limited to, community forums, workgroups, focus groups, surveys, as well as invited to share their thoughts during the public comment period of the Public Hearing.

Fiscal Impact:

The Agency has funds available under BHSA to support the BHSA Integrated Plan for Fiscal Year 2026-29.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 853 approving the Authority's Behavioral Health Services Act (BHSA) Integrated Plan (IP) for Fiscal Years 2026-29, as recommended by the TCMHA Mental Health Commission.

Attachments:

Attachment 11-A: Resolution No. 853 – Draft

Attachment 11-B: TCMHA's Behavioral Health Services Act Integrated Plan for Fiscal Years 2026-2029 – Draft

RESOLUTION NO. 853

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ADOPTING ITS BEHAVIORAL HEALTH SERVICES ACT (BHSA) INTEGRATED PLAN (IP) FOR FISCAL YEARS 2026-2029

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") wishes to adopt the Authority's Behavioral Health Services Act (MHSA) Integrated Plan for Fiscal Years 2026-29, as recommended by the Authority's Mental Health Commission.

B. The Welfare and Institutions Code Section (WIC) 5963 established the Integrated Plan for Behavioral Health Services and Outcomes, which each county must develop every three years, and to submit annual updates to that plan, for all Behavioral Health Services Act (BHSA) programs and expenditures.

C. The IP was developed through a Community Planning Process wherein stakeholders and community members participate in reviewing and recommending programming and services.

2. Action

The Governing Board approves the Authority's BHSA Integrated Plan for Fiscal Years 2026-29; and authorizes the Executive Director, or designee, to prepare and submit any and all reports related thereto.

[Continued on page 2]

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3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 15, 2026, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

DRAFT

2026 - 2029 Integrated Plan

Tri-City

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information .

General Information

County, City, Joint Powers, or Joint Submission
Joint Powers

Entity Name
Tri-City Mental Health Authority

Behavioral Health Agency Name
Tri-City Mental Health Authority

Behavioral Health Agency Mailing Address
1717 N. Indian Hill Blvd. Ste B Claremont, Ca 91711

Primary Mental Health Contact

Name
Elizabeth (Liz) Renteria

Email
erenteria@tricitymha.ca.gov

Phone
9097667324

Secondary Mental Health Contact

Name
Deborah Johnson

Email
djohnson@tricitymha.ca.gov

Phone
9097667307

Primary Substance Use Disorder Contact

Name
Elizabeth (Liz) Renteria

Email
erenteria@tricitymha.ca.gov

Phone
9097667324

Secondary Substance Use Disorder Contact

Name
Markie Sterner

Email
msterner@tricitymha.ca.gov

Phone
9097667295

Primary Housing Interventions Contact

Name
Mary Monzon

Email
mmonzon@tricitymha.ca.gov

Phone
9093264624

Compliance Officer for Specialty Mental Health Services (SMHS)

Name
Natalie Majors

Email
nmajors@tricitymha.ca.gov

Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

Name
Natalie Majors

Email
nmajors@tricitymha.ca.gov

Behavioral Health Services Act (BHSA) Coordinator

Name	Email address
Sara Rodriguez	srodriguez@tricitymha.ca.gov
Dana Barford	dbarford@tricitymha.ca.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email address
Elizabeth (Liz) Renteria	erenteria@tricitymha.ca.gov

Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Natalie Majors	nmajors@tricitymha.ca.gov
Tatiana Van Beeck	tvanbeeck@tricitymha.ca.gov

Medical Director

Name	Email address
Dr. Seeyam Teimoori MD	steimoori@tricitymha.ca.gov

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	793
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	000
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	000
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	000

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	24
Were chronically homeless or experiencing homelessness or at risk of homelessness	23
Were in the juvenile justice system	000
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	793
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	000

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	67

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	136
Received Medi-Cal SMHS	2028
Received DMC or DMC-ODS services	000
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	000
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	600

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	600
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	129
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	124
Were incarcerated (including state prison and jail)	143
Reentered the community from state prison or county jail	143
Received acute psychiatric services	195

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

000

Admitted for 14-day and 30-day periods of intensive treatment
000

Admitted for 180-day post certification intensive treatment
000

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
000

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
000

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
The data for this section came from client data from our Electronic Health Record for children and adults using service, demographic, and financial data. Information regarding justice involvement came from the Partnership Assessment Form for FSP participants. This information is from Fiscal Year July 1, 2023, to June 30, 2024.

If desired, provide documentation on the local data used during the planning process

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?

County participates in a Qualified Health Information Organization (QHIO)?

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website

Does the county wish to disclose any implementation challenges or concerns with these requirements?

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 . Does the county wish to disclose any implementation challenges or concerns with these requirements?

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)
a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21

q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**

Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

No

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Spoken Language

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Access to Care – Adult NSMHS

Tri-City Mental Health Authority (TCMHA) reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall adult NSMHS rate for LA County (7.7%) falls below the State mean (10.6%). Within LA County, disparities exist for different population groups. Regarding age, the penetration rates for age groups 57-68 (8.7%) and 69+ (6.6%) are below the county rate (8.9%). Regarding sex, the rate for males (5.8%) is below the county rate (8.9%). Regarding race, the rates for Hispanic (8.3%) and Asian/Pacific Islander (5.5%) are below the county rate (8.9%). Lastly, regarding language, the rates for Farsi (8.7%), Arabic (6.8%), Spanish (6.3%), Armenian (5.9%), Other Non-English (5.5%), Mandarin (4.3%), Korean (3.7%), Vietnamese (3.1%), Tagalog (3%), Cantonese (3%), Thai (2.2%), and Other Chinese Language (2.1%) are below the county rate (8.9%).

Access to Care – Children & Youth NSMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall children & youth NSMHS rate for LA County (12.6%) falls below the State mean (15.5%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rates for age groups 6-11 (8.2%) and 18-20 (8.3%) are below the county rate (11.8%).

Regarding sex, the rate for females (11.5%) is below the county rate (11.8%). Regarding race, the rates for Hispanic (11.5%) and Black/African American (10.3%) groups are below the county rate (11.8%). Lastly, regarding language, the rates for Other Chinese Language (11.5%), Spanish (11.3%), Other Non-English (10.3%), Arabic (10%), Tagalog (8.6%), Russian (7%), and Armenian (4.3%) are below the county rate (11.8%).

Access to Care – Adult SMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall adult SMHS rate for LA County (3.8%) exceeds the State mean (3.4%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rate for age group 65+ (1.9%) is below the county rate (4.3%). Regarding sex, the rate for females (4.0%) is below the county rate (4.3%). Regarding race, the rates for Hispanics (3.1%), and Asian/Pacific Islanders (2.1%) are below the county rate (4.3%).

Access to Care – Children & Youth SMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall children & youth SMHS rate for LA County (5.5%) exceeds the State mean (4.2%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rates for age groups 0-2 (2.1%), 3-5 (3.2%), and 18-20 (5.5%) are below the county rate (5.9%). Regarding sex, the rate for males (5.7%) is below the county rate (5.9%). Regarding race, the rates for White/Caucasian (5.7%), Asian/Pacific Islander (2.3%), and Other Race (3.5%) are below the county rate (5.9%).

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

To address disparities among Medi-Cal eligible adults aged 65+, who access Specialty Mental Health

services (SMHS) at a lower rate (1.9%) compared to the State penetration rate 4.3%, TCMHA plans to address barriers to accessing treatment. Plans include targeted outreach in local spaces where older adults gather, such as community centers, senior centers and assisted living communities; stigma reduction strategies; providing resources to address transportation challenges; and offering different methods of service delivery such as in-home services and telehealth options. Providing support and information about telehealth services may assist older adults in accessing different forms of service delivery that are available to them. Another approach is to collaborate with healthcare providers to provide whole person care as many older adults have co-morbid health conditions. One goal would be to start addressing barriers to treatment at the time-of-service request and continue throughout treatment.

Disparities exist among Hispanic (3.1%) and Asian (2.1%) Medi-Cal eligible adults who access Specialty Mental Health Services when compared to the state penetration rate of 4.3%. Disparities exist among Asian (2.3%) and other race (3.5%) Medi-Cal eligible children who access Specialty Mental Health Services when compared to the state penetration rate of 5.9%. Plans to address these disparities consist of targeted outreach in communities of Hispanic and Asian adults and children by collaborating with local schools and community organizations within TCMHA's service area. Continued focus will be on ensuring a diverse community of providers who are culturally competent and can offer bilingual services. TCMHA will continue to have language interpreter services available to meet language needs. Immigration and related legal concerns may prevent Hispanic and Asian adults, children, and families from accessing SMHS. Discussing confidentiality and reinforcing that TCMHA is a ‘safe space’ can assist in building trust amongst those who may be fearful. Having resources available that address immigration-related barriers for impacted communities will also be helpful.

The rates for Medi-Cal eligible children aged 0-2 (2.1%) and children aged 3-5 (3.2%) accessing Specialty Mental Health services are below the State penetration rate of 5.9%. Marketing and outreach in the cities of Pomona, Claremont, and La Verne are key to ensuring that the community is aware of services offered to young children. Recognition of mental health symptoms in young children is usually low, and providing psychoeducation to school and community members will assist in helping caregivers, providers, and families access mental health services for young children. Creating a pathway for referrals from warm handoffs between child welfare institutions such as the Department of Child and Family Services (DCFS) and schools to TCMHA mental health services will assist with addressing access disparities. Additional training for providers on appropriate evidence-based practices (EBPs), birth to 5 competencies, and completing ICARES assessments for youth 0-5 years old will be important in creating access to care for the 0-5 population.

The overall rate of Medi-Cal eligible adults accessing Non-Specialty Mental Health (NSMHS) services in Los Angeles County (7.7%) falls below the state mean (10.6%). The overall rate of Medi-Cal eligible adults accessing Specialty Mental Health Services in Los Angeles County (3.8%) is higher than the state rate (3.4%). Children access NSMHS at a lower rate in Los Angeles County (12.6%) when compared to the State rate (15.5%); children access SMHS at a higher rate in Los Angeles County (5.5%) when compared to the state rate of 4.2%. One goal is to utilize screening tools at the time-of-service request and at intake to assist in assessing and determining the appropriate level of care. This aim includes training staff to be competent at

utilizing tools to appropriately screen and assess individuals for the proper level of care. Additionally, establishing memoranda of understanding (MOUs) with local Managed Care Plans (MCPs) and other providers to facilitate warm-handoffs and proper transitions of care is important in supporting this goal.

File Upload

Please identify the category or categories of funding that the county is using to address the access to care goal
BHSA Behavioral Health Services and Supports (BHSS)
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Other

Please describe other
Other: grade level (varies), English learner (8.1%), students with disabilities (4.9%) and migrant status (8.4%) are all above the county rate (4.5%).

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Homelessness – PIT Rate of People Experiencing Homelessness

TCMHA reviewed the LA County FY 2024 rates from the CalMHSA Dashboard. The Point-in-Time (PIT) rate for LA County (78) is higher than the state mean (48). Within LA County, population groups experience disparities (FY 2024). Regarding age, the rates for the age group 35-44 (110) and 45+ (80) are above the county rate (78). Regarding gender, the rate for males (94) is above the county rate (78). Regarding race, the rates for American Indian/Alaska Native (578), Black/African American (278), Native Hawaiian (134), and multiple races (81) are above the county rate (78).

Homelessness – Rate of K-12 Students Experiencing Homelessness

TCMHA reviewed the LA County FY 2023-24 rates from the CalMHSA Dashboard. The rate for LA County (4.5%) is below the State mean (5.3%). Within LA County, different groups experience disparities (FY 2023-24). Regarding grade level, the rates for kindergarten (4.8%), grade 1 (4.6%), grade 2 (4.6%), grade 3 (4.7%), grade 4 (4.8%), grade 5 (4.7%), and grade 9 (4.6%) are all above the county rate (4.5%). Regarding race, the rates for American Indian/Alaska Native (7.9%), African American (7.4%), Pacific Islander (6.2%), and Hispanic/Latino (5.3%) are all above the county rate (4.5%).

Homelessness – Rate of People who Accessed Homelessness Services – Supplemental Goal

TCMHA reviewed FY 2024 rates from the CalMHSA Dashboard. The rate for LA County (119) exceeds the State mean (91). Within LA County, different groups experience disparities (FY 2024). Regarding age, rates for under 18 (87), 18-24 (87), and 65+ (42) are below the county rate (119). Regarding gender, the rate for females (85) is below the county rate (119). Regarding race, the rates for Hispanics (85), White/Caucasian (74), and Asian/Pacific Islander (9) are below the county rate (119).

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

TCMHA plans to strengthen and implement several programs, services, and partnerships to reduce homelessness among individuals experiencing severe mental illness (SMI), severe substance use disorders (SUD), and co-occurring conditions. A key initiative will be the development of a Direct Link Outreach Team, staffed through Full-Service Partnership (FSP) programs including FSP- Intensive Case Management FSP Assertive Community Treatment (ACT), Forensic Community Treatment (FACT) Housing Navigators, Mobile Crisis Care and street psychiatry and inclusive of other treatment team members. This team will provide proactive, field-based engagement, housing support services, offer immediate access to coordinated mental health and substance use services, and deliver integrated care for individuals with co-occurring disorders in unsheltered and high-need settings.

TCMHA also plans to work with community partners to establish a Homelessness Coalition that will formalize collaboration with cities, local law enforcement, housing providers, hospitals, and other community agencies. This coalition will focus on coordinated outreach, diversion from incarceration and emergency departments, shared data strategies, and streamlined access to housing and treatment resources. These partnerships are intended to address service gaps that contribute to outcomes below the statewide average, particularly in engagement, continuity of care, and housing stability for individuals with complex behavioral health needs.

Program development has been informed by local data that indicate approximately 46% of adult FSP clients and 22% of transition-age youth clients served by TCMHA have co-occurring mental health and substance use disorders. These data highlights a critical need for integrated, multidisciplinary approaches that address both conditions simultaneously. By expanding field-based outreach, strengthening cross-system coordination, and prioritizing interventions for individuals with co-occurring disorders—who experience higher rates of homelessness and poorer outcomes—TCMHA aims to improve engagement, reduce system fragmentation, and achieve measurable reductions in homelessness within this population, consistent with local needs and statewide performance benchmarks.

Tri-City Mental Health Authority provides coordinated, community-based support to individuals and families experiencing homelessness in the cities of Claremont, Pomona, and La Verne. Through its Direct Link Outreach model, Tri-City delivers field-based services across Full Service Partnership (FSP), Forensic

Assertive Community Treatment (FACT), Assertive Community Treatment (ACT), Intensive Case Management (ICM), Individual Placement and Support (IPS), and specialized Housing teams.

At the core of this work is a dedicated Housing Team that guides individuals through the full housing continuum—from initial street outreach and engagement to benefits enrollment, housing navigation, placement, and long-term stabilization. The team addresses key barriers to housing stability, including income limitations, documentation challenges, and unmet behavioral health needs, ensuring clients are positioned for sustained success in permanent housing.

Through strong community partnerships, the Housing Team supports street outreach efforts and facilitates access to emergency shelter, interim housing, permanent supportive housing (PSH), and other long-term housing options. Partnerships include collaboration with local shelter providers such as Hope for Home, as well as interim and permanent housing programs throughout the region.

In partnership with the Cities of Claremont, Pomona, and La Verne, Tri-City advances innovative housing solutions that expand local capacity and create dedicated housing opportunities for vulnerable residents. Current initiatives include collaboration on the St. Ambrose housing project in Claremont, the Tiny Homes initiative with the City of Pomona, and development of the Baseline Road housing project designed to serve eligible seniors. Collectively, these efforts strengthen the regional continuum of care and expand access to safe, stable, and permanent housing.

Dedicated Housing Team providing navigation, placement, and stabilization.

Field based outreach through FSP FACT, ACT,ICM, IPS , and Housing teams.

Street outreach

Emergency shelter (e.g., Hope for Home)

Interim housing

Permanent Supportive Housing (PSH)

TCMHA provides comprehensive, coordinated services to individuals and families experiencing homelessness across Claremont, Pomona, and La Verne. Central to this work is our dedicated Housing Team, which assists unhoused clients in navigating housing resources, securing permanent housing

placements, and maintaining housing stability once housed. The team works closely with clients to address barriers to housing, connect them to benefits, and ensure access to ongoing supports. City Mental Health Services provides comprehensive, coordinated services to individuals

TCMHA collaborates extensively with the three cities on a range of innovative housing initiatives designed to expand local housing capacity. These efforts include partnering on new housing developments and securing dedicated beds or units for eligible clients, such as the St. Ambrose housing project in Claremont and the Tiny Homes initiative in collaboration with the City of Pomona. In addition, TCMHA is financing a Baseline Road housing project specifically designed to serve eligible seniors, further strengthening the continuum of housing options for vulnerable populations. City collaborates extensively with the three cities on a range of innovative housing initiatives designed to expand local housing capacity. These efforts include partnering on new housing developments and securing dedicated beds or units for eligible clients, such as the St. Ambrose housing project in Claremont and the Tiny Homes initiative in collaboration with the City of Pomona. In addition, TriCity is financing a Baseline Road housing project specifically designed to serve eligible seniors, further strengthening the continuum of housing options for vulnerable populations.

Beyond new developments, TCMHA continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TCMHA delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing, but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability. TCMHA continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TCMHA delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability. City continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TriCity delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing, but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability.

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Please identify the category or categories of funding that the county is using to address the homelessness goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
Age

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Not Applicable

30-day involuntary detention rates per 10,000
Not Applicable

180-day post-certification involuntary detention rates per 10,000
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Above

Permanent Conservatorships
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Above

For children/youth
Above

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Below

Crisis Stabilization

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Spoken Language

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Institutionalization – Average Number of Inpatient Administrative Days (Adults)

TCMHA reviewed FY 2023 (overall average) and FY 2022 (demographic group average) data from the CalMHSA Dashboard. The overall average for LA County (35.3) is above the State mean (25.6). Within LA County, different population groups experience disparities (FY 2022). Regarding age, the average rate for age group 57-68 (53) is above the county rate (35.3).

Institutionalization – Average number of minutes of crisis intervention services utilized by individual – Supplemental Goal - ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (351) is above the State average (240). Within LA County, different population groups experience disparities (FY 2023). Regarding race, the average rates for for Asian American or Pacific Islander (358) and Black (353) populations are above the county rate (351). Regarding language, the average rates for Korean (540) and Mandarin (459) are above the county rate (351).

Institutionalization – Average number of minutes of crisis intervention services utilized by individual – Supplemental Goal - YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (330) is above the State average (267). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rates for age groups 12-17 (417), 18-20 (343), and 6-11 (335)) are above the county rate (330). Regarding race, the average rates for Black (460), Other (370), White (366), Hispanic (352), and Asian or Pacific Islander (339) populations are above the county rate (330). Regarding sex, the average rates for both females (378) and males (361) are above the county rate (330). Regarding language, the average rates for Vietnamese (525), Mandarin (403), English (383), Cantonese (357), and Spanish (340) are above the county rate (330).

Institutionalization – Average number of minutes of crisis stabilization by individual – Supplemental Goal - ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (18) is below the State average (24). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rates for age groups 45-56 (18.53) and 33-44 (18.4) are above the county average (18). Regarding race, the average rates for Black (20), White (19), Other (18.29), and Alaskan Native or American Indian (18.15) populations are above the county average (18). Regarding sex, the average rate for males (19) is above the county average (18). Regarding language, English (18.23) is above the county average rate (18).

Institutionalization – Average number of minutes of crisis stabilization by individual – Supplemental Goal - YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (14) is below the State average (19). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rate for age group 12-17 (15) is above the county average (14). Regarding race, the average rates for Black (18), White (16), and Other (15) populations are above the county average (14). Regarding sex, the average rates for both females (14.97) and males (14.42) are above the county average (14). Regarding language, English (15) is above the county average rate (14).

Institutionalization – Average number of minutes of crisis residential treatment services by individual – Supplemental Goal – ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (29) exceeds the State average (23). Within LA County, no adult population groups are experiencing disparities in crisis residential treatment

services for FY 2023.

Institutionalization – Average number of minutes of crisis residential treatment services by individual – Supplemental Goal – YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (20) is below the State average (22). Within LA County, different population groups experience disparities (FY 2023). Regarding age, youth 18-20 (21.32) is above the country average (20). Regarding sex, the average rate for female (26) is above the county average (20). Regarding language, English (23) is above the county average (20).

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
We are a JPA/City and do not have access to this local data specific to our three cities.

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Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Based on the institutionalization data, we are above the statewide data provided by CALMHSA across many domains; including inpatient days, temporary and permanent conservatorships, as well as crisis interventions. This may be due to lack of knowledge of resources and services provided by Tri-City. Therefore, TCMHA plans to reduce institutionalization rate through various measures that include effective outreach, engagement, crisis response, and treatment. Programming and services that incorporate peer support, first episode psychosis, psychoeducation, Individual Placement and Support (IPS) Supported

Employment, and community partnerships can reduce institutionalization.

