

C O N T R A C T

The COUNTY OF SAN BENITO ("COUNTY") and INTERIM, INC. ("CONTRACTOR") enter into this contract which shall be effective on the date stated in Paragraph 1.

1. Duration of Contract.

This contract shall commence on 07/01/2022, and end on 06/30/2023 unless sooner terminated as specified herein.

2. Scope of Services.

CONTRACTOR, for COUNTY's benefit shall perform the services specified on Attachment A to this contract. Attachment A is made a part of this contract.

3. Compensation for Services.

In consideration for CONTRACTOR's performance, COUNTY shall pay compensation to CONTRACTOR according to the terms specified in Attachment B. Attachment B is made a part of this contract.

4. General Terms and Conditions.

The rights and duties of the parties to this contract are governed by the general terms and conditions mutually agreed to and listed in Attachment C. Attachment C is made a part of this contract.

5. Insurance Limits.

CONTRACTOR shall maintain the following insurance policy limits of coverage consistent with the further insurance requirements specified in Attachment C.

- (a) Comprehensive general liability insurance: \$1,000,000
- (b) Professional liability insurance: \$1,000,000
- (c) Comprehensive motor vehicle liability insurance: \$1,000,000

6. Termination.

The number of days of advance written notice required for termination of this contract is thirty (30) days.

7. Specific Terms and Conditions (check one)

- There are no additional provisions to this contract.
- The rights and duties of the parties to this contract are additionally governed by the specific, additional terms mutually agreed to and listed in Attachment D. Attachment D is made a part of this contract.
- The rights and duties of the parties to this contract are additionally governed by the specific, additional terms mutually agreed to and listed in Attachment E. Attachment E is made a part of this contract.

8. Information about Contract Administrators.

The following names, titles, addresses, and telephone numbers are the pertinent information for the respective contract administrators for the parties.

Contract Administrator for COUNTY:
Name: Rachel White
Title: Assistant Behavioral Health Director
Address: 1131 Community Parkway
Hollister, California 95023

Telephone No.: (831) 636-4020
Fax No.: (831) 636-4025

Contract Administrator for CONTRACTOR:
Name: Barbara L. Mitchell, MSW
Title: Executive Director, Interim Inc.
Address: PO Box 3222
Monterey, CA 93942

Telephone No.: (831) 649-4522 ext. 204
Fax No.: _____


SIGNATURES

APPROVED BY COUNTY:

Name: Bea Gonzales
Title: Chair, Board of Supervisors
Date: _____

APPROVED BY CONTRACTOR:
DocuSigned by:
Barbara Mitchell
1B368FFD9676440...
Name: Barbara L. Mitchell, MSW
Title: Executive Director
Date: 5/11/2022

APPROVED AS TO LEGAL FORM:
San Benito County Counsel

By: 
Date: 05/12/2022

ATTACHMENT A Scope of Services

Program Description – Crisis Residential Bed Program for San Benito County

MP is licensed by the California Department of Social Service, Community Care Licensing Division and certified by Department of Healthcare Services as a social rehabilitation short-term crisis facility.

1. Program Services

MP will provide the following services within a Short-Term Crisis Residential program:

- a. Intake assessment and admission support*
- b. Structured, Non-institutional Environment:* Staff will support client with daily living skills, personal hygiene, and daily house maintenance. Staff will provide breakfast, lunch, dinner, and snacks, as well as hygiene items.
- c. Individual and Group Counseling:* Staff will work with clients to develop strategies to avoid reoccurrence of crisis situations. Clients are assisted in formulating and following through on client-centered goals, coping with mental illness, improving interpersonal relationships, and strengthening the client's existing support system.
- d. Medication Support:* All medications are stored in a secured medication room. Staff will assist clients with *self-administration* of medications and symptom awareness and education. Over the counter (OTC) medications as indicated by the treating physicians are provided.
- e. Onsite Structured social rehabilitation groups:* Group sessions and weekend activities are offered to the client.
- f. Discharge planning*

2. Length of Service

Admission and discharge is based on determination of medical necessity for services with an average of thirty (30) days length of stay and a **maximum 89 days length of stay**. (Any length of stay over thirty days must continue to meet medical necessary, as documented in client's chart.) Discharge is also determined by the client because MP is a voluntary program and all clients have the option to voluntarily discharge from the program at any time. Discharge from MP can also occur when a client is unwilling, unable, or unavailable to participate in services. Overall, assessments for admission and discharge are determined based on Department of Healthcare Services definition of Medical Necessity. See Medical Necessity defined in **Appendix F**.

3. Program Goals

- To reduce or prevent use of psychiatric hospitalization.
- To offer clients with serious mental illnesses, including co-occurring substance use disorders, an opportunity to address psychosocial challenges utilizing a community based social rehabilitation model.
- To teach clients how to cope with symptoms of mental illness and practice relapse prevention, manage medications, and improve interpersonal relationships.

4. Discharge Criteria

Interim determines the appropriateness of client discharge based on the following: 1) client is not meeting medical necessity (as defined in **Appendix F**) for the level of care, i.e. client has been restored to their prior level of functioning prior to the crisis; 2) MP is no longer able to meet the client's needs for care and supervision; or 3) client is unavailable for services, e.g. client is hospitalized or self-discharges from the MP, etc. Whenever possible through program care coordination and active discharge planning, clients will be linked to outpatient mental health and substance use treatment, housing, and essential social supports to promote client recovery and

resiliency to reduce risk of hospital readmission and achieve meaningful long-term outpatient outcomes. SBC staff are responsible for picking up the client upon discharge.

5. Program Staff

MP is staffed 24 hours, seven days per week. Staff provides Social Rehabilitation services implementing various evidenced based practices, such as Social Rehabilitation Oriented Practices, Motivational Interviewing, and Stages of Change, Person Centered counseling, Trauma Informed and Culturally Linguistically Appropriate Services. Services are based on individualized goals, established jointly between staff and clients. Services are provided by a multidisciplinary team including but not limited to Board of Behavioral Sciences licensed or licensed waived staff (LMFT, LCSW, or LPCC; ASW, APCC, AMFT), Registered or Licensed Vocational Nurse, Mental Health Rehabilitation Specialist and Mental Health Specialists. See regulations outlined in **Appendix G**.