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) are considered the highest level of care for individuals with severe mental illness who are at risk of hospitalization. Individuals participating in ACT or FACT services receive regular weekly visits that can be increased during times of crisis/stress to prevent escalation. ACT and FACT teams are composed of multi-disciplinary positions (psychiatrist, registered nurse, clinician, peer, behavioral health specialists) that provide a recovery and whole -person care approach within a team setting. ACT teams are closely involved in hospital admissions and hospital discharge for individuals to ensure continuity of care, coordinate services, and provide support and advocacy.

Peer staff are vital to helping instill hope and promoting recovery to the severe mental illness (SMI) population who often experience multiple hospitalizations or long-term hospitalization. Clients can benefit from incorporating peers in ACT/FACT and TCMHA's overall system of care. Peers are embedded in TCMHA's Mobile Crisis Care team and communicate hope in times of great distress, connect individuals to support networks, and model the fact that recovery is possible. Peers support individuals in accessing and participating services.

TCMHA's Mobile Crisis Care team is available 24/7 and provides phone and field response as needed for any behavioral health crisis. Trained to provide trauma-informed and culturally responsive crisis response (including Language Line interpretation/translation services, as necessary), the Mobile Crisis Care team responds in pairs on their own, with designated TCMHA treatment team members, or in co-response with law enforcement when needed. Mobile Crisis Care helps with de-escalation of crisis, connecting individuals to their support network or treatment teams, and follow-up connecting to behavioral health services and needed resources (i.e. food banks, health care, housing resources, etc.) as alternatives to hospitalization when appropriate. The team also provides outreach and debriefs to the community after critical incidents to provide additional support, psychoeducation on mental health, and access to behavioral health services.

TCMHA's Coordinated Specialty Care First Episode Psychosis program offers treatment, outreach, and workshops to inform the community about the early warning signs of psychosis, corresponding treatment, and how to access services. FEP provides services for individuals ages 12-25 who present with criteria for clinically high risk or experiencing a first psychotic episode. Services can be provided in the community or office to help remove barriers to services. Early identification and treatment of psychosis can lead to better recovery, long term outcomes, and overall reduction of psychiatric hospitalizations.

Both the CSC FEP and ACT teams provide psychoeducation to the individual and supportive people in their lives to assist with safety planning, reducing stressors, and helping with hospitalization when appropriate. Families/Supportive individuals participate in psychoeducation workshops and multi-family groups to help develop knowledge of psychosis, awareness of triggers and stressors that lead to increase in symptoms, and provide effective support when symptoms escalate. Individuals and families are provided with information regarding the difference between voluntary and involuntary hospitalization, the individual's rights, and overall process of a 5150/5585. Treatment teams and Mobile Crisis teams support individuals and families with the steps of voluntary hospitalization by connecting individuals to local psychiatric hospitals and transportation when possible.

TCMHA will also implement evidence-based Individual Placement and Support (IPS) Supported Employment to all adults receiving behavioral health services. Satisfying employment is a key factor in recovery for many individuals with mental illness. IPS services will be available for as long as individuals need them and follow an individualized approach. Individuals with mental illness who have employment can benefit from increased self-esteem, better control of psychiatric symptoms, and reduction of psychiatric hospitalizations and justice involvement.

TCMHA will continue to strengthen partnerships with local community agencies including schools, local law enforcement, and hospitals to help identify individuals who are underserved or untreated in the community and intervene before hospitalization. Collaborative meetings will be held to discuss individuals who have failed to connect to services and create a pathway to care for them. The local emergency room (ER) will identify and refer individuals who present a primary need for behavioral health services to increase access to services for high-risk individuals.

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Please identify the category or categories of funding that the county is using to address the institutionalization goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For juveniles
Below

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity
Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered

to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Justice Involvement – Arrest Rate per 100,000 People by Count – Adult

TCMHA reviewed FY 2023 (rates) and FY 2024 (demographic group rates) from the CalMHSA Dashboard. The rate for LA County (2,066) is lower than the State rate (2,440). Within LA County, population groups experience disparities (FY 2024). Regarding age, the rates for age groups 20-29 (3,118) and 30-39 (3,577) are above the county rate (1,987). Regarding sex, the rate for males (3,189) is above the county rate (1,987). Regarding race, the rate for total population (including adults/juvenile) for black people (4,526) is above the county rate (1,644).

Justice Involvement – Arrest Rate per 100,000 People by Count – Juvenile

TCMHA reviewed FY 2023 (rates) and FY 2024 (demographic group rates) data from the CalMHSA Dashboard. The rate for LA County (277) is lower than the State rate (372). Within LA County, different population groups experience disparities (FY 2024). Regarding sex, the rate for males (408) is above the county rate (277).

Justice Involvement – Adult Recidivism Conviction Rate

(Recidivism conviction rate refers to the percentage of individuals who reoffend after being released from incarceration.)

TCMHA reviewed FY 2019-20 data from the CalMHSA dashboard. The rate for LA County (35.9%) is below the State rate (39.6%). Within LA County, different population groups experience disparities (FY 19-20). Regarding age, 18-19 (65.6%), 20-24 (48.3%), 25-29 (45.9%), and 30-34 (41.1%) groups are above the county rate (35.9%). Regarding sex, the rate for males (36.6%) is above the county rate (35.9%). Regarding race, the Hispanic rate (38.7%) is above the county rate (35.9%).

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Across most domains, Tri-City is below the statewide average for justice. However, Tri-City plans to work with those involved in the criminal justice system with the following approaches. TCMHA will deliver an integrated, evidence-based continuum of behavioral health services designed to reduce recidivism, improve family functioning, and promote long-term stability for probation-involved youth. Services will include Children's Outpatient (COP), Wraparound, Substance Use Disorder (SUD) treatment, Full Service Partnership (FSP), Forensic Assertive Community Treatment (FACT), Intensive Case Management (ICM), and Individual Placement and Support (IPS).

This continuum ensures youth receive the appropriate level of care based on clinical acuity, criminogenic risk factors, and family needs.

Children's Outpatient (COP)

COP will provide individual therapy, family therapy, psychiatric evaluation, and medication management for youth with mild to moderate behavioral health needs. Services will address trauma, emotional regulation, decision-making skills, and family conflict. Functional Family Therapy (FFT) will be integrated within COP to target family-based risk factors linked to reoffending.

Wraparound Services

Wraparound will serve youth with complex, multi-system involvement. A Child and Family Team (CFT) will develop individualized service plans incorporating probation goals, educational needs, and behavioral

health interventions. Services include crisis response, intensive care coordination, and strength-based family engagement.

Substance Use Disorder (SUD) Treatment

SUD services will include screening, assessment, outpatient treatment, relapse prevention, and family education. Motivational Interviewing and cognitive-behavioral interventions will support accountability while reducing substance-related violations.

Full Service Partnership (FSP)

FSP will provide intensive “whatever it takes” services for youth with serious emotional disturbance (SED). Services include field-based support, psychiatric care, flexible funding to remove barriers, housing stabilization when necessary, and integrated care coordination to prevent detention or placement disruption.

Forensic Assertive Community Treatment (FACT)

FACT will serve TAY aged clients with high acuity mental health needs and repeated justice involvement. With small caseloads and field-based interventions, FACT will provide intensive psychiatric services, skill development, crisis intervention, and close collaboration with Probation.

Intensive Case Management (ICM)

ICM will support moderate-to-high need youth requiring structured care coordination, school advocacy, and linkage to pro-social supports. ICM bridges outpatient services and higher levels of care to maintain engagement and reduce system penetration.

Individual Placement and Support (IPS)

IPS will assist transition-age youth (TAY) in securing competitive employment through rapid job placement, employer engagement, and integrated employment planning within behavioral health treatment. Employment stability is a key protective factor against recidivism.

The following evidence-based models will be incorporated:

Multisystemic Therapy (MST): For high-risk youth, MST will provide intensive, home-based intervention addressing family, peer, school, and community systems contributing to delinquent behavior.

Functional Family Therapy (FFT): Integrated within COP and TAY services to reduce family conflict and improve communication and supervision practices.

Cognitive Behavioral Therapy (CBT)

Motivational Interviewing (MI)

Trauma-Informed Care

TCMHA will maintain structured collaboration with Probation through:

Joint case staffing and multidisciplinary team meetings t

Shared service planning aligned with court-ordered conditions

Defined communication protocols and progress reporting

Cross-training between clinical and probation staff

Compliance with confidentiality and information-sharing standards

Probation officers will be engaged as partners in rehabilitation, ensuring accountability while reinforcing therapeutic progress.

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity
Sex

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

TCMHA reviewed January 2025 Point in Time (PIT) rates from the CalMHSA dashboard in regard to children in foster care PIT count (per 100K). The rate for LA County (637) is above the State rate (525). Within LA County, age group disparities exist for PIT January 2025. Age groups rates for 1-2 (766) and Under 1 (706) are above the county rate.

TCMHA reviewed FY 2022 rates and FY 2021 (demographics) data from the CalMHSA Dashboards for open child welfare cases that received SMHS. The rate for LA County (48.2%) exceeds the State rate (43.0%). Within LA County, different groups experience disparities (FY 2021). The rates for age groups 0-2 (32.3%), 3-5 (44.2%), and 18-20 (39.8%) are below the County rate (50.6%). Regarding race, the rates for Other race (44.4%) and Black (49.6%) fall below the County rate (50.6%).

Removal of Children from Home – Children in Foster Care PIT Count (per 100K)

TCMHA reviewed January 2025 PIT rates from the CalMHSA dashboard. The rate for LA County (637) is above the State rate (525). Within LA County, different population groups experience disparities for children in foster care PIT count (Jan 2025). Regarding age, rates for ages 1-2 (766) and Under 1 (706) are above the county rate.

Removal of Children from Home – Open Child Welfare Case that receive SMHS

TCMHA reviewed FY 2022 rates and FY 2021 (demographics) data from the CalMHSA Dashboards. The rate for LA County (48.2%) exceeds the State rate (43.0%). Within LA County, different population groups experience disparities (FY 2021). Regarding age, the rates for groups 0-2 (32.3%), 3-5 (44.2%), and 18-20 (39.8%) are below the County rate (50.6%). Regarding race, the rate for Other race (44.4%) falls below the County rate (50.6%). Regarding sex, the rate for males (50.3%) falls below the County rate (50.6%).

Removal of Children from Home – Child Maltreatment Substantiation (per 1000)

TCMHA reviewed FY 2022 and FY 2024 (demographics) data from the CalMHSA Dashboard. The rate for LA County (6.7) is above the State rate (6.5). Within LA County, different population groups experience disparities (FY 2024). Regarding age, the rate for age group Under 1 (18.5) is above the County rate (6.4). Regarding sex, the rate for females (6.7) is above the County rate (6.4). Regarding race, the rates for Black/African American (17.3), Native American (10.2), and Hispanic (7.4) are above the County rate (6.4).

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Tri-City's review of CALMHSA dashboard data show rates higher than the statewide average across all measures. Particularly those ages 1-2 years old. This may suggest a more comprehensive approach is needed. Tri-City will be using High Fidelity Wraparound to address these disparities for youth of all ages in the community.

TCMHA's plans for reducing the level of removal of children from home include:
Tri-City Mental Health Authority is committed to strengthening families and preventing unnecessary out-of-home placement through coordinated, trauma-informed, and culturally responsive behavioral health services. Central to this approach is the implementation of High-Fidelity Wraparound, a family-driven, team-based planning process designed to prevent removal of children from their homes, improve functioning across life domains, and ensure coordinated service delivery across systems.

High-Fidelity Wraparound emphasizes collaboration among child welfare, probation (when applicable), schools, healthcare providers, community-based organizations, and natural supports identified by the family. Through the development of individualized Child and Family Teams (CFTs), services are aligned around shared goals that address safety, permanency, and well-being. Natural supports—such as extended family members, faith-based connections, mentors, and community partners—are intentionally incorporated to promote long-term sustainability beyond formal system involvement.

To support families connected to Child Welfare, TCMHA will:
Collaborate with key partners who have direct access to youth and families involved in the child welfare system to ensure a clear understanding of available behavioral health services and referral pathways. Ongoing cross-system communication strengthens coordination and reduces service gaps.

Leverage established partnerships to engage youth and families early in the child welfare process, supporting stabilization efforts and mitigating risk factors that may contribute to placement disruption.

Facilitate timely enrollment of eligible youth into Specialty Mental Health Services to ensure access to comprehensive assessment, individualized treatment planning, and psychiatric support when indicated.

Provide coordinated referrals and active collaboration with agencies working to stabilize the family unit, including social services, housing providers, educational institutions, and community-based organizations. This ensures services are integrated rather than fragmented.

Deliver developmentally appropriate, culturally responsive, and trauma-informed care tailored to the unique strengths and needs of each youth and family. Interventions address emotional regulation, parenting capacity, attachment, and behavioral stabilization.

Integrate peer support specialists into treatment planning and service delivery. Peers with lived experience enhance engagement, build trust, and model resilience for youth and caregivers navigating the child welfare system.
Link eligible families to Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) to provide structured, in-home interventions that strengthen family functioning, reduce behavioral crises, and minimize the risk of removal or re-entry into care.

Through High-Fidelity Wraparound and coordinated cross-system collaboration, Tri-City promotes improved family functioning, enhanced caregiver capacity, increased school stability, and reduced reliance on higher levels of care. This integrated approach ensures that families receive the right services at the right time, with natural and community supports positioned to sustain long-term success.

Non Hi-Fi Wrap solutions

Early School Age programming – School based MH services

Strengthening Families to Prevent Removal

HighFidelity Wraparound focuses on stabilizing youth within their homes and communities by addressing the underlying needs that often lead to CPS involvement or placement, such as untreated mental health needs, family stress, trauma, or lack of supports.

Individualized, strengthsbased plans are developed with families, not for them.

Natural supports (extended family, faith leaders, mentors) are intentionally integrated to reduce reliance on systems.

Families receive coaching, skillbuilding, and crisis planning that increases their capacity to safely care for their children.

Coordinated, CrossSystem Collaboration

Wraparound brings together mental health, child welfare, schools, probation, and community partners into one unified team.

Shared planning prevents fragmented or duplicative services.

Early identification of safety concerns allows teams to intervene before CPS thresholds are met.

Collaboration ensures compliance with California mandates (e.g., ICC/ICT, EPSDT, Continuum of Care Reform).

Intensive, Individualized Mental Health Support

Many youth enter foster care or group homes due to untreated or escalating mental health and behavioral needs. Wraparound addresses this directly by:

Coordinating timely access to specialty mental health services.

Embedding therapeutic interventions within daily routines and natural settings.

Supporting caregivers to manage behaviors safely and effectively.

Crisis Prevention and Safety Planning

HighFidelity Wraparound includes proactive crisis and safety planning, which is critical in preventing CPS reports and placement disruptions.

Teams identify triggers early and develop clear response strategies.

Families have 24/7 access to support and crisis response resources.
Plans are regularly updated based on realtime needs.

Reducing Placement Disruptions and ReEntry into Care

For youth already involved with CPS or at risk of placement, Wraparound helps:

Stabilize foster or kinship placements.

Support reunification and prevent reentry into care.

Reduce placement changes by addressing behavioral and emotional needs holistically.

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Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

TCMHA's Follow-up after Emergency Department Visit for Mental Illness rate (32.2%) is below the statewide rate (38.2%) and median (37.3%). Publicly available FUM equity data are not available. Rate of self-reported untreated BH needs in the county (50.4%) is slightly higher than State rate (48.4%). Rate of untreated BH needs is noticeably higher amongst 18–24-year-olds (60.2%). Slightly higher rates exist amongst males (53.9%), Asian/Pacific Islander (55.8%), and Hispanics (54.9%).

Untreated Behavioral Health Conditions - Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year – Supplemental Goal

TCMHA reviewed FY 2023 rates from the CalMHSA Dashboard. The rate for LA County (50.4%) is above the State rate (48.4%). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the rate for 18-24 year olds (60.2%) is above the County rate (50.4%). Regarding sex, the rate for males (53.9%) is above the County rate (50.4%). Regarding race, the rates for Asian/Pacific Islanders (55.8%) and Hispanics (54.9%) are above the County rate (50.4%).

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
TCMHA's plans to decrease the level of untreated behavioral health conditions involve different components. This is based on the county to statewide comparisons provided by CALMHSA.

TCMHA will establish MOUs with local hospitals to create a clear, easy pathway that ensures individuals connect to behavioral health services.

TCMHA staff (access to care team and/or MCC) will provide timely responses and contact individuals, identify appropriate behavioral health services, and provide warm hand offs to other providers (e.g., private insurance, local providers) when needed.

TCMHA staff will facilitate regular collaborative meetings with partners to address barriers and identify individuals who fail to connect to behavioral services or who have multiple ER visits related to behavioral health or substance use. Staff will outreach to, engage with, and connect individuals who meet criteria for Full-Service Partnership ACT or FACT as appropriate. FSP ACT and FACT will provide regular outreach in

community locations, homeless shelters, or spaces most appropriate and convenient for the individual. In addition, referred individuals will work with the same ACT team from outreach to treatment to help facilitate engagement, rapport, and participation in services.

Peer support staff in the FSP ACT or FACT teams will help engage and connect with all populations, specifically the chronically mentally ill and homeless. Peer staff will assist with development and implementation of solutions to improve follow-up to services.

TCMHA will ensure that all staff are trained and have access to Language Line to be able to outreach to target populations and provide services in a client's language of choice including but not limited to Spanish and Asian Pacific Islander languages.

TCMHA will leverage existing community partnerships (e.g., local universities and K-12 organizations) to bring awareness of and access to behavioral health services and reduce related stigma. TCMHA will make marketing materials available to increase mental health literacy and use peer support staff to assist in the development of marketing messaging and social media posts to increase engagement.

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Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For children/youth
Above

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Below

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Below

For children/youth (specific to Child and Adolescent Well-Care Visits)
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Above

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Below

For children/youth
Above

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Below

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals .

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below

the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Care experience

Care experience

Please describe why this goal was selected
The goal of improving client care experience and perceptions of cultural appropriateness was selected because there is a critical need to increase client engagement and generate reliable local data to effectively monitor progress. The plan is to use local, disaggregated data to identify disparities and understand clients' perceptions of cultural appropriateness, co-design solutions with community partners, and adjust care in real time based on client feedback. Services will be culturally responsive and family-centered, with attention to clients' cultural and ethnic identities, LGBTQ+ status, age, family context, and gender-specific needs. TCMHA will monitor access, retention, and client-reported outcomes using clear, measurable indicators.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Although countywide data do not indicate a significant disparity, local findings suggest opportunities to strengthen cultural responsiveness and client connectedness. In the May 2025 LACDMH Treatment Perception Survey, 90% of adults and 79% of youth reported that staff were sensitive to their cultural background; however, no disaggregated local data are currently available. In contrast, results from a TCMHA client survey indicate that meaningful improvements in culturally responsive care are still needed. To address these gaps, TCMHA will establish a baseline using its survey data and implement targeted strategies, including increasing clinical staffing levels, expanding therapy appointment availability, enhancing staff training to improve treatment quality, and implementing continuity-of-care protocols to ensure clients consistently see the same providers.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Care experience and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
To advance this Care Experience goal and increase perception of cultural appropriateness, TCMHA will use local, disaggregated data to identify gaps, set targets, and guide continuous improvement. Specifically, TCMHA will (1) analyze local data on access, engagement, and discharge by race/ethnicity, language, sexual orientation and gender identity (SOGI), and age bands; (2) synthesize themes from client experience surveys

and grievances/appeals to determine pain points in navigation and cultural responsiveness; and (3) monitor retention-in-care and no-show trends to inform and direct outreach. Within treatment, staff will deploy a feedback-informed approach that captures brief, session-by-session client-reported outcome and experience measures (e.g., wellbeing and alliance scales) so clinicians can tailor care in real time, escalate support when scores flag risk, and close the loop with clients and families. All services will be culturally responsive and person- and family-centered, explicitly attentive to each client's cultural and ethnic identity, LGBTQ+ status, age, family context, and gender-specific needs. Together, local data, community partnership, and real-time client feedback will help TCMHA deliver care that is equitable, trustworthy, and effective for the people the agency serves.

Please identify the category or categories of funding that the county is using to address this goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

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Please indicate the type of engagement used to obtain input on the planning process

County outreach through social media
County outreach through townhall meetings
County outreach through traditional media (e.g., television, radio, newspaper)
Focus group discussions
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings
Other
Public e-mail inbox submission
Key informant interviews with subject matter experts
Meeting(s) with county
Provided data to county

Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders

Attending community partner events, community meetings to enhance reciprocity of the relationships, touring community partner locations through immersive visits.

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

County outreach through social media

Date
1/10/2025

Type of engagement
County outreach through social media

Date
5/17/2025

Type of engagement
County outreach through townhall meetings

Date
1/29/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
1/1/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
5/22/2025

Type of engagement
Focus group discussions

Date
3/3/2025

Type of engagement
Focus group discussions

Date
3/6/2025

Type of engagement
Focus group discussions

Date
3/22/2025

Type of engagement
Focus group discussions

Date
3/25/2025

Type of engagement
Focus group discussions

Date
3/26/2025

Type of engagement
Key informant interviews with subject matter experts

Date
8/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
8/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/1/2025

Type of engagement
Meeting(s) with county

Date
8/18/2025

Type of engagement
Meeting(s) with county

Date
11/10/2025

Type of engagement
Provided data to county

Date
8/18/2025

Type of engagement
Provided data to county

Date
11/10/2025

Type of engagement
Public e-mail inbox submission

Date
10/29/2025

Type of engagement
Survey participation

Date
3/6/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/28/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/29/2025

Type of engagement
Training, education, and outreach related to community planning

Date
2/5/2025

Type of engagement
Training, education, and outreach related to community planning

Date
2/23/2025

Type of engagement
Training, education, and outreach related to community planning

Date
3/19/2025

Type of engagement
Training, education, and outreach related to community planning

Date
5/27/2025

Type of engagement
Workgroups and committee meetings

Date
7/15/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

Type of engagement
Workgroups and committee meetings

Date
9/16/2025

Type of engagement
Workgroups and committee meetings

Date
10/21/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
The community planning process involved organizations such as Compassionate Pomona, La Nueva Voz, Brownstone Mentoring Services, Community Research Translational Initiative (CRTI), City of Pomona, Lion's Club, House of Ruth, Bonita Unified School District, Pomona Unified School District, National Alliance on Mental Illness (NAMI), Police Department, World Peace Now, Pomona Valley Hospital Medical Center (PVHMC), University of La Verne, Meals on Wheels, Community Action for Peace, University Club of Claremont, League of Women Voters, Pomona Community Life Commission, the Immigrant Integration and Inclusion Grant, and Hope for Housing.

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name

	City name
1	n/a
2	n/a
3	n/a
4	n/a
5	n/a

Were you able to engage all required stakeholders/groups in the planning process?
No

If not, which required stakeholder/groups were you unable to engage in the planning process?
Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
Labor representative organizations
Local public health jurisdictions
The five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities.)

Labor representative organizations
Stakeholder group is not applicable to county

Local public health jurisdictions
Stakeholder group is not applicable to county

The five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities.)
Stakeholder group is not applicable to county

Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
Attempted but did not receive a response

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities

To ensure diverse community input, a variety of inclusive engagement strategies were implemented throughout 2025:

January Community Forum: Hosted at a community partner location and open to all stakeholders, including staff, partners, clients, and community members.
Community Planning Process Survey: Open from March to June 2025, this survey gathered broad input on community needs and priorities.
March Focus Groups: Targeted outreach to culturally diverse and historically marginalized populations to ensure equitable representation.
MHSA to BHSA Workgroups: Held from July 2025 and running until June 2026, these workgroups facilitated deeper dialogue and planning among stakeholders.
Community-Identified Strengths-
Participants consistently highlighted the Tri-City Mental Health Authority as a community asset, citing its:
Robust programs
Frequent community forums and events
Broad opportunities for engagement and support
Community-Identified Priorities-
Key themes emerged across engagement efforts:
Housing: A critical need for increased housing development and services for individuals experiencing homelessness.
Workforce Development: Emphasis on strategies to support, develop, and retain a strong behavioral health workforce
While we were unable to connect with labor representative organizations, the agency was still able to gather meaningful worker perspectives during our community planning process by using alternative methods to hear directly from workers and from groups that understand their experiences. Tri-City engaged workers through listening sessions, surveys, focus groups, and pop-up outreach at community hubs and events. Tri-City relies on ongoing advisory groups that include workers who are active in broader community networks—such as faith communities, cultural organizations, and neighborhood associations—ensuring that a wide range of lived experiences informs our planning efforts.
Although Local public health jurisdictions were not specifically engaged, Tri-City plans to expand our connection with the local public health department and meaningfully incorporate their perspective into future community planning by treating them as a core partner rather than an outside stakeholder. Public health staff can help frame issues, identify vulnerable populations, and highlight health impacts that might otherwise be overlooked. Their data—covering chronic disease, air quality, walkability, food access, emergency response, and other social determinants of health—can guide our priorities and clarify who benefits or is burdened by planning decisions. Tri-City intends to include them in cross-sector working

groups, advisory committees, and joint workshops, so their expertise is integrated into key discussions. Tri-City also recognizes their strong relationships with hospitals, clinics, schools, and community-based organizations, which means partnering with them expands our reach into populations that may be harder to engage directly.
While we could not identify a local Tribal and Indian Health Program designee established for Medi-Cal Tribal consultation purposes, Tri-City can still incorporate Tribal and Indian Health perspectives in our planning process. Tri-City can consult nearby Tribal governments, Indian Health Service regional offices, Urban Indian Health Programs, and state Tribal liaison offices to understand cultural priorities, health needs, and community concerns. Tri-City can also gather input directly from Indigenous residents through listening sessions and partnerships with Native-serving nonprofits and cultural organizations. These approaches ensure Indigenous perspectives are meaningfully reflected in our planning efforts, even without a formal local representative.

Upload File

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) **? Additional information regarding engagement requirements with other local program planning processes can be found in** Policy Manual Chapter 3, Section B.2.3.
Other

Please explain why or describe an alternate approach taken.
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Collaboration

Please select how the county collaborated with the LHJ
Other.

Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP

Other

Please describe

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Was data shared?

No

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development

Other

Please describe

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Was data shared?

No

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Other

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP **? Additional information regarding engagement requirements with other local program planning processes can be found in** Policy Manual Chapter 3, Section B.2.3
No

Please explain why the county did not consider the LHJ's CHA/CHIP or strategic plan when preparing its IP
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs'

respective community reinvestment planning and decision-making processes
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment
2/20/2026

Date the stakeholder comment period closed
3/23/2026

Date of behavioral health board public hearing on draft IP
4/14/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
Social Media 1 PDF.pdf
Website Posting.png
04-14-2026 TCMHA Notice of BHSA Public Hearing Eng-Spa.pdf
March 2026 Claremont Courier TCMHA BHSA Public Hearing.pdf
March 2026 La Nueva Voz BHSA Public Hearing.pdf
Social Media 2.pdf

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page

File Upload

Please select the process by which the draft plan was circulated to stakeholders
Public posting
Other
Email outreach

Attach email
Proof of External Notice.pdf
Proof of Internal Notice.pdf

Please specify the other process the draft plan was circulated to stakeholders
Additional processes used to circulate the plan included social media, website, flyers, public announcements (city council meetings, community meetings), newspapers, and public comment during Tri-City Commission and Governing Board meetings.

Please describe stakeholder input **in the table below. Please add each stakeholder group into their own row in the table**

Stakeholder group that provided feedback
Community member

Summarize the substantive revisions recommended this stakeholder during the comment period
Tri City's BHSA plan ignores the gut-brain connection, despite peer-reviewed evidence that gut health is central to mental health. By excluding nutrition and detoxification from its strategy, Tri City is failing its own mission statement and opting to "mask" symptoms rather than treat root causes. It is disappointing that a $30 million organization with significant carry-over funds would task a private citizen with policy change instead of using its own political clout to implement these essential, evidence-based health strategies.

Stakeholder group that provided feedback
Families of eligible children and youth, eligible adults, and eligible older adults

Summarize the substantive revisions recommended this stakeholder during the comment period

In the Integrated Plan both types of outreach (outreach provided by Community Navigators compared to outreach provided by Direct Link Outreach Team) were listed as only one type of outreach and Tri-City is encouraging staff to revise it for clarity.

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

This information will be provided after our 30-day public comment period, final stakeholder meetings, and Public Hearing.

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

Medical QI Plans.pdf

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

No

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided

Number of contracted BHSA provider locations

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	000
Substance Use Disorder (SUD) services only	000
Both MH and SUD services	000

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	000
DMC/DMC-ODS only	000
Both SMHS and DMC/DMC-ODS systems	000

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

No

If not, please describe how the county will monitor these providers for compliance with BHSA requirements

N/A

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
No

If not, please describe how the county will monitor these providers for compliance with BHSA requirements
Tri-City does not contract out for any mental health services, substance use disorder services or both MH/SUD services; all services are provided by Tri-City. Therefore, there is no provider(s) contracted to monitor.

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Children's System of Care (non-Full Service Partnership (FSP))
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care .

Please select the service types provided under Program

Supportive services

Please describe the specific services provided
n/a, there was no option to delete the program, so individual entries were deleted. Stigma reduction was removed under BHSS.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	0
FY 2027 – 2028	0
FY 2028 – 2029	0

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
n/a, there was no option to delete the program, so individual entries were deleted. Stigma reduction was removed under BHSS.

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care .

Please select the service types provided under Program
Supportive services

Please describe the specific services provided
The Family Wellbeing program offers a wide range of activities and supports designed to meet the needs of entire families, blending support groups, one-on-one guidance and culturally relevant wellness activities such as exercise and cooking to engage caregivers and community members in meaningful, peer-supported experiences. While the program is not clinical in nature, the team is equipped to assess individuals in crisis and, when necessary, coordinate with Mobile Crisis Care team or local law enforcement

to ensure the person receives the appropriate level of care, whether through the Tri-City clinic or a hospital emergency room. Families may also be connected with additional resources through Community Navigators or Tri-City's Housing Department, creating a network of support that extends beyond immediate wellbeing activities.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	362
FY 2027 – 2028	372
FY 2028 – 2029	384

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Supportive services

Please describe the specific services provided
Community Navigators program connects individuals and families to vital local resources. Their trained team provides referrals and linkage to services including but not limited to mental health care, legal aid, food banks, substance use treatment, support groups, parenting classes, medical support, free clothing and shoes. By collaborating with schools, law enforcement, and community-based organizations, Navigators implement a localized system of care which is responsive to the individual needs of communities, the people who receive services, and their families.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1359
FY 2027 – 2028	1400
FY 2028 – 2029	1442

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Supportive services

Please describe the specific services provided

Ending the Silence and NAMI 101 are community presentations offered through the National Alliance on Mental Illness (NAMI) and provide an overview of emotional disorders and mental health conditions commonly experienced among children, adolescents and youth. The presentations support the network surrounding the individual who is experiencing behavioral health symptoms and impairments, emphasizing the involvement of the individual's peers and family. Ending the Silence is a 50-minute presentation designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones, emphasizing the importance of psychosocial wellness and family engagement. The second presentation, NAMI 101, is designed to strengthen program participants' knowledge while providing a more solid development of skills through structured content. The topics to be covered in NAMI 101 include: an overview of what mental illness is, how to maintain wellness, how to identify symptom triggers, how to identify a support system such as peers and family and how that identification supports overall psychosocial rehabilitation, mental health warning signs, empathy, boundary setting, and self-care.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	298
FY 2027 – 2028	307
FY 2028 – 2029	316

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2

Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Supportive services

Please describe the specific services provided

Peer mentors provide supportive services by engaging in active listening, assisting individuals in identifying personal strengths and functional areas of need, assessing the types of support required, and offering guidance on appropriate resources to address those needs. Peer mentor services are provided by a culturally diverse team trained in recovery-oriented support. Using their own lived behavioral-health experience, peer mentors help individuals feel connected, offer hope, and provide guidance that supports coping skills and progress toward recovery goals. Peer Mentors aim to support individuals by Increasing their sense of connection and reduce isolation as individuals engage with a supportive peer who validates their experiences, improved self-awareness, including clearer identification of personal strengths, needs, and recovery goals, and enhance coping skills through guidance informed by the individual's lived behavioral-health experience. Mentors also support through providing recovery-oriented activities, services, and community support, increase hope, motivation, and confidence in the individual's ability to manage behavioral-health challenges, improve participants ability to identify and access appropriate resources, including clinical, social, and community support, support progress toward individualized recovery goals, supported by ongoing encouragement and strength-based interventions.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	62
FY 2027 – 2028	64
FY 2028 – 2029	66

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Supportive services

Please describe the specific services provided
The Family Wellbeing program offers a wide range of activities and supports designed to meet the needs of entire families, blending support groups, one-on-one guidance and culturally relevant wellness activities such as exercise and cooking to engage caregivers and community members in meaningful, peer-supported experiences. While the program is not clinical in nature, the team is equipped to assess individuals in crisis and, when necessary, coordinate with Tri-City's Mobile Crisis Care team or local law enforcement to ensure the person receives the appropriate level of care, whether through the Tri-City clinic or a hospital emergency room. Families may also be connected with additional resources through Community Navigators or Tri-City's Housing Department, creating a network of support that extends beyond immediate wellbeing activities.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	362
FY 2027 – 2028	372

Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	384

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Supportive services

Please describe the specific services provided

The Therapeutic Community Garden (TCG) is designed to promote mental wellness and decrease isolation. The program will serve Transition-Age Youth (TAY) and Adults and Older Adults residing in the three designated cities of Pomona, Claremont, and La Verne via structured therapeutic horticulture programming in a safe, inclusive, and recovery-oriented environment. Through nature-based activities, psychoeducational workshops, and peer-supported group engagement, participants will strengthen protective factors that support emotional resilience and overall well-being. Programming will also decrease social isolation by fostering meaningful social connections, intergenerational engagement, and community engagement. Participants will develop practical coping and healthy lifestyle skills through facilitated sessions focused on mindfulness, stress management, emotional regulation, and problem-solving. Additionally, TCG will increase access to services by providing direct linkages and warm handoffs to behavioral health and supportive services within TCMHA, including outpatient care, case management, peer support, and other appropriate levels of care.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1181
FY 2027 – 2028	1216
FY 2028 – 2029	1253

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Supportive services

Please describe the specific services provided

The Tri-City Wellness Center serves as a welcoming community space where people of all ages can access free services that support mental health recovery, resilience and overall wellness. Visitors are greeted by trained staff, peer advocates, volunteers and clinicians who foster a sense of belonging and encourage personal growth for individuals and families. Supported by highly trained staff and strong community partnerships, the center offers a wide range of holistic resources that promote independence and well-being, including peer support groups, family and youth services, employment and educational assistance, computer access, recreational and culturally responsive activities, as well as assessment, referral and linkage to additional supports.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	3312
FY 2027 – 2028	3411
FY 2028 – 2029	3513

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Access to Care

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Assessments

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply

Acceptance and Commitment Therapy (ACT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Peer Support Services (* Acceptance and Commitment Therapy (ACT) was selected above in order to circumvent a glitch, we are not utilizing ACT, only Peer Support Services)

Please describe intended outcomes of the program or service

The Access to Care Program serves as the centralized entry point for TCMHA's services Act Early Intervention (PEI) services. In accordance with PEI requirements, the program is designed to prevent mental health and substance use disorders from becoming severe and disabling, reduce behavioral health disparities, and promote timely access to culturally and linguistically responsive care.

Services are delivered across the lifespan, including children, adolescents, transition-age youth, adults, and older adults. The multidisciplinary Access Team conducts timely, trauma-informed, and culturally responsive assessments to identify early signs and symptoms of mental health and substance use concerns, assess risk and functional impairment, and determine appropriate level of care. Interpretation and translation services are available to ensure meaningful access for individuals and families with limited English proficiency and to advance health equity.

Consistent with PEI principles of early identification and rapid linkage, the program ensures expedited access to the least restrictive, community-based services appropriate to individual need. The team provides direct linkage to outpatient mental health and substance use treatment, early psychosis and youth-focused services, school-based supports, services for older adults, prevention programs, and recovery supports. When urgent needs are identified, the program coordinates same-day or priority appointments to reduce delays in care and prevent escalation.

The Access to Care Program strengthens system coordination and continuity by supporting appropriate placement, facilitating step-up or step-down transitions, and addressing social determinants of health through linkage to primary care, housing, food resources, and peer and family supports. Through proactive engagement, equity-driven practices, and rapid connection to services, the program advances BHSA/PEI goals of prevention, early intervention, and long-term wellness for individuals and families across the lifespan.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2964
FY 2027 – 2028	3053
FY 2028 – 2029	3145

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Mobile Crisis Care

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply
Acceptance and Commitment Therapy (ACT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Peer Support Services (* Acceptance and Commitment Therapy (ACT) was selected above in order to circumvent a glitch, we are not utilizing ACT, only Peer Support Services)

Please describe intended outcomes of the program or service
TCMHA's Mobile Crisis Care team provides 24/7 phone and field-based behavioral health crisis response. Services are trauma-informed, culturally responsive, and include interpretation and translation to ensure meaningful language access for all individuals served. While available across the lifespan, services prioritize children, adolescents, and young adults age 25 and under, with focused language-accessible support and coordination in school settings to promote early identification and intervention.
The team responds in pairs, with designated TCMHA clinicians, or in co-response with law enforcement when appropriate.
Aligned with BHSA Early Intervention principles, Mobile Crisis Care emphasizes rapid access, de-escalation, and linkage to the least restrictive, community-based services to prevent escalation and reduce unnecessary hospitalization. The team strengthens natural supports, connects individuals to ongoing behavioral health treatment, and links families to essential resources including food, healthcare, and housing.
Proactive outreach targets youth and young adults (25 and under) in schools and community settings through screening, psychoeducation, and culturally and linguistically responsive engagement. Following critical incidents, the team provides outreach and debriefings to promote recovery and increase awareness of available behavioral health services.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	93
FY 2027 – 2028	96
FY 2028 – 2029	99

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Peer Mentor Tay Wellbeing

Please select which of the three EI components are included as part of the program or service

Outreach

Access and Linkage: Other

Please specify "other" type of Access and Linkage

Peer mentors provide supportive services by engaging in active listening, assisting individuals in identifying personal strengths and functional areas of need, assessing the types of support required, and offering guidance on appropriate resources to address those needs.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Peer mentor services are provided by a culturally diverse team trained in recovery-oriented support. Using their own lived behavioral-health experience, peer mentors help individuals feel connected, offer hope, and provide guidance that supports coping skills and progress toward recovery goals. Peer Mentors support participants with increasing sense of connection and reduce isolation as individuals engage with a supportive peer who validates their experiences, improved self-awareness, including clearer identification of personal strengths, needs, and recovery goals, enhance coping skills through guidance informed by the individual's lived behavioral-health experience. Peer Mentors support aims to increase participants engagement in recovery-oriented activities, services, and community support, lead to increased hope, motivation, and confidence in the individual's ability to manage behavioral-health challenges, improve ability to identify and access appropriate resources, including clinical, social, and community support, increase progress toward individualized recovery goals, supported by ongoing encouragement and strength-based interventions.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	251

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	259
FY 2028 – 2029	266

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Community Wellbeing Grants

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Other

Please specify "other" type of Access and Linkage
The Community Wellbeing Grant program provides grantees and their communities the knowledge and information needed regarding the process of seeking an assessment when appropriate. Grantees are equipped with understanding of screening, intake and assessment processes and refer as needed to Tri-City or other resources as needed.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
The Community Wellbeing Grants aim to strengthen the capacity of local communities to increase social connection and mental wellbeing. The program builds upon the knowledge and valuable experience of local communities and supports them to accomplish their goals in a manner they see fit for their community. Mental and emotional wellbeing of their members are enhanced by the program providing ongoing guidance and support from Tri-City staff to achieve project goals, technical assistance to collect and receive data from their community and evaluate their project's impact. The program promotes increased awareness of mental health and wellbeing within grantees communities, including providing numerous opportunities to network and share with other local communities, access to evidence-based mental health and trauma-informed training, and connection to resources.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	8473
FY 2027 – 2028	8727
FY 2028 – 2029	8989

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name
First Episode Psychosis

CSC program description
The First Episode Psychosis (FEP) program is a Coordinated Specialty Care (CSC) initiative focused on providing early intervention for individuals experiencing their first episode of psychosis. This multidisciplinary, recovery-oriented program serves youth and young adults ages 12 to 40 who are within the first two years of the onset of psychotic symptoms. Services are grounded in evidence-based practices, including medication management, supported education and employment (SEE), cognitive behavioral therapy for psychosis (CBT), family education and support, and case management. The program emphasizes shared decision-making and cultural responsiveness and prioritizes community integration and reduction of long-term disability associated with psychosis.
Referrals come from emergency departments, primary care, schools, behavioral health providers, and families. Outreach and engagement strategies include psychoeducation, peer support, and mobile assessment. The program is currently co-located with other youth services and collaborates with county and community-based organizations to ensure continuity of care.
*Tri-City estimated numbers for CSC Eligible Population-Number of Medi-Cal Enrolled Individuals, to be 32 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Eligible Populations- Number of Uninsured Individuals, to be 4 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Practitioners and Teams Needed-Number of Practitioners Needed to Serve Total Eligible Population, to be 4 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Practitioners and Teams Needed-Number of Teams Needed to Serve Total Eligible Population, to be based on being 2% of the Los Angeles County population

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	1604
Number of Uninsured Individuals	218

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	196
Number of Teams Needed to Serve Total Eligible Population	46

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	4	5	5
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
No

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Direct Link Outreach

Please describe the program or activity
The Direct Treatment Link Outreach Team is designed to advance the core goals of the Behavioral Health Services Act (BHSA) by promoting early intervention, prevention, and equitable access to behavioral health services across the lifespan. The program aligns with BHSA priorities by emphasizing community collaboration, cultural responsiveness, and client- and family-driven care. Through proactive engagement and coordinated service delivery, the program seeks to reduce disparities, strengthen system navigation, and improve behavioral health outcomes for vulnerable and underserved populations. TCMHA will implement a multidisciplinary, field-based outreach and engagement model that provides a direct pathway

to assessment, treatment, recovery, and supportive services. The Direct Treatment Link Outreach Team is comprised of clinical and supportive services staff, including Full-Service Partnership (FSP) clinicians, housing specialists, substance use disorder (SUD) counselors, behavioral health clinicians, crisis staff, and certified peer support specialists. This integrated team approach ensures individuals receive timely screening, warm handoffs, and coordinated linkage to the most appropriate level of care, consistent with BHSA's early intervention and prevention framework.