Program Procedures - Short Term Crisis Residential Bed Program for San Benito County Behavioral Health Department

Grant to Use Facility - Crisis Residential Bed Program

Subject to the terms and conditions set forth in this Agreement, Interim hereby accepts referrals from SBC for a bed/s (SBC bed) in Interim's Manzanita Program (MP) located at 343 Dela Vina Monterey, California and at 200 Casentini St. Salinas, California for exclusive use for referrals for clients who meet San Benito Behavioral Health, Adult System of Care criteria, and are enrolled in Medi-Cal or private pay/insurance. The bed is not a specific bed and will be assigned by Interim based on available location in the MP, client's gender, mobility needs, or other needs of the client or MP. (Location of the SBC bed will most likely be in a shared two-person room.) There are limited beds available for individuals over age 60 or who are considered non-ambulatory/using assistive devices; therefore, a SBC referral may be rejected or waitlisted until there is an opening available for non-ambulatory or aged 60 and over. [Nonambulatory as defined in Health and Safety Code section 13131. (A) A person who uses postural supports is deemed non-ambulatory. (B) A person is not deemed non-ambulatory solely because they are deaf, blind, or prefers to use a mechanical aid.]

Interim has the right to accept or reject any referral from SBC and to discharge clients as appropriate.

Referral & Admission Process

Referrals to the SBC bed shall be submitted by SBC Behavioral Health Services. The referral form will be completed by SBC staff and include psychosocial assessments, laboratory reports, and discharge summary. SBC will indicate on the referral form designating "referral for SBC bed." (Client admitted to the "SBC bed" remains in the designated SBC bed until discharge.) Assessments for intake will be conducted via Zoom or on site at SBC, Monday through Friday from 9 am to 5 pm, as determined by MP. If a client referral is accepted into the MP, SBC staff are responsible for transporting clients to MP. If the client is admitted into the program during an onsite interview, Interim staff will transport the client to MP. SBC staff are responsible for picking up their clients upon discharge.

See Referral and Admission Process described in Appendix B.

Program Admission Criteria

- Adults (18 years of age and older) with DSM-V serious mental illness diagnostic categories i.e. schizophrenia, bipolar disorders, schizoaffective disorder, and major depression and significant impairment that substantially interferes with the person's functional ability to carry out primary aspects of daily living in the community.

- Individuals who are informed about services and express a desire to participate in services on a voluntary basis.
- Individuals who are able to safely participate in a milieu setting with other clients and staff.
- Interim staff will assess the ability of the MP to meet the individual's needs based on Community Care Licensing needs appraisal and Physicians Report that indicate the program can meet the client's needs in the following areas: social/family, emotional, physical, mental, functioning, and suicide prevention.
- Individuals diagnosed or otherwise reported to have Restricted Health Conditions must have a Restricted Health Condition Plan completed by their physician that indicates Interim Crisis Residential staff can meet the individual's Restricted Health Condition needs for care.
- Admission eligibility is determined by the MP Program Director or designee.

See Program Admission Criteria outlined in **Appendix C**, **Appendix D**, and **Appendix F**.
[Physicians Report including TB test results – fillable pdf included under Appendix B]

Program Exclusion Criteria

- Individuals with diagnosed or otherwise reported prohibited health conditions as defined by Community Care Licensing regulations. (Appendix D)
- Registered as sex offenders.
- Individuals with history of arson.
- Individuals evaluated as high risk for overdose, dependent/ needing medical detoxification from alcohol, opiates, or other substances, including but not limited to IV heroin use.
- Individuals with care and supervision needs that cannot be met by MP.
- Individuals meeting 5150 criteria for grave disability, danger to self or danger to others.
- Individuals with history of threatening Interim Inc. staff or other residents.
- Individuals with primary diagnosis of mild to moderate mental illnesses.

COUNTY OBLIGATIONS

Medical/Medications

Prior to client's admission to the MP, SBC will provide a completed Community Care Licensing Physicians Report including TB testing results and Restricted Health Condition Plans, if indicated (Appendix B). If discharging from hospital or other facility care, SBC will report all discharge prescriptions to the local pharmacy for order and pick up prior to client's admission to the MP. Interim staff will pick up prescriptions prior to client's admission. If admitting from home or other non-hospital setting, SBC will ensure client possesses all currently prescribed medications in original pharmacy containers. SBC will reimburse Interim for the cost of any prescribed medications and co-payments the SBC client is unable to pay. MP will not admit a client unless all the medications are available prior to admission.

Psychiatric Services

SBC will provide psychiatric services for the client in the SBC bed via telehealth (or face to face, if necessary) at no charge to Interim. SBC will provide psychiatric telephone consultation with qualified Interim staff as requested, e.g. Registered Nurse for psychiatric medication consultations and medication changes. SBC will re-evaluate client for re-hospitalization as needed. SBC will provide general psychiatric services including: 1) Telehealth (or face-to-face psychiatry, if necessary) consultations (medication management and psychiatric assessments) at least weekly or as needed; 2) Sharing of medical record documentation with MP including assessments and progress notes; 3) Crisis psychiatric services: Clients experiencing a psychiatric crisis episode will be seen by a psychiatrist at SBC for evaluation and triage to the appropriate level of care, i.e. inpatient psychiatric hospitalization, etc; and 4) Clients may be transported to nearest hospital (i.e. Natividad or CHOMP) by MP staff if client is deemed safe for transport by MP staff. If the client is not safe to transport, other transportation arrangements can be arranged

by MP staff (police or ambulance). If SBC needs the client transported to Hazel Hawkins Memorial Hospital or another hospital and does not wish to use the Monterey County hospitals, SBC staff are responsible for this transportation.

If SBC is unable to provide continued psychiatric services to the client, Interim will do for a fee of \$10/minute. Payment for this service is due at the same time as payment for the residential treatment portion.

END OF ATTACHMENT A.

**ATTACHMENT B
Payment Schedule**

B-1. BILLING

Charges for services rendered pursuant to the terms and conditions of this contract shall be invoiced on the following basis: (check one)

- One month in arrears.
 Upon the complete performance of the services specified in Attachment A.
 The basis specified in paragraph B-4.

B-2. PAYMENT

Payment shall be made by COUNTY to CONTRACTOR at the address specified in paragraph 8 of this contract, net thirty (30) days from the invoice date.

B-3. COMPENSATION

COUNTY shall pay to CONTRACTOR: (check one)

- a total lump sum payment of \$ _____, or
 a total sum not to exceed ONE HUNDRED THOUSAND DOLLARS (\$100,000) for services rendered pursuant to the terms and conditions of this contract and pursuant to any special compensation terms specified in this attachment, Attachment B.

B-4. SPECIAL COMPENSATION TERMS: (check one)

- There are no additional terms of compensation.
 The following specific terms of compensation shall apply: (Specify)

The daily rate is \$560.98. The board and care fee will increase January 1, 2023 and is determined by HHS DSS. Payments for all clients are due monthly no later than 30 days after the bill is received. The fee includes the treatment and room and board fees; the client will not be charged a separate room and board fee. The monthly fee does not include medication or psychiatric services, nor does it include transportation to and from psychiatric appointments at SBC nor does it include transportation to or from the facility. If the client requires medication support services at the facility by Interim staff, the cost is \$10/minute. Interim staff will provide social rehabilitative services within a Community Care Licensing and Department of Healthcare Services certified Short-Term Crisis Residential Facility. The fee is to be paid to Interim Inc., P.O. Box 3222, Monterey, CA 93942. Interim will not bill the client nor their insurance for this service.

END OF ATTACHMENT B

ATTACHMENT C General Terms and Conditions

C-1. INDEMNIFICATION.

CONTRACTOR and COUNTY each agree to indemnify, defend and save harmless the other party and the other party's officers and employees, from and against any and all claims and losses whatsoever arising out of, or in any way related to, the indemnifying party's performance under this contract, including, but not limited to, claims for property damage, personal injury, death, and any legal expenses (such as attorneys' fees, court costs, investigation costs, and experts' fees) incurred by the indemnitee in connection with such claims or losses. A party's "performance" includes the party's action or inaction and the action or inaction of that party's officers and employees.

C-2. GENERAL INSURANCE REQUIREMENTS.

Without limiting CONTRACTOR's duty to indemnify COUNTY, CONTRACTOR shall comply with the insurance coverage requirements set forth in the contract and in this attachment. Those insurance policies mandated by Paragraph C-3 shall satisfy the following requirements:

- (a) Each policy shall be issued by a company authorized by law to transact business in the State of California.
- (b) Each policy shall provide that COUNTY shall be given notice in writing at least thirty (30) days in advance of any change, cancellation, or nonrenewal thereof.
- (c) The comprehensive motor vehicle and comprehensive general liability policies shall each provide an endorsement naming the County of San Benito and its officers, agents and employees as additional insureds.
- (d) The required coverage shall be maintained in effect throughout the term of this contract.

CONTRACTOR shall require all subcontractors performing work under this contract to obtain substantially the identical insurance coverage required of CONTRACTOR pursuant to this agreement.

C-3. INSURANCE COVERAGE REQUIREMENTS.

If required by paragraph 5 of the contract, CONTRACTOR shall maintain the following insurance policies in full force and effect during the term of this contract:

- (a) Comprehensive general liability insurance. CONTRACTOR shall maintain comprehensive general liability insurance, covering all of CONTRACTOR's operations with a combined single limit of not less than the amount set out in paragraph 5 of this contract.
- (b) Professional liability insurance. CONTRACTOR shall maintain professional liability insurance with liability limits of not less than the amount set out in paragraph 5 of this contract.

- (c) Comprehensive motor vehicle liability insurance. CONTRACTOR shall maintain comprehensive motor vehicle insurance covering all motor vehicles (including owned, non-owned and hired) used in providing services under this contract, with a combined single limit of not less than the amount set out in Paragraph 5 of this contract.
- (d) Workers' compensation insurance. CONTRACTOR shall maintain a workers' compensation plan covering all of its employees as required by California Labor Code Section 3700, either through workers' compensation insurance issued by an insurance company or through a plan of self-insurance certified by the State Director of Industrial Relations. If CONTRACTOR elects to be self-insured, the certificate of insurance otherwise required by this contract shall be replaced with a consent to self-insure issued by the State Director of Industrial Relations.

C-4. CERTIFICATE OF INSURANCE.

Prior to the commencement of performance of services by CONTRACTOR and prior to any obligations of COUNTY, CONTRACTOR shall file certificates of insurance with COUNTY, showing that CONTRACTOR has in effect the insurance required by this contract. CONTRACTOR shall file a new or amended certificate promptly after any change is made in any insurance policy which would alter the information on the certificate then on file. In lieu of providing proof of insurance, CONTRACTOR may provide proof of self-insurance meeting requirements equivalent to those imposed herein. CONTRACTOR warrants that CONTRACTOR's self-insurance provides substantially the same protection to COUNTY as the insurance required herein. CONTRACTOR further agrees to notify COUNTY in the event any change in self-insurance occurs that would alter the obligations undertaken in this contract within thirty (30) days of such change.

C-5. RECORDS TO BE MAINTAINED.

CONTRACTOR shall keep and maintain accurate records of all costs incurred and all time expended for work under this contract. CONTRACTOR shall contractually require that all of CONTRACTOR's subcontractors performing work called for under this contract also keep and maintain such records. All such records, whether kept by CONTRACTOR or any subcontractor, shall be made available to COUNTY or its authorized representative, or officials of the State of California for review or audit during normal business hours, upon reasonable advance notice given by COUNTY, its authorized representative, or officials of the State of California.

C-6. RETENTION OF RECORDS.

CONTRACTOR shall maintain and preserve all records related to this contract for a period of three years from the close of the fiscal year in which final payment under this contract is made. CONTRACTOR shall also contractually require the maintenance of such records in the possession of any third party performing work related to this contract for the same period of time. Such records shall be retained beyond the three-year period, if any audit involving such records is then pending, until the audit findings are resolved. The obligation to insure the maintenance of the records beyond the initial three year period shall arise only if the COUNTY notifies CONTRACTOR of the commencement of an audit prior to the expiration of the three year period.

C-7. TITLE TO DOCUMENTS; COPYRIGHT.

All reports and other materials collected or produced by the CONTRACTOR or any subcontractor of CONTRACTOR shall, after completion and acceptance of the contract, become the property of COUNTY, and shall not be subject to any copyright claimed by the CONTRACTOR, subcontractor, or their agents or employees. CONTRACTOR may retain copies of all such materials exclusively for administrative purposes. Any use of completed or uncompleted documents for other projects by CONTRACTOR, any subcontractor, or any of their agents or employees, without the prior written consent of COUNTY is prohibited.