Outreach activities will include community-based engagement events, behavioral health education workshops, school and campus presentations, participation in health fairs, and targeted field outreach in high-need areas. Events will focus on early identification of behavioral health needs, stigma reduction, psychoeducation, and direct connection to services. TCMHA will collaborate with community-based organizations, local school districts, colleges, senior centers, hospitals, law enforcement, and other partners to expand access points and ensure broad community reach.

Target Populations include Early Childhood (Ages 0–5): Families with young children at risk of developmental, social-emotional, or behavioral health concerns, with an emphasis on early identification and family-centered support, Out-of-School and Secondary School Youth: Adolescents and young adults experiencing barriers to education, employment, or behavioral health services, including those at risk of system involvement, Older Adults: Individuals experiencing social isolation, co-occurring mental health and substance use challenges, and/or housing instability, Adults at Risk of Homelessness: Individuals with complex stressors, including co-occurring substance use and mental health conditions and LGBTQA+ Community Members: Individuals experiencing behavioral health disparities and barriers to culturally affirming care.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1037
FY 2027 – 2028	1068
FY 2028 – 2029	1100

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs

Since this will be a new program, Tri-City used numbers from 2024 and 2025 and estimated the number of individuals who would need additional outreach and engagement at the time-of-service request. 3% growth was added to the total number of clients for fiscal years 26/27, 27/28 and 28/29.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Relias

Please select which of the following categories the activity falls under
Continuing Education

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
TCMHA plans to expand its internship program into a comprehensive, agency-wide initiative by building partnerships with additional universities and providing enhanced comprehensive support. Efforts made to increase partnerships with local universities will support addressing the diversity of the behavioral health workforce.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be

addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Service Learner Program

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Working Independent Skills Helping (WISH) Program

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Community Mental Health Training

Please select which of the following categories the activity falls under
Other

Please define the other activity
Community Mental Health Training (CMHT) program offers free, evidence-based education to residents and community partners in Claremont, La Verne, and Pomona. These programs aim to build resilience, increase mental health awareness, and educate community members. Training offered include but are not limited to Mental Health First Aid (MHFA), Community Resiliency Model (CRM), Motivational Interviewing (MI), Adverse Childhood Experiences (ACEs), and Know the Signs. Sessions can be modified to meet specific group needs and are available as monthly webinars or in-person presentations. A practical focus of self-care strategies, trauma-informed practices, and tools for supporting friends and family are embedded in presentations.

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Electronic Health Record

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data exchange and interoperability
Electronic health record system
Monitoring
Telemedicine

Please describe the project
The primary goal of implementing a new EHR is to increase the organization's ability to track, manage, and analyze program data while reducing administrative burden and improving care coordination. As programs grow in volume and complexity, manual or fragmented systems limit visibility into service utilization, staff productivity, outcomes, and funding requirements. A robust EHR addresses these gaps by integrating clinical, operational, and reporting functions into a single system that currently does not exist.

A new EHR tailored for mental and behavioral health will enhance the organization's capacity in several critical areas:

1. Program and Service Tracking

Real-time tracking of client enrollment, attendance, service intensity, and discharge outcomes

Ability to differentiate and monitor multiple programs (e.g., various outpatient programs, case management, housing, outreach, crisis services, group services)

Standardized documentation across programs to ensure consistency and quality

2. Clinical/Non-Clinical Documentation and Care Coordination

Streamlined intake, assessments, treatment plans, progress notes, and discharge plans

Support for evidence-based practices and individualized treatment planning

Improved communication and continuity of care among clinicians, supervisors, and support staff

Case Coordination across multiple programs e.g. Initial Access service outreach, clinical programs, Billable non billable programs, Employment Services, Housing services, etc.

Integrated built in telehealth for all providers

Telemedicine and prescription management for Medical staff

3. Data, Reporting, and Outcomes Measurement

Customizable reports to track program performance, client outcomes, and service trends

Improved capacity to meet funder, grant, and regulatory reporting requirements

Data-driven decision-making to support program development, quality improvement, and strategic planning

4. Compliance and Risk Management

Built-in safeguards to support HIPAA compliance and data security

Audit trails and standardized workflows to reduce documentation risk

Support for licensing, accreditation, and payer requirements

5. Workforce and Operational Efficiency

Improved scheduling, productivity tracking, and workload management

Reduced duplication of data entry and paperwork

More efficient onboarding and supervision of new staff as the organization grows

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Human Resources Integrated System (HRIS)

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data warehouse
Monitoring

Please describe the project
Adding a fully integrated Human Resources Information System (HRIS) as strategic infrastructure is essential to organizational sustainability, compliance, quality of care, and financial health.

1. Managing Growth Across Multiple Programs and Divisions

We operate multiple, distinct programs (e.g., outpatient services, clinic-based services, crisis intervention, school-based services, case management, housing services), each with unique staffing models, credentialing requirements, productivity expectations, and funding sources.

A robust HRIS enables:

Centralized employee records while allowing program level differentiation

Clear tracking of staff assignments across multiple programs or cost centers

Consistent HR policies with flexibility for program specific workflows

Visibility into staffing capacity, vacancies, and turnover by program or division

2. Integration with Payroll and Finance for Accuracy and Compliance

Mental health organizations rely heavily on precise payroll and financial alignment, particularly when:

Staff split time across programs or grants

Billing and reimbursement depend on staff credentials or licensure

Funding sources require detailed labor cost reporting

An integrated HR–Payroll–Finance system allows:

Automatic synchronization of employee status, pay rates, and job changes

Accurate allocation of labor costs by program, grant, or funding stream

Reduced payroll errors and compliance risk

Realtime financial reporting tied directly to workforce data

This integration is critical for audit readiness, grant compliance, and informed financial decision making.

3. Advanced Data Analysis and Cross-referencing Capabilities

As organizations grow, leadership needs more than static reports—they need actionable insights.

A modern HRIS supports:

Cross referencing HR, payroll, and finance data to analyze true program costs

Workforce analytics on turnover, retention, overtime, and vacancy trends

Diversity, equity, and workforce demographic reporting

Forecasting staffing needs based on service demand and growth projections

These capabilities allow leadership to move from reactive problem solving to strategic workforce planning.

4. Program Specific Performance Management and Goal Setting

Performance management in a mental health organization cannot be onesizefitsall. Clinicians, supervisors, program managers, and administrative staff all require different performance frameworks aligned with their roles and program goals.

An integrated HR system enables:

Multiple performance management models within one platform

Program specific goals tied to clinical outcomes, productivity, or quality metrics

Individual and team based goal setting aligned with organizational strategy

Continuous feedback, not just annual evaluations

This ensures accountability while respecting the clinical, ethical, and operational differences across programs.

5. Built-in Clinical Supervision and Management Models

Supervision is foundational in mental health services—for quality of care, staff development, and regulatory compliance. A robust HRIS can embed supervision directly into workforce management.

Key capabilities include:

Tracking of supervisory relationships and ratios

Documentation of clinical and administrative supervision sessions

Monitoring licensure, certification, and supervision hours

Linking supervision outcomes to performance reviews and professional development plans

Embedding supervision within the HR system strengthens clinical governance and supports staff growth while reducing risk.

6. Supporting Workforce Wellbeing and Retention

Burnout and turnover are persistent challenges in mental health organizations. An integrated HR system supports proactive retention strategies by:

Identifying workload imbalances and overtime patterns

Tracking professional development and career progression

Supporting equitable supervision and performance feedback

Providing data to inform wellness, engagement, and retention initiatives

This is not only an HR concern—it directly impacts continuity of care and client outcomes.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Financial Management System

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data exchange and interoperability
Monitoring
Other

Please describe the other focus area of the project
Financial Management System

Please describe the project

As a growing mental health agency, our organization now operates multiple programs supported by diverse funding streams, including government contracts, grants, insurance reimbursements, and other restricted funds. This growth has increased the complexity of our financial operations, compliance requirements, and reporting obligations.

An integrated financial system would allow for program- and department-specific budgeting, forecasting, and tracking, ensuring that expenses and revenues are accurately aligned with funding requirements and organizational goals. Our agency operates a complex billing environment that includes multiple payer types and reimbursement methodologies. Financial data must align precisely with clinical services documented in the Electronic Health Record (EHR). Currently, limited system integration requires manual data transfers and reconciliations. An integrated financial system that “speaks” directly with the EHR and billing systems would enable:

Automated revenue recognition and reconciliation

Improved accuracy between clinical services and financial records

Faster billing cycles and improved cash flow

Stronger audit trails and compliance support

An integrated solution would link payroll, benefits, and staffing data directly to financial reporting and program budgets.

Need for Robust Budgeting, Forecasting, and Financial Controls

A modern integrated financial system supports:

Multi-year and grant-based budgeting

Real-time budget-to-actual comparisons

Program and department-level projections

Scenario modeling for funding changes or program expansion

These capabilities are essential for leadership to make informed strategic decisions, respond proactively to funding changes, and plan for sustainable growth. Our current system’s limitations restrict our ability to forecast accurately and manage financial risk.

Standard Accounting and Bookkeeping Requirements

As a Joint Powers Authority, we must maintain rigorous accounting and bookkeeping practices, including:

General ledger management

Accounts payable and receivable

Fund and grant accounting

Audit-ready documentation

An upgraded integrated system would streamline these processes, reduce manual workarounds, and strengthen internal controls—supporting both operational efficiency and fiduciary responsibility. An integrated financial system would provide standardized, customizable monthly reports and on-demand data access, improving transparency, accountability, and organizational decision-making.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

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Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	29452
Number of Uninsured Individuals	5027
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	9615

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	3817

ACT Eligible Population	Estimates
Number of Uninsured Individuals	652

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	1909
Number of Uninsured Individuals	326

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	680
Number of Teams Needed to Serve Total Eligible Population	68

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	17	25	30
Total Number of Teams	2	3	3

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	23726
Number of Uninsured Individuals	4049

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	1115

FSP ICM Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	223

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	44	46	47
Total Number of Teams	6	7	7

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	30

HFW Eligible Population	Estimates
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	12
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	12	13	16
Total Number of Teams	3	4	5

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	43105
Number of Uninsured Individuals	7644

IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	3173
Number of Teams Needed to Serve Total Eligible Population	1269

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	3	3	3

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	2	2	2

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
Yes

Please describe how the estimated practitioners will provide more than one EBP
TCMHA plans to utilize practitioners who are cross-trained in multiple EBPs to serve participants across different evidence-based modalities as appropriate. This approach allows for flexibility in addressing the complex behavioral health needs of participants. To maintain fidelity to the respective EBPs, practitioners will receive ongoing supervision, training, and support to ensure effective delivery of various interventions. EBP's will include Assertive Community Treatment, Forensic ACT, Coordinated Specialty Care for First Episode Psychosis, Individual Placement and Support, Multisystemic Therapy, Functional Family Therapy, High Fidelity Wraparound and Parent Child Interaction Therapy.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
TCMHA's FSP program implements a whole-person, trauma-informed approach by focusing on mental health, physical health, social supports, housing stability, and engaging clients in a supportive care planning process. Teams actively engage family members, caregivers, and natural supports in treatment planning and decision making. Care coordination prioritizes understanding of participants' lived experiences, cultural context, and trauma history to determine and provide personalized, strength-based care.

Please describe the county's efforts to reduce disparities among FSP participants
TCMHA is committed to reducing disparities through targeted outreach to identified communities and historically underserved populations in Pomona, La Verne, and Claremont. Strategies include culturally and linguistically competent services and resources such as traditional healers when available, bilingual bi-cultural staff, partnerships with community-based organizations, and data-driven monitoring to identify and address inequities in access, engagement, and outcomes.

Select which goals the county is hoping to support based on the county's allocation of FSP funding
Access to care

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM
FSP ICM teams conduct regular, proactive outreach including home visits, community-based engagement, and flexible appointment scheduling. Teams maintain continuous contact to ensure participants remain connected to services and support and adhere to individualized care plans. Mobile Crisis Care (MCC) services will be utilized to address urgent and emergent needs of individuals.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP
Beyond standard EBP requirements, teams provide additional engagement through peer support specialists, wellness checks, and community resource navigation to address social determinants of health and encourage sustained recovery.

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)
TCMHA will comply by basing the appropriate number of new ACT and FACT teams on data and maintaining FSP ICM teams for participants who require intensive, flexible support. Staffing, training, and supervision structures will align with state guidelines for level of care. TCMHA will utilize level of care tools to appropriately place individuals in programs and ensure smooth transitions in treatment.

Please indicate whether the county FSP program will include any of the following optional and allowable services
Please see below

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
Outreach activities will include collaboration with local clinics, shelters, and community organizations in Pomona, La Verne, and Claremont. Teams will conduct field visits, participate in community events, and leverage peer networks to engage eligible participants. There will be a Direct Link to Care Outreach with providers on FSP outreaching to potential participants.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
The FSP program will offer recovery-oriented services such as peer mentoring, wellness and life skills offered in individual and group formats, vocational support, and structured recreational activities to promote social inclusion and holistic recovery.

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
TCMHA reviewed local juvenile justice data, conducted stakeholder meetings with probation and

youth-serving agencies through its Behavioral Health Student Services Act (BHSSA) program, and integrated best practices to tailor FSP services for youth at risk of justice system involvement.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
TCMHA engaged LGBTQ+ advocacy groups and community stakeholders, including local schools and universities to ensure FSP services are culturally competent, affirming, and sensitive to the unique challenges faced by LGBTQ+ youth. TCMHA has a long-standing partnership with Pomona Valley Pride.

In the child welfare system
FSP program planning included data review, collaboration with child welfare agencies, and consultations with caseworkers to address the specific behavioral health needs of youth in foster care or under child protective services supervision.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults **in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are**

Older adults
TCMHA analyzed demographic and service utilization data, engaged senior advocacy groups, and coordinated with geriatric mental health providers to identify effective strategies for serving older adults.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Stakeholder engagement included consulting with LGBTQ+ adult organizations such as Pomona Valley Pride and community leaders to inform program design and training staff in culturally responsive, inclusive, and affirming care practices.

In, or are at risk of being in, the justice system
TCMHA reviewed criminal justice data, held focus groups with formerly incarcerated individuals, and partnered with probation and reentry programs to develop strategies that address behavioral health needs and reducing recidivism among justice-involved adults.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

n/a, as there are no current programs

Program descriptions

n/a, as there are no current programs

Current funding source

n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements

n/a, as there are no current programs

Expected timeline of operation

n/a, as there are no current programs

Mobile-field based programs

Existing programs

n/a, as there are no current programs

Program descriptions
n/a, as there are no current programs

Current funding source
n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements
n/a, as there are no current programs

Expected timeline of operation
n/a, as there are no current programs

Open-access clinics

Existing programs
n/a, as there are no current programs

Program descriptions
n/a, as there are no current programs

Current funding source
n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements
n/a, as there are no current programs

Expected timeline of operation
n/a, as there are no current programs

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Assertive field-based initiation program

Program descriptions

TCMHA will deploy a multidisciplinary, assertive field-based initiation program designed to proactively engage individuals living with substance use disorder (SUD), particularly those experiencing homelessness, justice involvement, or frequent emergency system utilization. Outreach teams will include peer support specialists, community health workers, and licensed clinicians who conduct regular field visits in encampments, shelters, transit hubs, and other high-need areas.

The program will facilitate rapid access to medications for addiction treatment (MAT) by offering same-day assessment and immediate linkage to care. Field teams will be equipped with mobile technology to conduct screenings, verify eligibility, and directly schedule appointments at partnering clinics. When clinically appropriate, buprenorphine induction may be initiated in the field or via telehealth connection to waivered providers. Transportation assistance, appointment reminders, and warm handoffs will ensure continuity of care.

Outreach strategies are informed by multiple data sources, including:

• Homeless Management Information System (HMIS) data identifying high-utilization individuals and encampment locations

• Emergency Medical Services (EMS) overdose call data and naloxone deployment reports

• Emergency department and hospital discharge data related to SUD

• Law enforcement and first responder incident data

• Community-based organization (CBO) referrals and lived-experience input from peer staff

Based on LAHSA's dashboards PIT homeless count 2025, there are 651 homeless individuals in the three cities including categories of sheltered (staying in a temporary shelter), unsheltered no dwelling, and dwellings (assuming at least one person per dwelling).For SUD, used 1 in 10 that DHCS sites the California Health Care Foundation https://www.dhcs.ca.gov/BHT/Pages/Fact-Sheet-Prop-1.aspx Used 1/10 for California Medi-Cal Beneficiaries it's 3,843 0-25 individuals and 6,939 26+ years total of 10, 781

Planned funding

FSP

Planned operations

TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.

Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions, engagement, and linkage to treatment and supportive services.

A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and

facilitate rapid engagement and warm handoffs.
TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation

Timeframe
Targeted Outreach – Key Activities
April–May 2026
Finalize program design, service hours/coverage, partner MOUs, field safety protocols, data tracking, and harm reduction supply logistics.
June 2026
Recruitment begins (SUD counselors, peer support specialists, MCC/field staff as applicable); initiate onboarding plan and training calendar.
July–August 2026
Hire and onboard staff; complete training (harm reduction, engagement, overdose follow-up, documentation/billing); establish referral workflow with hospitals/partners; soft-launch limited outreach days and refine.
September 2026
Scale field presence, expand partner referrals, confirm mobile routes/schedules, and ensure supply chain and supervision coverage.
Fall 2026
Full launch of Targeted Outreach as part of ACCESS Anywhere Recovery combined team operations, with routine outreach schedule and full referral/follow-up workflow.

Mobile-field based programs

New programs

Mobil Field-Based Program

Program descriptions

The field-based program emphasizes person-centered, trauma-informed engagement strategies to build trust and support long-term recovery. Outreach staff—especially peer specialists with lived experience—serve as the primary point of contact, meeting individuals where they are physically and emotionally.
Key components include:
• Harm reduction services: Distribution of naloxone, fentanyl test strips, sterile syringes (where permitted), and safe use education to reduce overdose risk and infectious disease transmission
• Basic needs support: Provision of hygiene kits, food, water, and connections to shelter and healthcare

services
• Motivational interviewing: Staff are trained in evidence-based techniques to support individuals in exploring readiness for change without judgment or coercion
• Trust building: Consistent, repeated contact in the field, prioritizing relationship development over immediate service uptake
• Rapid MAT access: Immediate referral or direct linkage to MAT providers, including same-day or next-day appointments, telehealth initiation, and transportation support

Planned funding
FSP

Planned operations
TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.
Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions, engagement, and linkage to treatment and supportive services.
A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and facilitate rapid engagement and warm handoffs.
TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation
April–May 2026
Confirm service model, field coverage plan, coordination protocols with PD/community partners, supervision structure, and documentation/billing workflows.
June 2026
Recruitment begins for added field capacity (SUD counselors, peers, and other field staff as needed).
July–August 2026
Hire/onboard; complete training (crisis de-escalation, harm reduction, safety, documentation); begin staged expansion of field outreach days and hours.
September 2026
Operational readiness check: staffing coverage, partner referral workflows, and performance monitoring; expand to routine coverage across target areas.

Fall 2026
Full launch of expanded Mobile Field-Based operations integrated with Mobile Clinic and Open Access pathways.

Open-access clinics

New programs
Open-Access

Program descriptions
To complement field-based outreach, the City will support open-access, low-threshold clinics designed to provide rapid, flexible access to MAT without requiring appointments, extensive documentation, or abstinence.
These clinics will:
• Offer same-day, walk-in access to MAT, including buprenorphine and extended-release naltrexone
• Establish partnerships with licensed opioid treatment programs (OTPs) to provide or refer patients for methadone treatment, including transportation or mobile medication unit access where feasible
• Utilize streamlined intake processes, minimizing paperwork and eliminating unnecessary barriers such as proof of residency or insurance preauthorization
• Operate with flexible hours, including evenings and weekends, to accommodate individuals with unstable schedules
• Co-locate or coordinate with syringe services programs (SSPs) and harm reduction services to provide a comprehensive continuum of care
• Provide drop-in outpatient services, including counseling, case management, and peer support
Additionally, clinics will implement care navigation services to ensure that individuals are matched with the most appropriate form of MAT based on clinical need and personal preference. Warm handoffs, real-time scheduling, and follow-up support will promote retention in treatment.