C-8. INDEPENDENT CONTRACTOR.

CONTRACTOR and its officers and employees, in the performance of this contract, are independent contractors in relation to COUNTY and not officers or employees of COUNTY. Nothing in this contract shall create any of the rights, powers, privileges or immunities of any officer or employee of COUNTY. CONTRACTOR shall be solely liable for all applicable taxes or benefits, including, but not limited to, federal and state income taxes, Social Security taxes, or ERISA retirement benefits, which taxes or benefits arise out of the performance of this contract. CONTRACTOR further represents to COUNTY that CONTRACTOR has no expectation of receiving any benefits incidental to employment.

C-9. CONFLICT OF INTEREST.

CONTRACTOR covenants that it presently has no interest and shall not acquire any interest, direct or indirect, financial or otherwise, which would conflict in any manner or degree with the performance of the services hereunder. CONTRACTOR further covenants that, in the performance of this contract, no subcontractor or person having such an interest shall be used or employed. CONTRACTOR certifies that no one who has or will have any financial interest under this contract is an officer or employee of COUNTY.

C-10. COMPLIANCE WITH APPLICABLE LAWS.

CONTRACTOR shall comply with all applicable federal, state and local laws now, or hereafter, in force, and with any applicable regulations, in performing the work and providing the services specified in this contract. This obligation includes, without limitation, the acquisition, and maintenance of any permits, licenses, or other entitlements necessary to perform the duties imposed expressly or impliedly under this contract.

C-11. NONDISCRIMINATION.

CONTRACTOR shall not discriminate in the employment of persons necessary to perform this contract on any legally impermissible basis, including on the basis of the race, color, national origin, ancestry, religion, age, sex, or disability of such person.

C-12. BANKRUPTCY.

CONTRACTOR shall immediately notify COUNTY in the event that CONTRACTOR ceases conducting business in the normal manner, becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or assets, or avails itself of, or becomes subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors.

C-13. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION OF DUTIES.

Except as specifically authorized herein, no rights under this contract may be assigned and no duties under this contract may be delegated by CONTRACTOR without the prior written consent of COUNTY, and any attempted assignment or delegation without such consent shall be void.

C-14. NEGOTIATED CONTRACT.

This contract has been arrived at through negotiation between the parties. Neither party is to be deemed the party which prepared this contract within the meaning of California Civil Code Section 1654.

C-15. SEVERABILITY.

Should any provision herein be found or deemed to be invalid, this contract shall be construed as not containing such provision, and all other provisions which are otherwise lawful shall remain in full force and effect. To this end, the provisions of this contract are declared to be severable.

C-16. ENTIRE CONTRACT.

This contract is the entire agreement of the parties. There are no understandings or agreements pertaining to this contract except as are expressly stated in writing in this contract or in any document attached hereto or incorporated herein by reference.

C-17. TIME IS OF THE ESSENCE.

Time is of the essence in the performance of this contract.

C-18. TERMINATION.

Either party may terminate this contract, with or without cause, at any time. In order to terminate this contract, the terminating party shall give advance written notice to the other party. The termination shall be effective no earlier than the expiration of the number of days specified in paragraph 6 of this contract. The termination notice shall be made as specified in paragraph C-19, below. In the event of termination, COUNTY shall pay CONTRACTOR for all work satisfactorily performed prior to the effective date of the termination.

C-19. NOTICES.

Notices to the parties in connection with the administration of this contract shall be given to the parties' contract administrator personally, by regular mail, or by facsimile transmission as more particularly specified in this paragraph. Notices will be deemed given on:

- (a) The day the notice is personally delivered to the contract administrator or the office of the party's contract administrator; or
- (b) Five days after the date the notice is deposited in the United States mail, addressed to a party's contract administrator as indicated in this contract, with first-class postage fully prepaid; or
- (c) On the day that the notice is transmitted by facsimile to a party's facsimile number specified in paragraph 8 of this contract, provided that an original of

such notice is deposited in the United States mail, addressed to a party's contract administrator as indicated in this contract, on the same day as the facsimile transmission is made.

C-20. RESPONSIBILITY OF CONTRACT ADMINISTRATORS.

All matters concerning this contract which are within the responsibility of the parties shall be under the direction of, or shall be submitted to, the respective contract administrators or to the party's employee specified, in writing, by the contract administrator. A party may, in its sole discretion, change its designation of its contract administrator and shall promptly give written notice to the other party of any such change.

C-21. MATERIALITY.

The parties consider each and every term, covenant, and provision of this contract to be material and reasonable.

C-22. WAIVER.

Waiver by either party of a breach of any covenant of this contract will not be construed to be a continuing waiver of any subsequent breach. COUNTY's receipt of consideration with knowledge of CONTRACTOR's violation of a covenant does not waive its right to enforce any covenant of this contract. The parties shall not waive any provisions of this contract unless the waiver is in writing and signed by all parties.

C-23. AUTHORITY AND CAPACITY.

CONTRACTOR and CONTRACTOR's signatory each warrant and represent that each has full authority and capacity to enter into this contract.

C-24. BINDING ON SUCCESSORS.

All of the conditions, covenants and terms herein contained shall apply to, and bind, the heirs, successors, executors, administrators and assigns of CONTRACTOR. CONTRACTOR and all of CONTRACTOR's heirs, successors, executors, administrators, and assigns shall be jointly and severally liable under this contract.

C-25. CUMULATION OF REMEDIES.

All of the various rights, options, elections, powers and remedies of the parties shall be construed as cumulative, and no one of them exclusive of any other or of any other legal or equitable remedy which a party might otherwise have in the event of a breach or default of any condition, covenant or term by the other party. The exercise of any single right, option, election, power or remedy shall not, in any way, impair any other right, option, election, power or remedy until all duties and obligations imposed shall have been fully performed.

C-26. INDEPENDENT ADVICE.

Each party hereby represents and warrants that in executing this contract it does so with full knowledge of the rights and duties it may have with respect to the other. Each party also represents and warrants that it has received independent legal advice from its attorney with

respect to the matters set forth in this contract and the rights and duties arising out of this contract, or that such party willingly foregoes any such consultation.

C-27. NO RELIANCE ON REPRESENTATIONS.

Each party hereby represents and warrants that it is not relying, and has not relied, upon any representation or statement made by the other party with respect to the facts involved or its rights or duties. Each party understands and agrees that the facts relevant, or believed to be relevant to this contract may hereunder turn out to be other than, or different from the facts now known to such party as true, or believed by such party to be true. The parties expressly assume the risk of the facts turning out to be different and agree that this contract shall be effective in all respects and shall not be subject to rescission by reason of any such difference in facts.

C-28. REDUCTION OF CONSIDERATION.

CONTRACTOR agrees that COUNTY shall have the right to deduct from any payments specified in Attachment B any amount owed to COUNTY by CONTRACTOR as a result of any obligation arising prior to the execution of this contract. For purposes of this paragraph, obligations arising prior to the execution of this contract may include, without limitation, any property tax, secured or unsecured, which tax is in arrears. If COUNTY exercises the right to reduce the consideration specified in Attachment B, COUNTY shall give CONTRACTOR notice of the amount of any offset and the reason for the deduction.

C-29. COUNTERPARTS.

This contract may be executed in any number of counterparts, each of which so executed shall be deemed to be an original. The counterparts shall together constitute one contract.

END OF ATTACHMENT C.

ATTACHMENT D
Specific Terms and Conditions

The following attached exhibits are incorporated herein by reference and constitute an integral part of this Agreement as if set forth in full:

Appendix A - Admission Criteria - subject to change.

Appendix B - SBC referral, wait list, and admission procedures and documents needed including Interim/SBC Bed Referral forms.

Appendix C - Community Care Licensing needs assessment requirements.

Appendix D - Regulations for Prohibited and Restricted Health Conditions and Restricted Health Condition Care Plans.

Appendix E - Admission Agreement information.

Appendix F - Medical Necessity definition.

Appendix G - CDSS/Community Care Licensing and Department of Healthcare Services Short Term Crisis Residential Facility staffing regulations.

END OF ATTACHMENT D.

Appendix A: Admission Criteria

Inclusion Criteria:

1 or > from criteria A below:

- Multiple psychiatric hospitalizations within the past 6 months
- Primary diagnoses of schizophrenia, schizoaffective disorder, bipolar I, major depressive disorder, severe, with or without psychotic features, associated with severe functional impairment
- Multiple suicide attempts (not gestures) within the past year
- ASOC patient within the past 2 years
- ASOC patient prior to 2 years ago now being discharged or discharged within the past 3 months from a psychiatric hospital
- History of LPS conservatorship

*The primary diagnoses listed above are the most common diagnoses affecting the Adult System of Care (ASOC) target population; however, any diagnosis, associated with severe and chronic functional impairment could be considered meeting criteria for ASOC.

4 or > from criteria B below:

- Suicide attempt (not gesture) within the past year
- Psychiatric hospitalization with the past year
- Current active suicidality with specific plan, intent
- Homelessness secondary to a primary psychiatric diagnosis
- Unemployment secondary to a primary psychiatric diagnosis
- Recurrent, problematic pattern of substance use (including alcohol) secondary to a primary psychiatric diagnosis
- Inability to maintain and/or absence of social support system

Exclusion Criteria

1 or > from exclusion criteria below:

- Primary substance abuse diagnosis
- Affective disorders that are not chronic, refractory and/or that have a prognostic indication of remission with effective time---limited treatment

**Please note: these criteria are intended as guidelines; clinical judgment should always be the most important deciding factor for each individual case; a subgroup of cases that meet criteria may not be appropriate for referral to ASOC and other cases that do not meet criteria may be appropriate for referral. Clinicians should consult with their Supervisors, when clinical judgment differs from the criteria above.

**MANZANITA PROGRAM
SHORT TERM RESIDENTIAL PROGRAM
INTERIM, INC.**

I. SCREENING/REFERRAL/ADMISSION PROCESS

Manzanita Program can screen, interview, and accept prospective residents immediately upon referral; individuals can be referred, interviewed, and accepted in the same day as referral if the bed is available. Assessments will be conducted Monday through Friday from 9:00am to 5:00pm. **If the bed is occupied or there are no other beds available at the Manzanita Program, SBC has the option to wait list the referral.** Upon request from SBC staff, the referral/patient's name will be placed on the **"bed wait list"** for when a bed becomes available.

Procedures:

- 1) A designated SBC staff will contact Manzanita Program staff as needed for availability of the bed, for updates related to the bed, and to coordinate assessments. (The Manzanita Program coordinator for bed will be the Program Director or Assistant Program Director. SBC will designate a staff contact authorized to conduct MP bed coordination with Manzanita staff.)
- 2) SBC will complete and submit all referral documents via fax or secure email to Manzanita House (manzanita_referrals@interiminc.org or 831.440.3644), referring to the Referral Checklist section for details.
 - a) Manzanita will maintain a bed waitlist for open beds.
 - b) SBC staff will provide client's history and involvement with the mental health system for all referrals, including suicide/self-harm risk assessment, violence/danger to others risk assessment, and substance use assessment. Manzanita will assist with assessments or answer any questions about the appropriateness of referrals.
- 3) If a referral is older than 30 days, updated referral information must be submitted to maintain an active referral on the bed wait list.

II. ADMISSION

Intake Process

1. Interview assessments will be coordinated and conducted by Manzanita Behavioral Health Clinician staff or trained Counseling staff at the Hospital where the client is located Monday through Friday 9am to 5pm at a time scheduled by Manzanita and SBC staff.
2. At the onset of the interview, staff will help orientate the prospective resident to Manzanita services.
3. Staff will review the Resident Handbook with the client, that includes:

- a. A brief description of the physical environment, number of residents, typical schedules, staffing, and the way counseling is conducted.
 - b. House agreements and generally what is expected, e.g. chores, meetings, curfew, safety status, structured time, etc.
 - c. Determining if the prospective resident is interested in participating in the program and discuss their needs and goals.
4. Staff will assess for **current** suicidality/self-harm, violence, and substance use risk.
 5. Staff will ensure that the prospective resident meets the criteria for admission.
 6. All admissions are approved by the Program Director or Program Managers.
 7. Admissions of individuals under conservatorship must involve the conservator and the conservator must sign necessary documents prior to admission.
 8. Treatment contracts may need to be drawn up as conditions of admittance to ensure safety.
 - a. If the person is on probation or parole, terms of probation/parole must be submitted with the referral packet. Person must release of information to allow Manzanita direct care program staff to communicate with probation or parole officers.
 - b. If the person is under conservatorship conditions, conservatorship paperwork needs to be submitted with the referral packet.
 - c. All clients collaborate in creating a safety contract.
 9. SBC and Manzanita staff will inform the individual that residency is based on a day-to-day, week-to-week basis with 89-day maximum, based their medical necessity for short term crisis residential services.
 10. Manzanita staff will wait for SBC Hospital discharge process to be completed and will review remaining referral packet paperwork (discharge summary and active order list) before final determination of admission.