Planned funding
FSP

Planned operations
TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.
Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and

medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions, engagement, and linkage to treatment and supportive services.
A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and facilitate rapid engagement and warm handoffs.
TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation
April–May 2026
Confirm service model, field coverage plan, coordination protocols with PD/community partners, supervision structure, and documentation/billing workflows.
June 2026
Recruitment begins for added field capacity (SUD counselors, peers, and other field staff as needed).
July–August 2026
Hire/onboard; complete training (crisis de-escalation, harm reduction, safety, documentation); begin staged expansion of field outreach days and hours.
September 2026
Operational readiness check: staffing coverage, partner referral workflows, and performance monitoring; expand to routine coverage across target areas.
Fall 2026
Full launch of expanded Mobile Field-Based operations integrated with Mobile Clinic and Open Access pathways.

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
TCMHA will conduct an internal assessment to identify gaps between existing Medications for Addiction Treatment (MAT) capacity and the level of resources required to meet estimated population need. This assessment will include an inventory of county-operated services, Field Psychiatry capacity, contracted MAT providers, and community-based providers participating in Medi-Cal managed care and fee-for-service delivery systems. Quantitative data sources will include MAT utilization rates, wait times for medication initiation, emergency department and inpatient utilization related to substance use disorders, overdose surveillance data, and referral outcomes.

Field Psychiatry teams will contribute real-time data regarding unmet need, including the frequency of same-day MAT requests, delays in medication initiation, and barriers to access encountered in community and field-based settings. TCMHA will analyze service capacity by geography and population to identify service gaps and prioritize expansion through targeted contracting, referral agreements, and service delivery redesign. Findings will inform a phased implementation plan to ensure adequate MAT capacity and same-day access,.

Select the following practices the county will implement to ensure same day access to MAT

Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Contract directly with MAT providers in the County

What forms of MAT will the county provide utilizing the strategies selected above?

Buprenorphine
Naltrexone
Methadone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of

Care (CoC) Housing Inventory Count (HIC) **to inform responses to this question.**

Supportive housing
Large gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Small gap

(Interim) Single room occupancy units
Small gap

Accessory dwelling units, including junior accessory dwelling units
No gap

(Permanent) Tiny homes
Small gap

Shared housing
Small gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Large gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large gap

License-exempt room and board
Small gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Small gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Small gap

Recuperative Care
Medium gap

Short-Term Post-Hospitalization housing
Small gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Small gap

Peer Respite
Medium gap

Permanent rental subsidies
Large gap

Housing supportive services
Large gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals ?
TCMHA will connect with different non-BHSA resources to expand housing. New LA County funds through Measure A will add to the development of additional supportive housing. TCMHA will work with LA's Flexible Housing Subsidy Pool to connect clients with rental subsidies and Intensive Case Management Services while building partnerships with landlords. TCMHA will also coordinate with the housing authorities for LA county and City of Pomona as a subrecipient in the CoC certificate program (pending NOFO). These efforts will be supported through data-sharing agreements and Memorandums of Understanding (MOUs) to streamline referrals and prioritize individuals who qualify for BHSA assistance.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
TCMHA's programs align with and enhance non-BHSA resources. TCMHA provides a structured process that connects clients to the most appropriate housing supports available. Clients who are identified as being eligible for BHSA housing assistance will complete a housing assessment to determine needs and establish their goals while outlining a plan to address obstacles to housing such as missing personal documents or legal barriers. This approach prepares clients to successfully access external programs as they become available. TCMHA's field-based case management services help clients address housing-related issues before they escalate. Staff will provide in-home visits, landlord mediation, and problem-solving support to prevent eviction and preserve tenancy.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
TCMHA advocates for and supports clients in securing and maintaining stable housing. Although preferred housing resources are not guaranteed, TCMHA provides high quality, person-centered housing services that lead to the most favorable and realistic outcome possible. TCMHA takes a Housing First approach and participates in the Coordinated Entry System designed by LA County. This team-based approach assists clients in locating, applying for, and securing permanent housing. Each client who is determined to be eligible for BHSA housing will receive case management that focuses on addressing existing barriers to housing, housing stability, and skill-building. Each client will complete a Housing Support Plan to outline barriers to housing, specific, measurable, achievable/attainable, relevant, and time-bound (SMART) goals, and a corresponding action plan. TCMHA participates in the Coordinated Entry System to connect client with eligible resources. Field-based supportive services will be provided to eligible housed individuals to promote housing stability and assist in promptly addressing emerging issues.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

TCMHA has partnered with six housing developers to provide permanent supportive housing (PSH) units, allowing direct referrals for BHSA-eligible individuals. On-site supportive services are provided to tenants in these units, and additional tenants can access assistance with connecting to community resources, including enrollment in mental health services. TCMHA also owns a property that was converted into an 8-unit, low-barrier housing option, designed to accommodate individuals with housing vouchers or subsidies. Through these combined efforts, BHSA-eligible individuals have access to PSH while receiving the wraparound support necessary to maintain stability and enhance long-term housing retention. TCMHA's connection to the Coordinated Entry system ensures that clients have access to additional PSH resources throughout the County.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

TCMHA will integrate on-site and field-based services to ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care. After developing standardized processes upon finalizing Memoranda of Understanding (MOUs), Residential Services Coordinators (RSCs) and housing staff collaborate with property management, treatment teams, and community partners to connect tenants with mental health services, substance use support, and other resources. Clinical staff conduct assessments, develop individualized service plans, and coordinate care for tenants in both permanent supportive housing and other housing settings. Field-based services, including in-home visits and problem-solving support, ensure that clients facing housing-related challenges, such as risk of eviction, receive timely interventions and linkage to appropriate services. By embedding these supports and maintaining active communication, the system ensures that all residents have consistent access to the behavioral health care and housing services needed to maintain stability and well-being.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

TCMHA identifies, screens, and refers individuals eligible for BHSA Housing Interventions through a coordinated, multi-step process. Community members can connect to TCMHA by contacting the Access to Care team or through a referral from another agency. Intake staff first conduct an assessment to confirm they meet criteria for mental health services. Clinical staff identify clients with housing-related needs during

routine assessments or treatment interactions. Housing staff then conduct individualized housing assessments to determine eligibility and appropriate housing goals, such as obtaining housing, maintaining current housing, or preventing eviction. Housing staff complete a Housing Support Plan which is shared with the rest of the client care team to guide next steps and to connect clients to suitable housing resources, including permanent supportive housing units, vouchers, or other low-barrier options. Housing staff will confirm that the client is connected to the Los Angeles Coordinated Entry System, or they will open them in the system, to ensure the client is able to be matched to county-wide resources.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only **?**
No

Please indicate why the county behavioral health system will not provide BHSA funded Housing Interventions to individuals living with a SUD only and include data to support
Other

Other than insufficient need or insufficient resources, please explain why the county is not providing BHSA-funded Housing Interventions to individuals living with a SUD only
Currently TCMHA does not serve SUD only clients. It serves clients with co-occurring MH and SUD. TCMHA BHSA-funded Housing Interventions have historically been designed to serve individuals with co-occurring behavioral health conditions, with a particular focus on those experiencing both serious mental illness and substance use disorder (SUD). This approach reflects the program's emphasis on addressing the complex and intersecting needs of individuals whose housing instability is closely linked to both mental health and substance use challenges, and who often require more intensive, integrated care coordination to achieve housing stability.
TCMHA is now embarking on expanding its efforts to directly support individuals with SUD-only needs. This evolution recognizes the critical role that stable housing plays in recovery and overall well-being for individuals experiencing substance use challenges, even in the absence of a co-occurring mental health diagnosis.
Through this expanded approach, individuals with SUD-only needs will be eligible for housing-related assistance, including housing navigation, short-term interventions, and connections to community-based housing resources. In addition, individuals will be actively linked to appropriate SUD treatment services, including outpatient, residential, and medication-assisted treatment (MAT) programs, to support their recovery.
This enhanced model ensures a more inclusive and responsive system of care, maintaining strong support for individuals with co-occurring conditions while also extending meaningful housing interventions to individuals with SUD-only needs.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
TCMHA reviewed data, behavioral health clinical records, and the Homeless Management Information System (HMIS) information to assess trends in housing instability and service utilization.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
TCMHA analyzed research regarding affirming housing interventions.

In the child welfare system
Stakeholder engagement included engagement of school officials and child services and transition age youth organizations and community members.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
TCMHA also analyzed demographic data to identify disparities among subpopulations, including veterans, older adults, and individuals with disabilities, ensuring housing programs are equitable, person-centered, and recovery-oriented.

In, or are at risk of being in, the justice system
TCMHA engaged the police departments for the three cities to participate in conversations during our stakeholder meetings as well as a smaller focus group

In underserved communities
TCMHA invited all community members and a variety of organizations to our stakeholder meetings as well as focus groups targeting the following populations: African American, Asian American/Pacific Islander, Hispanic, law enforcement, first Responders, and Healthcare Professionals. LGBTQ+, Native/Indigenous Americans, Older Adults, Peers, Clients/Caregivers/Community Members, People Experiencing Homelessness or who are at risk, people with disabilities, people with substance use disorders, school officials/child services, and transition age youth. Among those were Pomona's African American advisory Alliance, Kennedy Austin Foundation, the Asian American Studies Department at Pomona College, Galan Cultural Center, Pomona Valley Pride, Costanoan Rumsen Tribe, Hope for Home homeless shelter, Service Center for Independent Life, and Just Us 4 Youth.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

TCMHA will coordinate closely with the local Continuum of Care (CoC) through a structured referral and communication process to ensure timely access to Housing Intervention services for individuals with behavioral health needs. Coordination will occur through regular case conferencing, shared data systems, and established referral protocols between behavioral health providers and CoC partners.

Behavioral health staff will work directly with CES navigators to identify eligible clients, complete necessary assessments, and ensure that referrals include comprehensive information regarding behavioral health status, service needs, and ongoing supports.

TCMHA will designate a Housing Liaison to serve as the primary point of contact with the CoC. This liaison will participate in CoC meetings, maintain communication with housing providers, and facilitate bi-directional referrals. When clients are enrolled in behavioral health programs, staff will support their engagement in housing services by coordinating care plans, attending case management meetings, and ensuring continuity of behavioral health treatment during transitions into housing.

Additionally, data sharing agreements between TCMHA and the CoC's Homeless Management Information System (HMIS) will support tracking of referrals, placements, and outcomes, enabling both systems to monitor progress and identify service gaps.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

TCMHA will collaborate with local CoCs through integration of the coordinated entry system, braided funding, and participating in collaborative meetings to identify successes and areas for improvement.

Public Housing Agency

TCMHA is actively engaged with the local housing authorities including Pomona and LA County. TCMHA has access to the county HMIS database and partners with the CoCs as sub-recipients of CoC certificates.

TCMHA will work with the housing authorities to collaborate on local plans and align resources.

MCPs
TCMHA and the local MCPs will collaborate to outline the resources available through each agency and implement a system to communicate regarding joint participants. TCMHA will confirm BHSA eligibility and resources available while the MCPs will confirm insurance eligibility and availability of funding through their CalAIM Community Supports.

ECM and Community Supports Providers
TCMHA will build a partnership with the ECM and Community Supports providers to align goals, share data, and conduct case conferencing for joint clients. Both will identify when there is a need to refer to each other's services when a community member is only connected to one partner. TCMHA will provide updates on eligible resources available for clients, and ECM and Community Support providers will identify when they have exhausted funds for each client.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
TCMHA will build connections with other programs such as CalWORKS/TANF housing programs, child welfare housing programs, and PSH developers and when appropriate, implement an MOU to streamline communication. TCMHA will seek out partners to identify a unified goal of supporting BHSA eligible community members with housing needs. By building a cross-system approach that leverages housing, social services, and behavioral health resources, this collaboration will help prevent homelessness, promote stability, and increase sustainable recovery.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?
TCMHA will provide on-site supportive services at partnered PSH properties and case management for individuals and families, with CoC certificates, living in scattered-site housing. TCMHA's care teams will work directly at these locations to support client recovery as well as connect them to healthcare, employment, education, and other community resources, while collaborating with property management to promote housing stability and prevent eviction. TCMHA will be available to offer support to Homekey+ projects by providing coordinated services, case management, and referrals for BHSA-eligible individuals, ensuring stable housing and improved health outcomes.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
114

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
88

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
11

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
TCMHA estimated total rental subsidies using Fair Market Rent (FMR) and number of clients in need of assistance from historical client trends. Using data we identified the distribution of household size needs. Total rental subsidies were identified by unit size and incorporated annual rent, security deposit, and utility allowance comparable to the schedule used by the Los Angeles County Development Authority. Interim housing subsidies were estimated based on local bed rates for the maximum allowable time frames.

For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

TCMHA will provide rental subsidy assistance to qualifying clients for a duration based on individual need and, to the extent possible. TCMHA will work with local landlords to identify units that fall at or below Fair Market Rents, are open to partnering with the agency, and will accept the rental subsidy directly from the agency.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

TCMHA will leverage its strong partnerships with local organizations, housing authorities, and state and local agencies to identify and maintain a portfolio of available housing units for BHSA-eligible individuals. This will include close collaboration with county partners such as the Continuum of Care (CoC), local public housing authorities, and community-based housing providers to ensure access to a range of housing options, including permanent supportive housing and units secured through master leasing.
Through coordinated data sharing and regular case conferencing, TCMHA will track housing availability, assess client needs, and match eligible individuals to appropriate placements in real time. In partnership with local developers, non-profit housing agencies, and county housing departments, TCMHA will work to expand and sustain the housing portfolio, leveraging both existing resources and new development opportunities.
These collaborative efforts will ensure a responsive, integrated system that supports timely placement of BHSA participants into safe, stable, and recovery-oriented housing environments.

Total number of units funded with BHSA Housing Interventions per year

135

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year
47

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
TCMHA will use BHSA Housing Interventions to maintain ongoing operations at current property that provides stable housing for 8 separate households along with 3 new projects that will add 39 additional units. These funds will support core housing-related expenses necessary to sustain the property's operations and continued occupancy for residents. TCMHA contracts with a local property management company to oversee day-to-day operations, including collecting rent, property maintenance, coordination of unit turnover, inspections, and compliance with applicable housing standards.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
47

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
88

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Funds will be used to engage landlords and provide education and ongoing support through monthly meetings and special trainings geared at landlord-identified areas of concern. Funds will also be available for financial mitigation, such as holding fees, covering unit repairs, rental losses, or damages, to reduce barriers to tenancy. Workshops geared to address tenant and landlord rights and responsibilities will be available to present at properties throughout the three cities or in a local community hub that is accessible to local landlords and their tenants.

Total number of units funded with BHSA Housing Interventions per year
88

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
41

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Funds may cover essential costs such as security deposits, rental application fees, move-in expenses, storage fees or rent/utility arrears. Integrated with TCMHA's established housing referral and supportive service framework, this intervention allows staff to quickly address financial barriers that normally present delays in completing applications, getting a client approved at a property, or moving in, provided they have exhausted Medi-Cal assistance first.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

80

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

TCMHA will provide housing transition navigation and tenancy-sustaining services to individuals who are determined to be ineligible for these supports through their MCP. Using BHSA Housing Interventions funding, TCMHA staff will assist clients with locating and securing housing, completing applications, and coordinating move-in logistics. Ongoing tenancy-sustaining services will include landlord engagement, eviction prevention, and linkage to clinical and community supports to maintain housing stability. Field-based staff will provide direct, personalized support to address barriers to successful tenancy. BHSA funds may also cover short-term assistance such as application fees, deposits, or basic household needs necessary for successful housing retention.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year
350

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
TCMHA will use BHSA Housing Interventions funding to support outreach and engagement through its Forensic Assertive Community Treatment (FACT) and Assertive Community Treatment (ACT) Full Service Partnership (FSP) teams. Each team will be comprised of specialized staff: psychologist, clinician, peer support specialist, behavioral health support staff, and a dedicated housing specialist. They will actively engage unhoused or at-risk community members to build trust, assess needs, and connect them to behavioral health and housing services. The same team will provide continuity of care, supporting clients through enrollment, housing navigation, and ongoing tenancy support. BHSA funds will be used for staff outreach activities, engagement supplies, transportation, and flexible resources that reduce barriers to accessing and maintaining housing.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
2

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
City of Pomona Tiny Homes Project

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
37

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
16

Total number of units funded with Housing Interventions funds only
12

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
9/1/2026

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
278478

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
Under the BHSA Integrated Plan, housing support staff will be funded through Housing funds and will serve Transitional Age Youth (TAY) populations. Hosing program intends to increase access to permanent supportive housing for people meeting BHSA eligibility who are chronically homeless, experiencing homelessness, or are at risk of homelessness. These housing staff represent 63% of the housing team and

will provide comprehensive housing support services, including system navigation, tenant services, housing stabilization, and linkage to community resources.
Core services will include supporting individuals who are homeless, at risk of homelessness or chronically homeless with assistance with housing applications and documentation, landlord engagement and advocacy, coordination with property management, support with lease compliance, crisis intervention related to housing retention, benefits linkage, and referrals to behavioral health, employment, and social services. Staff will work to promote long-term housing stability and self-sufficiency through individualized service planning and ongoing supportive engagement.
In addition, Residential Coordinators who support as landlord liaisons, represent 37% of staff and will provide direct supportive services to individuals residing in program-supported housing. These services may include skills related to maintaining housing, conflict resolution, community integration activities, independent, and coordination of care with behavioral health providers and other service partners. Residential Coordinators play a key role in maintaining a safe, supportive, and recovery-oriented living environment.

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year
000

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
n/a

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
Undecided

Housing Deposits
Undecided

Housing Tenancy and Sustaining Services
Undecided

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Undecided

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs **(including Transitional Rent)?**
Clinical and housing staff will assess client needs during intake and ongoing treatment planning to confirm Medi-Cal eligibility and appropriateness for MCP-covered housing services such as Housing Transition Navigation or Tenancy Sustaining Services. Once confirmed, TCMHA's Housing Division will coordinate directly with MCP partners to complete and submit referrals, ensuring warm handoffs and continuity of care. Clients ineligible for MCP-covered supports will be connected to BHSA-funded housing interventions for comparable assistance, maintaining equitable access to housing stability resources.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

TCMHA will collaborate closely with LACDMH and local MCPs to ensure that the county's behavioral health contracted provider network for Housing Interventions is known, updated, and accessible. TCMHA will provide MCPs with up-to-date contact information, service descriptions, and referral pathways for housing-related behavioral health supports. Additional coordination will occur through regular cross-system meetings, data-sharing agreements, and participation in county-level housing and care coordination workgroups.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

Yes

Please describe the county behavioral health system's coordination efforts to align network development

We are in the process of developing formal workflows and Memorandums of Understanding (MOUs) to strengthen coordination and align network development between TCMHA and the MCPs. We are focused on establishing standardized referral pathways, data-sharing protocols, and regular cross-system meetings to support collaboration between use.

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

Members of the client's care team will maintain active oversight of the client's housing status and contact the MCPs for regular updates on service utilization. When MCP-covered housing supports reach their limits, the client's treatment team will assess ongoing needs and client's access to BHSA Housing Interventions funding to maintain housing stability and prevent service gaps. Care transitions are supported by joint planning meetings between treatment teams, MCP representatives, and county housing partners, ensuring timely communication, shared care plans, and ongoing engagement.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools -

Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
No

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
n/a

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?
No

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
No

If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner
N/A

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
19

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Psychiatric Technician (PT)
Licensed Clinical Social Worker
Psychiatrist
Other qualified provider
Licensed Marriage and Family Therapist

Please describe any other key workforce gaps in the county
Several key workforce gaps have been identified. Tri-City continues to experience challenges recruiting and retaining staff in high-acuity behavioral health services, particularly in crisis response, adult FSP programs, and medication support. These roles often require specialized licensure and involve demanding working

conditions, which may contribute to ongoing vacancies.

Tri-City is also experiencing challenges in developing and recruiting clinical supervisors. Compensation for supervisory roles does not always keep pace with the financial burden of advanced clinical education, including student loan debt. In addition, supervisory roles carry increased administrative, clinical, and liability responsibilities, which may not be proportionately incentivized.

These challenges are further compounded by regulatory and licensing requirements related to supervision, including required supervision ratios, documentation standards, and time commitments. These requirements can limit the availability of qualified supervisors and reduce overall system capacity to support and advance clinical staff.