Coordinating Transfer

As a condition of Manzanita admission, medications must be secured to ensure a safe and successful transition to Manzanita.

1. Client must have a 30-day supply of all medical medications and medical equipment and at least a 7-day supply of mental health related medications.
2. SBC staff will call the pharmacy to confirm receipt of prescription orders and will coordinate copays if needed.

- a. In the event the client does not have insurance or is unable to cover the cost of copays or any other out-of-pocket medication expenses, SBC staff will assume responsibility for the cost of medication or future orders while participating in SBC bed at Manzanita. If MP staff pay for the medication, SBC is liable for reimbursing the full amount on the next invoice.
 - b. Inability to secure medications will result in discharge to the program if coverage cannot be coordinated with SBC or client.
3. Manzanita or SBC staff will call the pharmacy to confirm all medications are filled and ready for pick up (see referral checklist)
4. When medications are ready, SBC staff will pick up the client and transport the client to the pharmacy to pick-up medications; client must have a valid ID to collect controlled prescriptions.
5. SBC staff will transport the client to the program and MP staff will complete new resident orientation.

Interim, Inc.

Manzanita House Referral Packet Checklist

Please email referrals to manzanita_referrals@interiminc.org. Call Joanne Fontanilla or Sandra Pena at 831.440.7030 to confirm receipt of packet and if you have any questions or need additional assistance.

* DUE TO CALIFORNIA HEALTH & SAFETY CODE-HSC 1564, MANZANITA IS UNABLE TO ACCEPT CLIENTS WHO ARE REGISTERED SEX OFFENDERS AGAINST A MINOR. Please refer to <https://www.meganslaw.ca.gov/> to confirm.

Forms

- Medical History & Physical (including Labs and drug tests)
- Initial Psychiatric Evaluation and daily psychiatric notes
- ED Report
- Crisis Report
- Consultation Reports and All Follow Up Notes
- Social Worker Assessments and Daily Social Worker Notes
- Copy of 5150 Application, 5250, and Conservatorship Paperwork
- Mental Health Progress Notes (including Injection and TB test documentation)
- Medical and Mental Health Discharge Instructions/Summary
- Medication & Health Condition-related forms (see below)

Psychiatric & Medical Medication Check List

The SBC Coordinator will pick-up the client and collect the medications from the pharmacy. In the case that a client has multiple medical conditions and medical specialists, the SBC Coordinator will collect the medications and forms from the medical specialist(s) unless otherwise agreed-upon by the hospital and the Coordinator.

- Prescriptions (must have prescriptions for all diagnoses mental and medical)
 - o Orders from Order Connect OR
 - o Doctor's orders on hospital or medical office letterhead with MD signature OR
 - o Copies of original prescription
- At least 7-day supply of medications in bubble packs, original medication bottle, or labeled samples
- Medication labels match doctors' orders
- Over the counter (OTC) medication authorization by doctor
- Wheelchairs, walkers, and canes must be in operable condition *and require a letter from doctor*

Restricted Health Condition Care Plans

Licensing requires that all physical health conditions/diagnoses have a form describing how the condition is to be treated and acknowledging that the client is able to manage the condition without staff assistance. *The following conditions require specific forms: diabetes, asthma/breathing, Hepatitis C, Staph and other communicable infections, and wounds.* The most common forms requested are:

Diabetes

- Completed Health Condition Care Plan signed by a medical doctor prior to admission:
 - o indicating whether client needs blood sugar monitoring and frequency
 - o special instruction if applicable (e.g. before meals, sliding scale order)
 - o insulin orders (if applicable)
- If client is monitoring blood sugar, client needs a glucometer, test strips, and lancets (at least 7-day supply)
- If client is using insulin injections client needs insulin and syringes (7-day supply)

Hepatitis and other Contagious Diseases

Completed Health Condition Care Plan signed by a medical doctor prior to admission

Assistive Inhalation Devices (e.g. inhalers & CPAP machine)

Completed Health Condition Care Plan signed by a medical doctor prior to admission

CPAP with attachments and in good working order

Wound Care (e.g. stitches, blisters, open sores)

Completed Health Care Condition Plan signed by a medical doctor prior to admission

Mobility Assistive Devices (e.g. walkers)

Signed orders by a medical doctor

*Manzanita staff will review the referral information and fax or email appropriate Health Condition Care Plan form during referral process.



REFERRAL FORM – MANZANITA – SAN BENITO COUNTY

This Referral Form Accompanies the Referral Packet

The SBC staff signing this referral form is authorizing the assignment of this referral specifically to the contracted bed located at the Manzanita Program.

List all current psychiatric medications and dosage: _____

List all other medications the client is taking, including Over-The-Counter Medications: _____

Psychiatrist Name: _____ Office: _____

Name of Primary Care Physician (if known): _____ Telephone: _____

Name of SBC BH Social Worker (if known): _____ Telephone: _____

Is client conserved? Yes No Conservator Name: _____ Telephone: _____

Does client take medications consistently? Yes No

Comments: _____

Has client currently or in the past abuse drugs/substances? Yes No

Describe type(s) and current substance diagnosis/es: _____

Does client have history of suicide attempts? Yes No Describe: _____

Does client have a history of anger control problems or striking out? Yes No

Describe: _____

Does client have any criminal conviction(s)? Yes No Describe: _____

Is client on parole/probation? Yes No Parole/Probation Officer: _____ Telephone: _____

Describe living situation: _____

Describe reason for referral: _____

SBC Staff/Social Worker _____ authorizes services beginning _____

Sign Name		Date
Client Name	Social Worker	Medical Record Number

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:

The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.