Broader workforce pipeline challenges also contribute to staffing gaps. Academic and training programs do not always adequately prepare students for work in public behavioral health settings, particularly in areas such as crisis intervention, community-based care, and working with high-acuity populations. This can result in a mismatch between new graduates' expectations and the realities of public sector behavioral health work.

Additionally, overall compensation for behavioral health professionals often lags behind comparable roles in the broader healthcare system, including medical and allied health positions. This disparity can make recruitment and retention more difficult, particularly for licensed and specialized roles, and may contribute to workforce migration to higher-paying sectors.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Over the next three fiscal years, the county expects workforce needs to shift toward expansion of multidisciplinary, community-based behavioral health teams needed to implement new and expanded evidence-based practices under Behavioral Health Transformation and BH-CONNECT. This will likely increase demand for licensed clinicians, psychiatric prescribers, peer support specialists, employment specialists, community health workers, care coordinators, and clinical supervisors, as well as staff with experience in fidelity-based implementation and quality oversight. In addition, there are new professions introduced such as Nurse(s) and Occupational Therapist(s) that traditionally have not been a part of the Tri-City workforce. Tri-City also anticipates greater need for training, supervision, and retention strategies to support ACT, FACT, Coordinated Specialty Care, IPS Supported Employment, and other emerging practice requirements. As these reforms are implemented, workforce needs are expected to become more specialized, team-based, and community-focused, with particular pressure in high-acuity and field-based service settings.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Tri-City plans to share information about the scholarship program with staff and local colleges to encourage applications.

The initiative aims to:

Address behavioral health workforce shortages

Improve access to culturally responsive care

Promote long-term staff retention and professional development

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Tri-City has actively promoted the student loan repayment program by disseminating information to staff and encouraging eligible individuals to submit applications. Tri-City intends to integrate the student loan repayment program into a comprehensive workforce development strategy aimed at:

Mitigating behavioral health workforce shortages

Enhancing access to culturally responsive care

Supporting long-term staff retention and professional growth

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Tri-City plans to apply for funding through the Behavioral Health Recruitment and Retention Program. Tri-City plans to utilize these funds to expand outreach efforts, strengthen partnerships with graduate programs, and help with offsetting vacancy-related recruitment impacts and reduce turnover.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
We plan to expand our internship program into a comprehensive, agency-wide initiative by building partnerships with additional universities and providing enhanced comprehensive support.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Integrated Plan Budget Template Version 3.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
4/3/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification Template for OP Signed.pdf
Behavioral Health Director Certification. Additional Text.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
County Administrator or Designee Certification Template (2).pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Data Suppression Notice:

Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"

12. CONSIDERATION OF RESOLUTION NO. 854 APPROVING THE NAME CHANGE OF ITS ADVISORY BOARD FROM "TRI-CITY MENTAL HEALTH COMMISSION" TO "TCMHA BEHAVIORAL HEALTH COMMISSION", AND REVISING THE BYLAWS OF THE COMMISSION PURSUANT TO PROPOSITION 1 (SB 326)

This Agenda Item was pulled from the Agenda, and it will be presented to the Governing Board for approval at its regular meeting of May 20, 2026.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 15, 2026**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson, Placide, LMFT, Executive Director**

BY: **Diana Acosta, CPA, Chief Financial Officer**

SUBJECT: **Consideration of Resolution No. 854 Approving Financing in the Amount of $2,160,000 for the Development of Senior Affordable and Permanent Supportive Housing Units in the St. Ambrose Episcopal Church Project located at 155 N. Mountain Avenue in Claremont, California and authorizing the Executive Director to execute the loan agreement and take other related actions**

Summary:

Staff seeks Governing Board approval financial assistance for the St. Ambrose senior affordable housing project in the City of Claremont in the amount of $2,160,000 and authorization for the Executive Director to execute the necessary loan documents and related agreements to secure 12 units exclusively reserved for TCMHA clients for permanent supportive housing.

Background:

On June 18, 2026 the TCMHA Governing Board adopted Resolution No. 796 designating unspent MHSA Community Services and Supports (CSS) funding for support of three housing projects, including $2,160,000 for the St. Ambrose Senior Affordable Housing project located at 155 N Mountain Avenue in the City of Claremont (the “Project”).

The Project is being developed by National CORE, which is a non-profit developer of affordable housing based in Rancho Cucamonga, and includes construction and operation of a 59-unit affordable housing development for seniors aged 55 and older on a 1.2-acre site adjacent to St. Ambrose Episcopal Church. Of the 59 units, 29 will be for low-income seniors, 28 will be for low-income seniors who have experienced homelessness or are at risk of homelessness, and one will house an onsite manager. Onsite amenities will include supportive services and case management, a senior-oriented community room, outdoor recreational spaces, technology hub, active and passive landscape areas, and outdoor seating and barbecues. Supportive services will be provided in partnership TCMHA and the Hope through Housing Foundation.

In exchange for providing $2,160,000 in financing for the Project in the form of a forgivable loan, TCMHA would receive exclusive use of 12 units for permanent supportive housing for persons who are sixty (60) years of age or older (and their family) who have a

diagnosed mental illness and are homeless or at risk of homelessness, and whose income (when first becoming an occupant/tenant) is not greater than thirty percent (30%) of AMI for Los Angeles County, as published by the California Department of Housing and Community Development.

Project financing is presently scheduled to close on May 22, 2026. Other sources of funding for the Project are being provided by RBC Community Investments (an equity investor), the Los Angeles County Development Authority ("LACDA") as Housing Authority and a junior lender, and tax exempt bonds issued by the California Municipal Finance Authority (the "CMFA"). The City of Claremont is not providing any direct financial assistance but is a member of the CMFA and has approved the bond issuance for the Project.

Staff has prepared the following documents for the Governing Board's consideration in order for Tri-City to provide assistance to the Project.

- Promissory Note Secured by Deed of Trust – The Note would provide a loan from Tri-City to developer in the amount of $2,160,000 on or before fifty-five (55) years after the conversion of Project to permanent financing as reasonably determined by Tri-City. Interest would accrue on the unpaid loan amount at the rate of three percent (3%) per annum, simple interest annually. If, as of the maturity date, there are no uncured defaults or amounts otherwise payable under the Note, the balance would be forgiven.

- Deed of Trust with Assignment of Rents – The Deed of Trust would be recorded against the property to secure Tri-City's loan to the developer, and default on the Note would result a default under the terms of the Deed of Trust

- Regulatory Agreement – The Regulatory Agreement secures the developer's commitment to provide Tri-City with the 12 units within the Project for senior adult homeless diagnosed extremely low income households at an affordable rent for a term of fifty-five (55) years after the completion of the Project. A default under the Regulatory Agreement would result in a default on the Note.

The Governing Board's approval of the attached Resolution would approve all of these agreements in substantially the form presented and authorize the Executive Director to execute the agreements and take any other actions or execute any other agreements necessary to achieve the purposes of the proposed financial assistance for the Project, which may include subordination agreement(s) and other adjustments prior to execution that would not result in material changes to the terms of the Note in order to accommodate LACDA's position as a superior lender to Tri-City. It would also include a Supportive

Services Agreement that establishes the terms and conditions for TCMHA to provide supportive services to Project residents, which staff is currently finalizing.

Fiscal Impact:

The commitment of $2,160,000 of Tri-City's funds to the St. Ambrose Project will come from MHSA CSS Unspent funds, which were previously authorized by the Governing Board by the approval of Resolution No. 796 approved on June 18, 2026.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 854 authorizing the Executive Director to enter into, execute and take further actions as necessary and appropriate to implement the Promissory Note Secured by Deed of Trust, the Deed of Trust with Assignment of Rents, the Regulatory Agreement and the Contract for Supportive Services with National Core for the development, construction, financing and operation of 59 units, of which 12 will be reserved exclusively for TCMHA clients, for permanent supportive housing for seniors.

Attachments:

Attachment 13-A: Resolution No. 854 (DRAFT)

Attachment 13-B: Resolution No. 796, approved June 18, 2026.

Attachment 13-C: Promissory Note Secured By Deed of Trust (DRAFT)

Attachment 13-D: Deed of Trust (DRAFT)

Attachment 13-E: Regulatory Agreement (DRAFT)

RESOLUTION NO. 854

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY APPROVING FINANCING IN THE AMOUNT OF $2,160,000 FOR THE DEVELOPMENT OF SENIOR AFFORDABLE AND PERMANENT SUPPORTIVE HOUSING UNITS IN THE ST. AMBROSE EPISCOPAL CHURCH PROJECT LOCATED AT 155 N. MOUNTAIN AVENUE IN CLAREMONT, CALIFORNIA AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE LOAN AGREEMENT AND TAKE OTHER RELATED ACTIONS

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares as follows:

A. Tri-City Mental Health Authority ("TCMHA") adopted Resolution No. 796 on June 18, 2025 authorizing the Executive Director to utilize Unspent Community Services and Support (CSS) MHSA funds in the amount of $2,160,000 to support of the St. Ambrose Senior Affordable Housing project located at 830 W. Bonita Avenue in the City of Claremont (the "Project") by National CORE, a non-profit developer of affordable housing.

B. The Project involves the development and construction of a 59-unit affordable housing development for seniors aged 55 and older on a 1.2-acre site adjacent to St. Ambrose Episcopal Church. Of the 59 units, 29 will be for low-income seniors, 28 will be for low-income seniors who have experienced homelessness or are at risk of homelessness, and one will house an onsite manager. Development will include access to supportive services provided through partnerships between the developer and the Hope through Housing Foundation and TCMHA.

C. In exchange for Project financing in the amount of $2,160,000 in the form of a forgivable loan, TCMHA will receive exclusive use of 12 units for permanent supportive housing for persons who are sixty (60) years of age or older (and their family) who have a diagnosed mental illness and are homeless or at risk of homelessness, and whose income (when first becoming an occupant/tenant) is not greater than thirty percent (30%) of AMI for Los Angeles County, as published by the California Department of Housing and Community Development. To accomplish this purpose, the following agreements and related documents have been prepared and were presented to the Governing Board at its regular meeting of April 15, 2026: (i) a Promissory Note Secured by Deed of Trust; (ii) a the Deed of Trust with Assignment of Rents; and (iii) a Regulatory Agreement (collectively "Project Agreements").

2. Action

The Governing Board hereby approves the Project Agreements in substantially the same form as presented at its meeting on April 15, 2026 and authorizes the Executive Director to execute the Project Agreements and to take any related actions or execute any other instruments or agreements that are necessary or advisable to achieve the purposes of the Project Agreements and this Resolution.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 15, 2026, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

RESOLUTION NO. 796

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AUTHORIZING THE EXECUTIVE DIRECTOR TO UTILIZE MENTAL HEALTH SERVICES ACT UNSPENT FUNDS FROM COMMUNITY SERVICES AND SUPPORT PLAN IN THE ESTIMATED AMOUNT OF $8,552,475.00 FOR THREE HOUSING AND SHELTER PROJECTS APPROVED THROUGH A COMMUNITY PLANNING PROCESS

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("Authority" or "TCMHA") desires to utilize Mental Health Services Act (MHSA) unspent excess funds subject to reversion in the approximate amount of $8,552,475.00 from the Community Services and Supports (CSS) Plan to support the completion of three housing and shelter projects before June 30, 2027 to prevent the reversion these funds.

B. After careful consideration and evaluation of all recommendations received through a Community Planning Process wherein stakeholders and community members participated and provided feedback, a decision was made to allocate excess CSS funds subject to reversion to the following projects:

1) Modular Housing Project #1 – 10 Units (Permanent) 252 E 4th Street in Pomona, California	$2,767,800
Modular Housing Project #2 – 6 Units (Permanent) 464 W 8th Street in Pomona, California	$1,681,050
2) St Ambrose Senior Affordable Housing A National Core Project - 12 Units 830 W. Bonita Avenue in Claremont, California	$2,160,000
3) Hope for Home Year-Round Emergency Shelter Beds increase from 31 to 71 resulting in additional 3 beds for each City	$1,943,625
TOTAL ESTIMATED AMOUNT	**$8,552,475**

2. Action

The Governing Board authorizes the Executive Director to allocate unspent excess MHSA funds in the estimated amount of $8,552,475.00 from the CSS Plan for three housing and shelter projects to prevent the potential reversion of these funds.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 18, 2025, by the following vote:

AYES: Board Members Lorraine Canales, Carolyn Cockrell, Sandra Grajeda, Paula Lantz, and Elizabeth Ontiveros-Cole; Vice-Chair Wendy Lau; and Chair Jed Leano.

NOES: None.

ABSTAIN: None.

ABSENT: None.

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

RECORDING REQUESTED BY,
AND WHEN RECORDED MAIL TO:

Tri-City Mental Health Authority
1717 N. Indian Hill Blvd, Suite B
Claremont, CA 91711
Attn: Executive Director

This document is exempt from payment of a recording fee pursuant to Government Code Sections 27383 and 6103.

DEED OF TRUST WITH ASSIGNMENT OF RENTS
(SHORT FORM)

This **DEED OF TRUST** is made as of _____, 2026 between NCRC CLAREMONT LP, a California limited partnership, herein called TRUSTOR, whose address is 9692 Haven Avenue, Suite 100, 9173, [*Commonwealth Land Title Company*], herein called TRUSTEE, and TRI-CITY MENTAL HEALTH AUTHORITY, a California joint powers authority, herein called BENEFICIARY.

WITNESSETH: That Trustor grants to Trustee in trust, with power of sale, that property in the City of Claremont, County of Los Angeles, State of California, described as:

SEE EXHIBIT "A " ATTACHED HERETO AND MADE A PART HEREOF.

together with the rents, issues and profits thereof, subject, however, to the right, power and authority hereinafter given to and conferred upon Beneficiary to collect and apply such rents, issues and profits for the purpose of securing (1) that Promissory Note Secured by Deed of Trust (Tri-City Construction Note) dated even date herewith, made by Trustor in favor of Beneficiary, in the maximum principal sum of TWO MILLION ONE HUNDRED SIXTY THOUSAND DOLLARS ($2,160,000) (the "Promissory Note "), with the balance of the indebtedness, due and payable on occurrence of a Default as defined in the Promissory Note, (2) the performance of each agreement of Trustor incorporated by reference or contained herein (including without limitation Exhibit "C " hereto [Rider to Deed of Trust]; and (3) payment of additional sums and interest thereon which may hereafter be loaned to Trustor, or its permitted successors or assigns, when evidenced by a promissory note or notes reciting that they are secured by this Deed of Trust.

To protect the security of this Deed of Trust, and with respect to the property above described, Trustor expressly makes each and all of the agreements, and adopts and agrees to perform and be bound by each and all of the terms and provisions set forth in subdivision A, and it is mutually agreed that each and all of the terms and provisions set forth in subdivision B of the fictitious deed of trust recorded in Los Angeles County on August 18, 1964, in Book T3878 commencing at page 174, in the book and at the page of Official Records in the office of the county recorder of Los Angeles County, shall inure to and bind the parties hereto, with respect to the property above described. Said agreements, terms and provisions contained in said subdivisions A and B, (identical in all counties, and printed in Exhibit "B " on pages 3 and 4 hereof) are by the within reference thereto, incorporated herein and made a part of this Deed of Trust for all purposes as fully as set forth at length herein, and Beneficiary may charge for a statement regarding the

obligation secured hereby, provided the charge therefor does not exceed the maximum allowed by law.

The undersigned Trustor, requests that a copy of any notice of default and any notice of sale hereunder be mailed to him or her at his or her address hereinbefore set forth.

[Signature on following page]

DRAFT

Trustor:

NCRC CLAREMONT LP,
a California limited partnership

By: NCRC CLAREMONT MGP, LLC,
a California limited liability company,
its general partner

By: National Community Renaissance of California,
a California nonprofit public benefit corporation,
its sole member and manager

By: _____
Kevin Lim, Chief Financial Officer

DRAFT

CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF _____

On _____ before me, _____ Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity(ies) upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____ Place Notary Seal Above

Signature of Notary Public

DRAFT

EXHIBIT "A " TO DEED OF TRUST

LEGAL DESCRIPTION

[legal description to be inserted]

DRAFT

EXHIBIT "B " TO DEED OF TRUST

The following is a copy of Subdivisions A and B of the fictitious Deed of Trust recorded in each county in California as stated in the foregoing Deed of Trust and incorporated by reference in said Deed of Trust as being a part thereof as if set forth at length therein.

A. To protect the security of this Deed of Trust, Trustor agrees:

(1) To keep said property in good condition and repair; not to remove or demolish any building thereon; to complete or restore promptly and in good and workmanlike manner any building which may be constructed, damaged or destroyed thereon and to pay when due all claims for labor performed and materials furnished therefor; to comply with all laws affecting said property or requiring any alterations or improvements to be made thereon; not to commit or permit waste thereof; not to commit, suffer or permit any act upon said property in violation of law; to cultivate irrigate, fertilize, fumigate, prune and do all other acts which from the character or use of said property may be reasonably necessary, the specific enumerations herein not excluding the general.

(2) To provide, maintain and deliver to Beneficiary fire insurance satisfactory to and with loss payable to Beneficiary. The amount collected under any fire or other insurance policy may be applied by Beneficiary upon any indebtedness secured hereby and in such order as Beneficiary may determine, or at option of Beneficiary, the entire amount so collected or any part thereof may be released to Trustor. Such application or release shall not cure or waive any default or notice of default hereunder or invalidate any act done pursuant to such notice.

(3) To appear in and defend any action or proceeding purporting to affect the security hereof or the rights or powers of Beneficiary or Trustee; and to pay all costs and expenses, including cost of evidence of title and attorney's attorneys' fees in a reasonable sum, in any such action or proceeding in which Beneficiary or Trustee may appear, and in any suit brought by Beneficiary to foreclose this Deed.

(4) to pay: at least ten days before delinquency all taxes and assessments affecting said property, including assessments on appurtenant water stock; when due, all encumbrances, charges and liens, with interest, on said property or any part thereof, which appear to be prior or superior hereto; all costs, fees and expenses of this trust.

Should Trustor fail to make any payment or to do any act as herein provided, then Beneficiary or Trustee, but without obligation so to do and without notice to or demand upon Trustor and without releasing Trustor from any obligation thereof, may: make or do the same in such manner and to such extent as either may deem necessary to protect the security hereof, Beneficiary or Trustee being authorized to enter upon said property for such purposes; appear in and defend any action or proceeding purporting to affect the security hereof or the rights or powers of Beneficiary or Trustee; pay, purchase, contest or compromise any encumbrance, charge or lien which in the judgment of either appears to be prior or superior hereto; and, in exercising any such powers, pay necessary expenses, employ counsel and pay his or her reasonable fees.

DRAFT

(5) To Pay immediately and without demand all sums so expended by Beneficiary or Trustee, with interest from date of expenditure at the amount allowed by law in effect at the date hereof, and to pay for any statement provided for by law in effect at the date hereof regarding the obligation secured hereby any amount demanded by the Beneficiary not to exceed the maximum allowed by law at the time when said statement is demanded.

B. It is mutually agreed:

(1) That any award of damages in connection with any condemnation for public use of or injury to said property or any part thereof is hereby assigned and shall be paid to Beneficiary who may apply or release such monies received by him in the same manner and with the same effect as above provided for disposition of proceeds of fire or other insurance.

(2) That by accepting payment of any sum secured hereby after its due date, Beneficiary does not waive his or her right either to require prompt payment when due of all other sums so secured or to declare default for failure so to pay.

(3) That at any time or from time to time, without liability therefor and without notice, upon written request of Beneficiary and presentation of this Deed and said note for endorsement, and without affecting the personal liability of any person for payment of the indebtedness secured hereby, Trustee may: reconvey any part of said property; consent to the making of any map or plat thereof; join in granting any easement thereon; or join in any extension agreement or any agreement subordinating the lien or charge hereof.

(4) That upon written request of Beneficiary stating that all sums secured hereby have been paid, and upon surrender of this Deed and said note to Trustee for cancellation and retention or other disposition as Trustee in its sole discretion may choose and upon payment of its fees, Trustee shall reconvey, without warranty, the property then held hereunder. The recitals in such reconveyance or any matters or facts shall be conclusive proof of the truthfulness thereof. The Grantee in such reconveyance may be described as "the person or persons legally entitled thereto. "

(5) That as additional security, Trustor hereby gives to and confers upon Beneficiary the right, power and authority, during the continuance of these Trusts, to collect the rents, issues and profits of said property, reserving unto Trustor the right, prior to any default by Trustor in payment of any indebtedness secured hereby or in performance of any agreement hereunder, to collect and retain such rents, issues and profits as they become due and payable. Upon any such default, Beneficiary may at any time without notice, either in person, by agent, or by a receiver to be appointed by a court, and without regard to the adequacy of any security for the indebtedness hereby secured, enter upon and take possession of said property or any part thereof, in his or her own name sue for or otherwise collect such rents, issues, and profits, including those past due and unpaid, and apply the same, less costs and expenses of operation and collection, including reasonable attorney's attorneys' fees, upon any indebtedness secured hereby, and in such order as Beneficiary may determine. The entering upon and taking possession of said property, the collection of such rents, issues and profits and the application thereof as aforesaid, shall not cure or waive any default or notice of default hereunder or invalidate any act done pursuant to such notice.

DRAFT

(6) That upon default Trustor in payment of any indebtedness secured hereby or in performance of any agreement hereunder, Beneficiary may declare all sums secured hereby immediately due and payable by delivery to Trustee of written declaration of default and demand for sale and of written notice of default and of election to cause to be sold said property, which notice Trustee shall cause to be filed for record. Beneficiary also shall deposit with Trustee this Deed, said note and all documents evidencing expenditures secured hereby.

After the lapse of such time as may then be required by law following the recordation of said notice of default, and notice of sale having been given as then required by law, Trustee, without demand on Trustor, shall sell said property at the time and place fixed by it in said notice of sale, either as a whole or in separate parcels, and in such order as it may determine, at public auction to the highest bidder for cash in lawful money of the United States, payable at time of sale. Trustee may postpone sale of all or any portion of said property by public announcement at such time and place of sale, and from time to time thereafter may postpone such sale by public announcement at the time fixed by the preceding postponement. Trustee shall deliver to such purchaser its deed conveying the property so sold, but without any covenant or warranty, express or implied. The recitals in such deed of any matters or facts shall be conclusive proof of the truthfulness thereof. Any person, including Trustor, Trustee, or Beneficiary as hereinafter defined, may purchase at such sale.

After deducting all costs, fees and expenses of Trustee and of this Trust, including cost of evidence of title in connection with sale, Trustee shall apply the proceeds of sale to payment of: all sums expended under the terms hereof, not then repaid, with accrued interest at the amount allowed by law in effect at the date hereof; all other sums then secured hereby; and the remainder, if any, to the person or persons legally entitled thereto.

(7) Beneficiary, or any successor in ownership of any indebtedness secured hereby, may from time to time, by instrument in writing, substitute a successor or successors to any Trustee named herein or acting hereunder, which instrument, executed by the Beneficiary and duly acknowledged and recorded in the office of the recorder of the county or counties where said property is situated, shall be conclusive proof of proper substitution of such successor Trustee or Trustees, who shall, without conveyance from the Trustee predecessor, succeed to all its title, estate, rights, powers and duties. Said instrument must contain the name of the original Trustor, Trustee and Beneficiary hereunder, the book and page where this Deed is recorded and the name and address of the new Trustee.

(8) That this Deed applies to, inures to the benefit of, and binds all parties hereto, their heirs, legatees, devisees, administrators, executors, successors and assigns. The term Beneficiary shall mean the owner and holder, including pledgees, of the note secured hereby, whether or not named as Beneficiary herein. In this Deed, whenever the context so requires, the masculine gender includes the feminine and/or neuter, and the singular number includes the plural.

(9) That Trustee accepts this Trust when this Deed, duly executed and acknowledged, is made a public record as provided by law. Trustee is not obligated to notify any party hereto of pending sale under any other Deed of Trust or of any action or proceeding in which Trustor, Beneficiary or Trustee shall be a party unless brought by Trustee.

DRAFT

EXHIBIT "C "

RIDER TO DEED OF TRUST

This **RIDER TO DEED OF TRUST** is made and delivered pursuant to and in implementation of the Regulatory Agreement entered by and between the Trustor and the Beneficiary dated _____, 2026 ("Agreement"), a copy of which is on file as a public record with the Beneficiary at 1717 N. Indian Hill Blvd., Suite B, Claremont CA 91711, and is incorporated herein by reference. Unless definitions of terms have been expressly set out at length herein, each term shall have the same definition as set forth in the Agreement. Trustor and Beneficiary further covenant and agree as follows:

1. Acceleration of Payment. All sums outstanding under the Note secured by this Deed of Trust and all other payments due under this Deed of Trust and under the Agreement shall become due and be immediately payable to the Beneficiary by the Trustor upon the occurrence of any one of the following events of acceleration:

a) the sale or transfer of the Site (or any part thereof) by any means, including, without limitation, the lease, exchange or other disposition of the Site or any interest therein, whether voluntary or involuntary, except a sale or transfer of the Site as to which the prior written approval of Beneficiary has been obtained and where the transferee agrees to perform in accordance with the Agreement;

b) the Trustor refinances any purchase money lien or encumbrance to which this Deed of Trust is subordinate (each such lien, a "Superior Lien ") for a loan amount in excess of the then current loan balance secured by such lien or encumbrance and loan closing costs; and/or

c) the Trustor (and all co-signors and co-mortgagors, if any) fails in any material respect to operate the Site in conformity with the Regulatory Agreement.

At the request of the Trustor, and for a specific occasion, the Beneficiary may, in its sole and absolute discretion, in writing waive the requirements of these subparagraphs. Any waiver or deferment shall be on a case by case basis, and no future rights for waiver or deferment shall arise or be implied. Notwithstanding the foregoing, the Trustor may, upon prior written approval by the Beneficiary, refinance any Superior Lien for a loan amount equal to or less than the then current loan balance secured by such Superior Lien.

[Signature on following page]

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IN WITNESS WHEREOF, Trustor has executed this Rider to Deed of Trust as of the date set forth below.

TRUSTOR:

NCRC CLAREMONT LP,
a California limited partnership

By: NCRC CLAREMONT MGP, LLC,
a California limited liability company,
its general partner

By: National Community Renaissance of California,
a California nonprofit public benefit corporation,
its sole member and manager

By: _____
Kevin Lim, Chief Financial Officer

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CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF _____

On _____ before me, _____ Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity(ies) upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____ Place Notary Seal Above

Signature of Notary Public

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RECORDING REQUESTED BY,
AND WHEN RECORDED RETURN TO:

Tri-City Mental Health Authority
1717 N. Indian Hill Blvd., Suite B
Claremont, CA 91711

APN(s):

SPACE ABOVE THIS LINE FOR RECORDER'S USE

This Regulatory Agreement is exempt from Recording Fees pursuant to Sections 6103, 27383 and 27388.1 of the California Government Code.

REGULATORY AGREEMENT

This REGULATORY AGREEMENT (this "**Agreement**") is dated as of _____ 2026, and is entered into by and between the TRI-CITY MENTAL HEALTH AUTHORITY, a California joint powers authority ("**TCMHA**") and NCRC CLAREMONT LP, a California limited partnership ("Developer").

RECITALS

A. Pursuant to a Promissory Note Secured by Deed of Trust (Tri-City Construction Note) dated of even date herewith between TCMHA and Developer (the "**Note**"), TCMHA has: (i) committed a "forgivable loan" (or conditional grant) to Developer to be used for the capital development of a senior affordable housing project located at 155 North Mountain Avenue, Claremont, CA described on Exhibit "A" hereto (the "**Site**").

B. The Note requires Developer to construct an apartment complex including fifty-nine (59) residential units (including one (1) manager's unit) on the Site (the "**Project**"). As a condition to its commitment of funds, Developer must enter into and record this Agreement restricting twelve (12) of such residential units to Senior Adult Homeless Diagnosed Extremely Low Income Households(defined below) at an Affordable Rent (defined below) (the "**Required Affordable Units**") for fifty-five (55) years after the completion of the Project.

C. Developer intends to acquire and develop the Site utilizing, among other things, the proceeds of a loan from the Los Angeles County Development Authority (the "**County**") which requires that Developer enter into an agreement with the County, to be recorded prior to this Agreement, that restricts all fifty-nine (59) units in the apartment complex (the "**County Regulatory Agreement**").

D. The parties hereto acknowledge that tenants of Required Affordable Units, in addition to housing, will require supportive services which are to be provided by TCMHA pursuant to a Services Agreement between the parties dated substantially concurrently herewith, and that TCMHA shall be the lead provider of services to all tenants of the Project to the extent they qualify for TCMHA services (as provided in said Services Agreement).

ATTACHMENT 13-D

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants and conditions set forth herein and in the Note the parties hereto agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Definitions.

(a) The term "**Affordability Period**" shall mean the period commencing upon the completion of the Project and expiring fifty-five (55) years thereafter.

(b) The term "**Affordable Rent**" shall mean rent, including a reasonable utility allowance/amount, no greater than the rent permitted for Extremely Low Income households under California law (i.e., the product of thirty percent (30%) times thirty percent (30%) of area median income ("**AMI**") for Los Angeles County, as published by the California Department of Housing and Community Development, adjusted for family size appropriate to the unit). Affordable Rent shall be determined in conformity with Health and Safety Code Section 50052.5 and related regulations.

(c) The term "**Senior Adult Homeless Diagnosed Extremely Low Income Households**" shall mean persons who are sixty (60) years of age or older (and their family) who have a diagnosed mental illness and are homeless or at risk of homelessness, and whose income (when first becoming an occupant/tenant) is not greater than thirty percent (30%) of AMI for Los Angeles County, as published by the California Department of Housing and Community Development.

ARTICLE 2
RESTRICTIONS

2.1 Permitted and Required Uses. The Project shall be used only for private rental dwelling purposes and related amenity uses, for the purposes described in the County Regulatory Agreement. Additionally, throughout the Affordability Period, Developer covenants and agrees to make available, restrict occupancy to, and rent not fewer than the Required Affordable Units in the Project to Senior Adult Homeless Diagnosed Extremely Low Income Households at an Affordable Rent. Developer shall not maintain or cause to be maintained any public nuisance or private nuisance on or about the Project.

2.2 Selection of Tenants. Developer shall be responsible for the selection of tenants in compliance with all applicable laws and this Agreement, and as to the Required Affordable Units, (i) fully consult, coordinate and cooperate with TCMHA in the selection of qualified tenants; and (ii) provide reasonable evidence to TCMHA that a tenant is permitted under the terms of this Agreement to rent a Required Affordable Unit before so renting a Required Affordable Unit to the tenant; (iii) provide a copy of the applicable rental agreement and addenda to TCMHA, with evidence that the rent is Affordable Rent for the tenant, prior to signing the rental agreement, and (iv) comply with TCMHA's process for selecting tenants for the Affordable Units is set forth in Exhibit "B".

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2.3 Increases in Tenant Income and Rent. A tenant who qualifies as an Extremely Low Income Household prior to occupancy of a Required Affordable Unit but whose income increases such that such tenant household ceases to be income qualified, may continue to occupy such Required Affordable Unit and be charged rent including a reasonable utility allowance, not greater than [the lesser of (x)] thirty percent (30%) of the household's adjusted monthly income, recertified annually[, or (y) the market rent applicable to the Required Affordable Unit as published by HUD]. No rent for a Required Affordable Unit may be increased without the reasonable consent of TCMHA after delivery to TCMHA of a reasonable written explanation together with reasonable evidence of the increased income.

2.4 Tenant Protections.

(a) Lease. Developer shall execute or cause to be executed a written lease/rental agreement for each Required Affordable Unit which complies with all applicable federal, state and local laws, statutes, ordinances, rules and regulations, and with each tenant household identifying by name all permitted occupants, both adults and minors.

(b) Prohibited Lease Terms. The tenant lease/rental agreement may not contain any of the following provisions:

(i) *Agreement to be sued*. Agreement by the tenant to be sued, to admit guilt, or to a judgment in favor of the owner in a lawsuit brought in connection with the lease;

(ii) *Treatment of property*. Agreement by the tenant that the owner may take, hold, or sell personal property of household members without notice to the tenant and a court decision on the rights of the parties. This prohibition, however, does not apply to an agreement by the tenant concerning disposition of personal property remaining in the housing unit after the tenant has moved out. The owner may dispose of this personal property in accordance with State law;

(iii) *Excusing owner from responsibility*. Agreement by the tenant not to hold Developer or Developer's agents legally responsible for any action or failure to act, whether intentional or negligent;

(iv) *Waiver of notice*. Agreement of the tenant that Developer may institute a lawsuit without notice to the tenant;

(v) *Waiver of legal proceedings*. Agreement by the tenant that Developer may evict the tenant or household members without instituting a civil court proceeding in which the tenant has the opportunity to present a defense, or before a court decision on the rights of the parties;

(vi) *Waiver of a jury trial*. Agreement by the tenant to waive any right to a trial by jury;

(vii) *Waiver of right to appeal court decision*. Agreement by the tenant to waive the tenant's right to appeal, or to otherwise challenge in court, a court decision in connection with the lease;

(viii) *Tenant chargeable with cost of legal actions regardless of outcome*. Agreement by the tenant to pay attorneys' fees or other legal costs even if the tenant wins in a court proceeding by Developer against the tenant. The tenant, however, may be obligated to pay costs if the tenant loses; and

(ix) *Mandatory supportive services*. Agreement by the tenant (other than a tenant in transitional housing) to accept supportive services that are offered.

(c) Termination of Tenancy. Developer may not terminate the tenancy or refuse to renew the lease of a tenant within the Project except for failure to pay rent, serious or repeated violation of the terms and conditions of the lease; for violation of applicable federal, state, or local law; or for other good cause. Any termination or refusal to renew must be preceded by not less than thirty (30) calendar days (or such longer period as may be required by applicable laws) by Developer's service upon the tenant of a written notice specifying the grounds for the action.

2.5 Nondiscrimination. There shall be no discrimination against or segregation of, any person or group of persons on account of any basis listed in subdivision (a) or (d) of Section 12955 of the Government Code, as those bases are defined in Sections 12926, 12926.1, subdivision (m) and paragraph (1) of subdivision (p) of Section 12955, and Section 12955.2 of the Government Code, in the sale, lease, sublease, transfer, use, occupancy, tenure, or enjoyment of the premises which are the subject of this Agreement, nor shall the grantee or any person claiming under or through him or her, establish or permit any practice or practices of discrimination or segregation with reference to the selection, location, number, use or occupancy of tenants, lessees, subtenants, sublessees, or vendees in the premises herein conveyed. The foregoing covenants shall run with the land and shall remain in effect in perpetuity.

ARTICLE 3
OPERATION, MANAGEMENT AND MAINTENANCE OF THE PROJECT

Developer shall comply with all the terms and provisions of the County Regulatory Agreement, including without limitation those relating to operation, management, financing and maintenance of the Project.

ARTICLE 4
RUNS WITH LAND; PROHIBITIONS ON ASSIGNMENT

4.1 Covenants to Run With the Land. The covenants and restrictions set forth in this Agreement shall run with the land, and shall bind all successors in title to the Project. Each and every contract, deed or other instrument hereafter executed covering or conveying the Project or any portion thereof shall be held conclusively to have been executed, delivered and accepted subject to such covenants and restrictions, regardless of whether such covenants or restrictions are set forth in such contract, deed or other instrument.

4.2 Transfers; General Prohibition of Transfer without Consent. The qualifications and identity of Developer as an experienced and successful developer and operator/manager of affordable housing are of particular concern to TCMHA. Accordingly, until the Note has been forgiven, no voluntary or involuntary successor in interest of Developer shall acquire any rights or

powers this Agreement, nor shall Developer make any total or partial sale, transfer, conveyance, assignment, subdivision, refinancing or lease of the Project or the Site, or any part thereof, or this Agreement (collectively referred to herein as a "**Transfer**") without the prior written approval of TCMHA, which approval shall not however be unreasonably withheld, conditioned or delayed.

Notwithstanding the foregoing, the Transfers that do not require County consent under the County Regulatory Agreement or the Note shall not require TCMHA consent.

ARTICLE 5
ENFORCEMENT; REMEDIES; CROSS DEFAULT WITH LOAN

5.1 Remedies. In the event of default or breach of any of the terms or conditions of this Agreement by Developer, its heirs, executors, administrators or assigns, which continues beyond a period of thirty (30) days following the date of receipt by Developer of written notice from TCMHA of such default, TCMHA may pursue the remedy thereof by any and all means of enforcement, both in equity and at law, as provided by the laws of the State of California, including, but not limited to, injunctive relief and/or specific performance.

5.2 No Third Parties Benefited. Except as provided herein as to the County, this Agreement is made for the purpose of setting forth rights and obligations of Developer and the County, and no other person shall have any rights hereunder or by reason hereof.

5.3 Default Hereunder Is Default Under TCMHA Loan. A default under this Agreement shall constitute a default under the Note, and shall entitle TCMHA to demand payment thereof and if not paid, enforce its rights and remedies under the deed of trust securing the Note.

ARTICLE 6
INSURANCE AND INDEMNITY

Developer shall, at Developer's expense, cause TCMHA to be named as additional insured under all liability insurance maintained by Developer for the Project, and shall promptly provide TCMHA with reasonable evidence of such insurance and additional insured status.

Except to the extent caused by the fraudulent acts, gross negligence or willful misconduct of the Indemnified Parties (as hereinafter defined), Developer shall indemnify, defend (with counsel reasonably acceptable to TCMHA), and hold TCMHA, and its employees, officers, agents, and board members (collectively the "Indemnified Parties") harmless against all claims which arise out of or in connection with the ownership or occupancy of or construction on the Project (including, without limitation, rehabilitation) by Developer or Developer's contractors, subcontractors, agents, employees, or tenants, including claims resulting from the Developer's failure to comply with applicable federal, state and local Fair Housing laws regarding discrimination in rental housing, handicapped accessibility, prevailing wage (California Labor Code Section 1720 et seq.) and/or Davis Bacon (40 U.S.C. 276(a) et seq.) (as applicable), and the relocation of persons displaced by the Project, if applicable, including rehabilitation of the Project. Developer agrees that Developer, and not TCMHA, is responsible for assuring compliance with such laws. This section shall survive the termination of this Agreement.

ARTICLE 7
NOTICES

Written notice, demands and communications between TCMHA and Developer shall be deemed sufficient if dispatched by overnight delivery by a regarded courier service, registered or certified mail, postage prepaid, return receipt requested to the principal offices of TCMHA and Developer, the addresses of which are hereinafter set forth. Such written notices, demands and communications may be sent in the manner prescribed to each other's addresses as either party may, from time to time, designate by mail, or the same may be delivered in person to representatives of either party upon such premises. Said addresses are as follows:

If to Developer:
NCRC CLAREMONT LP
c/o National Community Renaissance of California
9692 Haven Avenue, Suite 100
Rancho Cucamonga, CA 91730
Attention: CFO

If to TCMHA:
Tri-City Mental Health Authority
1717 N. Indian Hill Blvd., Suite B
Claremont, CA 91711
Attention: Executive Director

Notices herein shall be deemed given one business day after delivery to a reputable overnight delivery service for next day delivery, or three (3) consecutive calendar days after deposit of the same in the custody of the United States Postal Service.

ARTICLE 8
MISCELLANEOUS

8.1 Waiver. Failure by a party to insist upon the strict performance of any of the provisions of this Agreement by the other party or the failure by the party to exercise its rights under or upon a default by the other party herein shall not constitute a waiver of such party's right to demand strict compliance from such other party in the future.

8.2 Severability. If any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect, then such provision or provisions shall be deemed severable from the remaining provisions contained in this Agreement, and this Agreement shall be construed as if such invalid, illegal or unenforceable provision(s) had never been contained herein.

8.3 Relevant Agreements; Merger. This Agreement and the Note contain the sole and entire agreements and understandings of the parties with respect to the subject matter hereof. No representations, oral or otherwise, express or implied, other than those contained herein, have been made by the parties.

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8.4 Counterparts. Counterparts of this Agreement may be executed, acknowledged, delivered and recorded, and each of which, and all of which together, shall constitute one and the same Agreement.

[Signatures on following pages]

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IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the day and year first above written.

DEVELOPER:

NCRC CLAREMONT LP
a California limited partnership

By: NCRC CLAREMONT MGP, LLC,
a California limited liability company,
its general partner

By: _____
Kevin Lim
Chief Financial Officer

TCMHA:

TRI-CITY MENTAL HEALTH AUTHORITY,
a California Joint Powers Authority

By: _____
Ontson Placide
Executive Director

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CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF _____

On _____ before me, _____ Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity(ies) upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____ Place Notary Seal Above

Signature of Notary Public

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CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

COUNTY OF _____

On _____ before me, _____ Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity, and that by his/her/their signature(s) on the instrument the person(s), or the entity(ies) upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____ Place Notary Seal Above

Signature of Notary Public

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EXHIBIT "A"

LEGAL DESCRIPTION OF THE PROPERTY

EXHIBIT B

TENANT SELECTION PROCESS FOR REGULATED UNITS

Tenant selection for Tri-City Mental Health Authority (TCMHA) housing will be consistent with the eligibility and guiding requirements of the Mental Health Services Act (MHSA) and the Coordinated Entry Systems (CES). The target populations for TCMHA units in the project are MHSA eligible Adults, older adults, Transitional Age Youth and families with at least one member meeting MHSA eligibility. Applicants must be able to pay the rent and have income in the amount of social security level or above and be within the income restrictions of the unit.