The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:		TELEPHONE:
		4321134
ADDRESS: NUMBER	STREET	CITY
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:		TELEPHONE:
ADDRESS: NUMBER	STREET	CITY
		SOCIAL SECURITY NUMBER:
NEXT OF KIN:	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:				
SECONDARY DIAGNOSIS:				
LENGTH OF TIME UNDER YOUR CARE				
AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO
TUBERCULOSIS EXAMINATION RESULTS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> NONE			DATE OF LAST TB TEST:	
TYPE OF TB TEST USED:		TREATMENT/MEDICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		
OTHER CONTAGIOUS/INFECTIOUS DISEASES: A) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		TREATMENT/MEDICATION: B) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		
ALLERGIES C) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		TREATMENT/MEDICATION: D) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: Yes No

2. For purposes of a fire clearance, this person is considered:

- Ambulatory Nonambulatory Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.

Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		COMMENTS:		
	YES (Check One)	NO	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		COMMENTS:		
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		COMMENTS:		
	YES (Check One)	NO	COMMENTS:	
1. Able to care for all personal needs				
2. Can administer and store own medications				
3. Needs constant medical supervision				
4. Currently taking prescribed medications				
5. Bathes self				
6. Dresses self				
7. Feeds self				
8. Cares for his/her own toilet needs				
9. Able to leave facility unassisted				
10. Able to ambulate without assistance				
11. Able to manage own cash resources				

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS

- 1. Headache
- 2. Constipation
- 3. Diarrhea
- 4. Indigestion
- 5. Others (*specify condition*)

OVER-THE-COUNTER MEDICATION(S)

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____

PHYSICIAN'S NAME AND ADDRESS:

TELEPHONE:

DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE

ADDRESS:

DATE:

Interim Inc. Health Condition Care Plan (SRF)
Diabetes

This plan shall neither require nor recommend that any residential facility personnel implement any health care procedure that may legally be provided only by a physician or licensed professional.

RESIDENT NAME		DATE OF BIRTH	FACILITY NAME
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE

PART A. TO BE COMPLETED BY PHYSICIAN

1. Is this client's medical condition chronic and stable or temporarily in nature and expected to return to a condition normal for this client? Yes No

2. Does this client require 24-hour nursing care and/or monitoring for this condition? Yes No
 If yes, please identify the Skilled Nursing Facility to which you will be referring: _____

3. Is this client mentally and physically capable of performing his/her own glucose testing and injections if needed? Yes No
 If no, please note in what area the resident is incapable of self-care: _____

4. The normal blood glucose for this client should be no lower than _____ and no higher than _____.

5. How frequently should this client check his/her blood glucose level? _____

6. Additional requirements or comments: _____

7. This client's primary care physician should be contracted under the following conditions: _____

8. Emergency medical services should be obtained when the following occur: _____

9. This Plan must be reviewed and updated by the following date (at least annually): _____

PHYSICIAN:	DATE OF EVALUATION	TODAY'S DATE (IF DIFFERENT)
ADDRESS:	TELEPHONE:	
SIGNATURE:	<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN'S ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER	

Interim Inc. Restricted Health Condition Care Plan- Hepatitis C (SRF)

As a non-medical residential facility licensed by Community Care Licensing, we are permitted to admit or retain a client with this restricted health condition as long as requirements noted in Section 80092.7 of CCLD Title 22 are met. This plan shall neither require nor recommend that any residential facility personnel implement any health care procedure that may legally be provided only by a physician or licensed professional.

RESIDENT NAME		DATE OF BIRTH	FACILITY NAME
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE

PART A. TO BE COMPLETED BY PHYSICIAN

1. Is this infection a risk to other clients or staff at this facility? Yes No

2. Is this client's medical condition chronic and stable or temporary in nature and expected to return to a condition normal for this client? Yes No

3. Does this client require 24-hour nursing care and/or monitoring for this condition? Yes No
 If yes, please identify the Skilled Nursing Facility to which you will be referring: _____

4. Is this client mentally and physically capable of performing his/her own self-care for this condition? Yes No
 If no, please note in what area the resident is incapable of self-care: _____

5. When should this client be reassessed to evaluate treatment and progress toward healing? _____

6. How frequently should this client be reassessed by a licensed professional to evaluate treatment and progress? _____

7. Additional requirements or comments:

8. This client's primary care physician should be contacted under the following conditions:

9. Emergency medical services should be obtained when the following occur:

10. This plan must be reviewed and updated by the following date (at least annually):

PHYSICIAN:	DATE OF EVALUATION:	TODAY'S DATE (IF DIFFERENT)
ADDRESS:	TELEPHONE:	
SIGNATURE	<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN'S ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER	

**Interim Inc. Restricted Health Condition Care Plan (SRF)
Inhalation-Assistive Devices**

As a non-medical residential facility licensed by Community Care Licensing, we are permitted to admit or retain a client with this restricted health condition as long as requirements noted in Section 80092 of CCCLD Title 22 are met. This plan shall neither require nor recommend that any residential facility personnel implement any health care procedure that may legally be provided only by a physician or licensed professional.

RESIDENT NAME		DATE OF BIRTH	FACILITY NAME
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE

PART A. TO BE COMPLETED BY PHYSICIAN

1. Please list the health condition(s) that require use of this inhalation-assistive device:
 - a. _____
 - b. _____

2. Is this client's medical condition chronic and stable or temporary in nature and expected to return to a condition normal for this client? Yes No

3. Does this client require 24-hour nursing care and/or monitoring for this condition? Yes No
 If yes, please identify the Skilled Nursing Facility to which you will be referring: _____

4. Please list the inhalation assistive device(s) prescribed to this client for the above-mentioned condition:
 - a. _____
 - b. _____
 - c. _____
 - d. _____

5. Is this client mentally and physically capable of operating and caring for this or these device(s)?
 If no, please note in what area the resident is incapable of self-care:

6. Can this or these device(s) be operated by an unlicensed person? Yes No

7. Additional requirements or comments:

8. This client's primary care physician should be contacted under the following conditions:

9. Emergency medical services should be obtained if the following occur:

10. This plan must be reviewed and updated by the following date (at least annually):

PHYSICIAN:	DATE OF EVALUATION:	TODAY'S DATE (IF DIFFERENT):
ADDRESS:		TELEPHONE:
SIGNATURE:	<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN'S ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER	

Interim Inc. Restricted Health Condition Care Plan (SRF)
Staph or Other Serious, Communicable Infections
Type of Communicable Infection _____

As a non-medical residential facility licensed by Community Care Licensing, we are permitted to admit or retain a client with this restricted health condition as long as requirements noted in Section 80092.7 of CCLD Title 22 are met. This plan shall neither require nor recommend that any residential facility personnel implement any health care procedure that may legally be provided only by a physician or licensed professional.