Mental Health Services Act (MHSA)

MHSA stipulates that those eligible for MHSA funded permanent supportive housing must be homeless, at risk of homelessness, and have been diagnosed with a serious mental illness. Generally households eligible for residency must have income limited to between 30 – 50% of area median income (AMI) with rents restricted to 30% or less of household income. All eligible applicants will need to assure TCMHA staff that they: 1) are capable of living under the terms of their lease; and 2) are able to pay rent on time. TCMHA staff will certify that the applicant, or a member of their household, is a client of TCMHA or a Los Angeles County Department of Mental Health -contracted service provider and has a Single Fixed Person of Responsibility.

The purpose of the CES is to identify, assess, and prioritize homeless individuals and families for housing and services based on their vulnerability and severity of need. The CES is designed to: 1) ensure that people experiencing homelessness receive the appropriate housing intervention; and 2) prioritize people who would benefit the most from supportive housing and be able to access it as quickly as possible.

Coordinated Entry System (CES) Process

During the clinic intake process, an individual that is identified as homeless will be referred to housing to identify if the client has already been entered into the Homeless Management Information System (HMIS) and have an acuity score through a completed CES Service Prioritization Decision Tool (SPDAT). If they are not already in the system with a score, they will be informed of the CES SPDAT and of the benefits of having an acuity level score that may lead to permanent supportive housing. If they are comfortable with following this process, they will be referred to an agency to take the steps for getting the SPDAT completed. The names of the client who are identified as fitting the criteria for literally homeless, will be added to a contact list. The client's name and acuity score will be added to a CES SPDAT housing prioritization list. In the event that the client is hesitant/resistant/inaccessible to follow up with the CES SPDAT, his/her clinical support will be contacted for assistance with setting up a meeting.

A prioritization list of eligible referrals will be maintained at all times by TCMHA. Knowing that their status can change over time, TCMHA staff will use HMIS, treatment team, emails, phone calls, postal services, and field visits to update the CES priority referral list on a quarterly basis. The client will be asked about their continued eligibility and interest in housing. Vacancy notifications will be sent to applicants in order of the CES prioritization list and applicants will be given up to two weeks to respond to the invitation for a housing unit.

Applicants shall be removed from the CES prioritization list if: 1) they ask to be removed; 2) they fail to respond to requests for information or confirmation of ongoing interest, three times; or 3) TCMHA housing staff and supportive services staff, after reasonable effort, can no longer locate the applicant.

Once the applicant has been identified as the first person or household on the CES prioritization list and meets the targeting restrictions of the unit, the applicant will be referred to the property's management to complete a full application. This application will be processed in a supportive and open process. The property management's application process will consist of income verification, credit check, criminal background check to screen for prior criminal and or violent behaviors, verifying accuracy of information reported on the application form, checking with former landlords, and meeting with the applicant and any supportive services staff that the applicant may wish to have with them during the process. If there are concerns about the applicant's history, there will be a conversation about requesting a reasonable accommodation on the part of the project or support from the applicant's service provider(s). TCMHA's housing staff will work with TCMHA's supportive services staff as required to ensure timely processing of the application review.

Upon review of the application, property management will notify the applicant, in writing, that they have been accepted or their application has not been accepted while stating the reasons. In the case of the second outcome, the applicant will be offered the opportunity to discuss the letter with property management and/or appeal the decisions.

TCMHA is an active CES partner for LA County. TCMHA Housing Supervisor, Rosemary Perich will oversee this process. She can be contacted at rperich@tricitymhs.org and by phone at (909) 326-46345. A prioritization list of eligible referrals will be maintained at all times by TCMHA. Knowing that their status can change over time, TCMHA staff will use HMIS, treatment team, emails, phone calls, postal services, and field visits to update the CES priority referral list on a quarterly basis. The client will be asked about their continued eligibility and interest in housing. Vacancy notifications will be sent to applicants in order of the CES prioritization list and applicants will be given up to two weeks to respond to the invitation for a housing unit.

Appeal Process

Prospective tenants or their Case Manager may request an appeal form from property management or supportive services staff. The site's Residential Services Coordinator and/or the applicant's Case Manager may assist the prospective tenant, if needed, through the appeal process.

If the applicant has a physical or mental disability, and as a result of this disability there are reasonable accommodations that should be considered in the appeal process, TCMHA staff will assist applicant with including a reasonable accommodation request to the appeal letter. The request would describe the reasonable accommodation(s) needed and why they should be considered.

If a prospective tenant applied for a project housing unit and is rejected, they also have a right to a hearing. If requested by the applicant, support services staff may be present at the hearing.

PROMISSORY NOTE SECURED BY DEED OF TRUST

(TRI-CITY CONSTRUCTION NOTE)

$2,160,000 Claremont, California _____, 2026

FOR VALUE RECEIVED, NCRC CLAREMONT LP, a California limited partnership ("Developer"), promises to pay to the Tri-City Mental Health Authority, a California joint powers authority ("Tri-City"), at its offices at 1717 N. Indian Hill Blvd., Suite B, Claremont, California 91711, or at such other place as Tri-City may from time to time designate in writing, (a) the principal sum of TWO MILLION ONE HUNDRED SIXTY THOUSAND DOLLARS ($2,160,000) ("Tri-City Construction Note Amount") or so much thereof as may be disbursed by Tri-City to Developer; and (b) all costs and expenses payable hereunder on or before the date that is fifty-five (55) years after the conversion of Project to permanent financing, and said date is hereinafter referred to as the "Maturity Date."

NOW, THEREFORE, for good valuable consideration, receipt of which is hereby acknowledged, Developer agrees as follows:

1. Agreement; Disbursements. The principal sum hereunder has been and is being disbursed after the closing of escrow for the St. Ambrose Senior Affordable Housing project ("Project") generally located at 155 N Mountain Ave., Claremont, CA (the "Site"), in the manner set forth in that Construction Monitoring and Disbursement Agreement] by and among Tri-City, Developer, [insert other named parties as applicable].

2. Interest; Payments of Interest and Principal. Interest shall accrue on the unpaid Tri-City Construction Note Amount at the rate of three percent (3%) per annum, simple interest annually.

Developer shall make annual payments to Tri-City, which shall be applied to principal, of the Residual Receipts Payment (as hereinafter defined), if any. The payments shall be paid to Developer no later than 120 days after the end of each fiscal year of the Project, with the first such payment due after the end of the calendar year in which the Project receives final certificates of occupancy.

A. The "Residual Receipts Payment" shall equal Residual Receipts (as defined below), if any, multiplied by the Lender's Share of 50% of Residual Receipts (as hereinafter defined). The "Lender's Share of 50% of Residual Receipts" shall be determined by multiplying (i) 50% of Residual Receipts by (ii) the Agency Loan Ratio (as hereinafter defined). The "Agency Loan Ratio" shall be equal to (x) the amount of the Tri-City Construction Note Amount divided by (y) the combined amount of the Tri-City Construction Note Amount and the loan from the Los Angeles County Development Agency in the amount of $5,040,000. The parties agree that the Agency Loan Ratio shall be equal to 30%. (The remainder of Residual Receipts may be retained by Developer or used to pay fees or distributions to its partners or affiliates.)

B. For the purposes of this Note, "Operating Income" means all income derived from the Project, and shall include, without limitation: (i) rents; (ii) rent subsidy payments received on

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behalf of tenants; (iii) amounts withdrawn from the capitalized operating subsidy reserve established and maintained by Developer; (iv) interest on income other than interest on reserve accounts approved by Lender; and (v) receipts from laundry, parking, vending, or other services in which a fee is charged. "Residual Receipts" shall mean all annual Operating Income less amounts paid therefrom for the following:

(1) salaries, wages, and any other compensation due and payable to the employees or agents of the Developer employed on site in connection with the maintenance, administration or operation of the Project, along with all withholding taxes, insurance premiums, Social Security payments and other payroll taxes or payments required in connection with such employees;

(2) all charges incurred in the operation of the Project in connection with utilities, real estate taxes and assessments, and liability, fire and other hazard insurance premiums;

(3) regularly scheduled non-contingent payments of interest, principal, impounds, fees and charges, if any, required on loans which are secured by liens on the Project and which have been approved by Tri-City (but excluding payments based on net cash flow, residual receipts, or the like);

(4) all other incurred operating expenses, including the fee of the managing agent and any extraordinary expenses, that are included in the annual operating budget of the Project approved in advance by Tri-City;

(5) deposits to required reserve accounts;

(6) deferred developer fees (subject to limits thereon under applicable law and Project financing); and

(7) asset management, partnership management and similar fees, in the maximum annual combined amount of $25,000, increasing by 3% per year, and any amount not paid in one year may not be carried over into future years.

3. Payment At Term Expiration. If, as of the Maturity Date, there are no uncured Defaults (as hereinafter defined) hereunder, and there are no amounts which have become payable pursuant to Section 8 hereof, the balance of this Tri-City Construction Note shall be forgiven.

4. Form of Payments. All amounts due hereunder are payable in immediately available funds and lawful monies of the United States of America.

5. Application of Payments. All payments shall be applied: (i) first, to costs and fees owing hereunder, (ii) second, to the payment of unpaid accrued interest owing hereunder, and (iii) third, to the payment of principal.

6. Prepayment. At any time, Developer may prepay in whole or in part the outstanding principal balance under this Tri-City Construction Note, together with all accrued interest, if any, and unpaid fees, costs and expenses, if any, payable hereunder, without penalty or premium. In the event of prepayment by Developer, that certain Regulatory Agreement by and between TCMHA

and Developer of even date herewith ("Regulatory Agreement") shall remain intact, and shall be unaffected by the prepayment of this Tri-City Construction Note by Developer.

7. Security. This Tri-City Construction Note and all amounts payable hereunder are secured by a Deed of Trust with Assignment of Rents of even date herewith ("Tri-City Deed of Trust"), executed by Developer in favor of Tri-City and recorded against the Site in the Official Records of Los Angeles County. The terms of the Tri-City Deed of Trust are incorporated herein and made a part hereof to the same extent and with the same force and effect as if fully set forth herein. A default under any of the provisions of the Tri-City Deed of Trust shall be a Default hereunder, and a Default hereunder shall be a default under the Tri-City Deed of Trust.

8. Acceleration and Other Remedies. If elected by Tri-City pursuant to the following sentence, the entire balance due under this Tri-City Construction Note shall be paid to Tri-City upon the earlier of any of the following (each, a "Default"): (i) the uncured default of Developer under this Tri-City Construction Note, or the Tri-City Deed of Trust or the Regulatory Agreement, in each case, after delivery of notice and expiration of the applicable cure period provided in the respective agreement (and, if no such cure period is stated, then on the date that is 30 days after Tri-City provides written notice to Developer of such default); (ii) the default by Developer under any obligation secured by a deed of trust that is senior to the Tri-City Deed of Trust that is not cured within the cure period, if any, provided thereunder; (iii) the default by Developer under any deed of trust that is senior to the Tri-City Deed of Trust that is not cured within the cure period, if any, provided thereunder; or (iv) the sale, lease or other transfer or conveyance (other than the Permitted Transfers as defined in Section 16) of all or any part of the Project, or any interest therein (individually or collectively a "Transfer"), without the prior written consent of Tri-City, which consent shall not be unreasonably withheld, conditioned or delayed, (v) Developer becomes insolvent or the filing of bankruptcy or insolvency proceedings by or against Developer or if Developer makes a general assignment for the benefit of creditors, or (vi) Developer dissolves or liquidates. Upon the occurrence and during the continuance of a Default, Tri-City may, at Tri-City's option, declare the outstanding principal amount of this Tri-City Construction Note, and other charges hereunder, and all other sums secured by the Tri-City Deed of Trust, to be due and payable immediately, and upon such declaration, such principal and interest and other sums shall immediately become and be due and payable without demand or notice, all as further set forth in the Tri-City Deed of Trust. All costs of collection, including, but not limited to, reasonable attorneys' fees and all expenses incurred in connection with protection of, or realization on, the security for this Tri-City Construction Note, may be added to the principal hereunder, and shall accrue interest as provided herein. Tri-City shall, upon the occurrence and during the continuance of a Default, have the right to proceed against any portion of the security for this Tri-City Construction Note in such order and in such manner as Tri-City may consider appropriate, without waiving any rights with respect to any of the security. Any delay or omission on the part of Tri-City in exercising any right hereunder, under the Regulatory Agreement or under the Tri-City Deed of Trust shall not operate as a waiver of such right, or of any other right. No single or partial exercise of any right or remedy hereunder or under the Regulatory Agreement, the Tri-City Deed of Trust or any other document or agreement shall preclude other or further exercises thereof, or the exercise of any other right or remedy. The acceptance of payment of any sum payable hereunder, or part thereof, after the due date of such payment shall not be a waiver of Tri-City's right to either require prompt payment when due of all other sums payable hereunder or to declare a Default for failure to make prompt or complete payment. In addition, upon any Default, the Tri-City

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Construction Note Amount and all outstanding amounts due under this Tri-City Construction Note shall accrue interest at the default rate of ten percent (10%) per annum (based on a 360-day year and charged on the basis of the actual number of days elapsed).

9. Waivers. Except to the extent notice is required under the Regulatory Agreement, Developer waives presentment, demand, notice of acceleration, notice of costs, expenses or losses or interest thereon, notice of dishonor, diligence in collection or in proceeding against any of the rights or interests in or to any and all property securing this Tri-City Construction Note, and the benefit of any exemption under any homestead exemption laws, if applicable. Developer expressly agrees that this Tri-City Construction Note or any payment hereunder may be extended from time to time at Tri-City's sole discretion and that Tri-City may accept security in consideration for any such extension or release any security for this Tri-City Construction Note at its sole discretion all without in any way affecting the liability of Developer. No extension of time for payment of this Tri-City Construction Note made by agreement by Tri-City with any person now or hereafter liable for the payment of this Tri-City Construction Note shall operate to release, discharge, modify, change or affect the original liability of Developer under this Tri-City Construction Note, either in whole or in part. The obligations of Developer under this Tri-City Construction Note shall be absolute and Developer waives any and all rights to offset, deduct or withhold any payments or charges due under this Tri-City Construction Note for any reasons whatsoever. No previous waiver and no failure or delay by Tri-City in acting with respect to the terms of this Tri-City Construction Note or the Tri-City Deed of Trust shall constitute a waiver of any breach, default, or failure or condition under this Tri-City Construction Note, the Tri-City Deed of Trust or the obligations secured thereby. A waiver of any term of this Tri-City Construction Note, the Tri-City Deed of Trust or any of the obligations secured thereby must be made in writing and shall be limited to the express written terms of such waiver.

10. Consents. Developer consents to: (a) the release or surrender or exchange or substitution of all or any part of the security, whether real or personal, or direct or indirect, for the payment hereof to the extent requested or approved by Developer, and (b) the granting of any other indulgences to Developer.

11. Successors and Assigns. Whenever “Tri-City” is referred to in this Note, such reference shall be deemed to include Tri-City, and its successors and assigns, including, without limitation, any subsequent assignee or holder of this Tri-City Construction Note. All covenants, provisions and agreements by or on behalf of Developer which are contained herein shall inure to the benefit of Tri-City's successors and assigns. Tri-City may, at its option, assign its right to receive payment under this Tri-City Construction Note without necessity of obtaining the consent of Developer. Whenever "Developer" is referred to in this Tri-City Construction Note, such reference shall be deemed to include NCRC Claremont LP, a California limited partnership, and its approved successors and assigns, including, without limitation, any approved subsequent assignee or obligor of this Tri-City Construction Note, if such approval is required and (if required) given in accordance with this Tri-City Construction Note. In no event shall Developer assign or transfer any portion of this note without the prior express written consent of Tri-City, except as permitted in this Tri-City Construction Note.

12. Usury. It is the intention of Developer and Tri-City to conform strictly to the Interest Law, as defined below, applicable to this loan transaction. Accordingly, it is agreed that notwithstanding any provision to the contrary in this Tri-City Construction Note, or in any of the

documents securing payment hereof or otherwise relating hereto, the aggregate of all interest and any other charges or consideration constituting interest under the applicable Interest Law that is taken, reserved, contracted for, charged or received under this Tri-City Construction Note, or under any of the other aforesaid agreements or otherwise in connection with this loan transaction, shall under no circumstances exceed the maximum amount of interest allowed by the Interest Law applicable to this loan transaction. If any excess of interest in such respect is provided for in this Tri-City Construction Note, or in any of the documents securing payment hereof or otherwise relating hereto, then, in such event:

(a) the provisions of this paragraph shall govern and control;

(b) neither Developer nor Developer's heirs, legal representatives, successors or assigns shall be obligated to pay the amount of such interest to the extent that it is in excess of the maximum amount of interest allowed by the Interest Law applicable to this loan transaction;

(c) any excess shall be deemed canceled automatically and, if theretofore paid, shall be credited on this Tri-City Construction Note by Tri-City or, if this Tri-City Construction Note shall have been paid in full, refunded to Developer; and

(d) the effective rate of interest shall be automatically subject to reduction to the Maximum Legal Rate of Interest (as defined below), allowed under such Interest Law, as now or hereafter construed by courts of appropriate jurisdiction. To the extent permitted by the Interest Law applicable to this loan transaction, all sums paid or agreed to be paid to Tri-City for the use, forbearance or detention of the indebtedness evidenced hereby shall be amortized, prorated, allocated and spread throughout the full term of this Tri-City Construction Note. For purposes of this Tri-City Construction Note, "Interest Law" means any present or future law of the State of California, the United States of America, or any other jurisdiction which has application to the interest and other charges under this Tri-City Construction Note. The "Maximum Legal Rate of Interest" means the maximum rate of interest that Tri-City may from time to time charge Developer, and under which Developer would have no claim or defense of usury under the Interest Law.

13. Costs of Enforcement. Developer agrees to pay upon demand all reasonable costs and expenses, including attorneys' fees, expert witness fees, and costs of suit (including appeals), incurred by Tri-City to enforce the terms hereof. In addition to the foregoing award of attorneys' fees, Tri-City shall be entitled to its reasonable attorneys' fees incurred in any post-judgement proceedings to enforce any judgment in connection with this Tri-City Construction Note. This provision is separate and several and shall survive the merger of this provision into any judgment.

14. Miscellaneous. Time is of the essence hereof. If this Tri-City Construction Note is now, or hereafter shall be, signed by more than one party or person, it shall be the joint and several obligation of such parties or persons (including, without limitation, all makers, endorsers, guarantors and sureties), and shall be binding upon such parties and upon their respective successors and assigns. This Tri-City Construction Note shall be governed by and construed under the laws of the State of California. Developer irrevocably and unconditionally submits to the jurisdiction of the Superior Court of the State of California for the County of Los Angeles or the United States District Court of the Central District of California, as Tri-City hereof may deem appropriate, in connection with any legal action or proceeding arising out of or relating to this Tri-

City Construction Note. Developer also waives any objection regarding personal or in rem jurisdiction or venue to the extent such action is filed in the above-referenced courts.

15. Non-Recourse Obligation. In the event of any Default under the terms of the Regulatory Agreement, the sole recourse of Tri-City for any such Default shall be the Site and the Project. Developer and its partners and affiliates shall not be personally liable for the payment of any obligations under this Agreement; provided, however, that the foregoing shall not in any way affect any rights Tri-City may have hereunder, or any right of Tri-City to recover or collect funds, damages or costs (including without limitation reasonable attorneys' fees and costs) incurred by Tri-City as a result of fraud, intentional misrepresentation, failure to discharge any materialmen's' liens or other liens against any portion of the Project, retention by Developer of any income from the Project or insurance proceeds or condemnation awards that should, by the terms hereof, by law or by equity, by paid to Tri-City, or bad faith waste, and/or any costs and expenses incurred by Tri-City in connection therewith (including without limitation reasonable attorneys' fees and costs) or gross negligence of Developer.

16. Permitted Transfers. Notwithstanding any provision to the contrary, the consent of TCMHA shall not be required for Transfer pursuant to that certain Purchase Option and Right of First Refusal Agreement between Developer, National Community Renaissance of California, RBC Community Investments, LLC (the "Investor Limited Partner"), and RBC Community Investments Manager II, Inc. (the "Special Limited Partner"), of even date herewith.

17. Notices. Any notice required or permitted to be given hereunder shall be given in accordance with Article 7 of the Regulatory Agreement.

18. Counterparts. Counterparts of this Tri-City Construction Note may be executed and delivered, and each of which, and all of which together, shall constitute one and the same Tri-City Construction Note.

[Signatures on following page]

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IN WITNESS WHEREOF, the parties hereto have caused this Tri-City Construction Note to be executed on the date first set forth above.

TRI-CITY:
TRI-CITY MENTAL HEALTH AUTHORITY,
a California joint powers authority

By: _____
Ontson Placide, Executive Director

DEVELOPER:
NCRC CLAREMONT LP,
a California limited partnership

By: NCRC CLAREMONT MGP, LLC,
a California limited liability company,
its general partner

By: National Community Renaissance of California,
a California nonprofit public benefit corporation,
its sole member and manager

By: _____
Kevin Lim, Chief Financial Officer

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