RESIDENT NAME		DATE OF BIRTH	FACILITY NAME
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE

PART A. TO BE COMPLETED BY PHYSICIAN

1. Is this infection a risk to other clients or staff at this facility? Yes No

2. Is this client's medical condition chronic and stable or temporary in nature and expected to return to a condition normal for this client? Yes No

3. Does this client require 24-hour nursing care and/or monitoring for this condition? Yes No
 If yes, please identify the Skilled Nursing Facility to which you will be referring: _____

4. Is this client mentally and physically capable of performing his/her own self-care for this condition? Yes No
 If no, please note in what area the resident is incapable of self-care: _____

5. When should this client be reassessed to evaluate treatment and progress toward healing? _____

6. How frequently should this client be reassessed by a licensed professional to evaluate treatment and progress? _____

7. Additional requirements or comments:

8. This client's primary care physician should be contacted under the following conditions:

9. Emergency medical services should be obtained when the following occur:

10. This plan must be reviewed and updated by the following date (at least annually):

PHYSICIAN:	DATE OF EVALUATION:	TODAY'S DATE (IF DIFFERENT)
ADDRESS:	TELEPHONE:	
SIGNATURE:	<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN'S ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER	

PART B. TO BE COMPLETED BY RESIDENTIAL FACILITY
Staph or Other Serious, Communicable Infections

1. The resident will demonstrate compliance with this treatment plan by:
- a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____

2. If resident is unable to perform self-care, the person(s) listed below will assist with resident care:
- a. Licensed Professional (if applicable): _____
 - b. Facility Staff:
 - 1. _____ 2. _____
 - 3. _____ 4. _____
 - 5. _____ 6. _____
 - 7. _____ 8. _____

3. Facility staff will monitor and document resident's compliance with this treatment plan and his/her ability to continue to provide self-care using the following tracking tools:
- a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____

4. Form LIC625 – Appraisal/Needs and Services Plan updated: _____
Administrator Date

5. All staff who provide care for this resident have received training in and are able to follow Universal Precautions and any other procedures recommended by the licensed professional for protection of the client who has the infection, other clients and staff.

Administrator Date

Comments: _____

The following people participated in the development and review of this plan:

_____ Facility Administrator	_____ Date	_____ Resident	_____ Date
_____ Conservator (if applicable)	_____ Date	_____ Coordinator	_____ Date

Interim Inc. Restricted Health Condition Care Plan (SRF)
Wound(s)

As a non-medical residential facility licensed by Community Care Licensing, we are permitted to admit or retain a client with this restricted health condition as long as requirements noted in Section 80092 of CCLD Title 22 are met. This plan shall neither require nor recommend that any residential facility personnel implement any health care procedure that may legally be provided only by a physician or licensed professional.

RESIDENT NAME		DATE OF BIRTH	FACILITY NAME
PRIMARY CARE PHYSICIAN	ADDRESS		TELEPHONE

PART A. TO BE COMPLETED BY PHYSICIAN

1. Is the wound an unhealed, surgically closed incision or wound expected to completely heal? Yes No

2. Is this a stage 3 or 4 Dermal Ulcer? Yes No
If yes, we are not permitted to maintain at current non-nursing facility, please indicate Skilled Nursing Facility where client will continue to receive medical care: _____

3. Is this Stage 1 or 2 Dermal Ulcer Yes No

4. Is this client's medical condition chronic and stable or temporary in nature and expected to return to a condition normal for this client? Yes No

5. Does this client require 24-hour nursing care and/or monitoring for this condition? Yes No
 If yes, please identify the Skilled Nursing Facility to which you will be referring: _____

6. Is this client mentally and physically capable of performing his/her own self-care for this condition? Yes No
 If no, please note in what area the resident is incapable of self-care: _____

7. When should this client be reassessed to evaluate treatment and progress toward healing? _____

8. How frequently should this client be reassessed by a licensed professional to evaluate treatment and progress? _____

9. Additional requirements or comments: _____

10. This client's primary care physician should be contacted under the following conditions: _____

11. Emergency medical services should be obtained when the following occur: _____

12. This plan must be reviewed and updated by the following date (at least annually): _____

PHYSICIAN:	DATE OF EVALUATION:	TODAY'S DATE (IF DIFFERENT)
ADDRESS:		TELEPHONE:
SIGNATURE:	<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN'S ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER	

MANZANITA HOUSE
Interim, Inc. Crisis Residential Treatment Program
Fax: 831-647-3004

PRN AUTHORIZATION AND OVER-THE-COUNTER MEDICATION ORDER FORM

CLIENT NAME: _____ **CLIENT NUMBER:** _____

Manzanita House is a residential facility licensed by the Department of Social Services, Community Care Licensing Division. The completion of this form by this client's physician is necessary prior to Manzanita House staff assisting with self-administering non-prescription PRN medication(s).

The following over-the-counter medications are permissible for this client to take according to the written directions given on each bottle label. This client is able to determine and communicate his/her need for both prescription and non-prescription PRN medications listed below.

PAIN RELIEF: These medications should not exceed 8 doses in 24 hours:

<input type="checkbox"/> Ibuprofen (NSAID), 200mg 2 Tabs PO PRN Pain/Fever Q 4-6 Hrs w/food NTE 6 tabs/24 hrs	<input type="checkbox"/> Acetaminophen (Tylenol), 325mg 2 Tabs PO PRN Pain/Fever Q 4-6 Hrs NTE 10 tabs/24 hrs NTE (Fever) 3 Consecutive Days	<input type="checkbox"/> Other: _____
---	---	---

ANTACID:

<input type="checkbox"/> Pepto Bismol (Bismuth Subsalicylate) 525mg 30 ML PO Q 30-60 mins. PRN: Indigestion NTE 8 doses/24 hrs	<input type="checkbox"/> Tums (Calcium Carbonate) 1000mg PO 1-2 PRN: Indigestion NTE 7 tabs/24 hrs.	<input type="checkbox"/> Other: _____
---	--	---

DIGESTIVE:

<input type="checkbox"/> Metamucil PO 1 tablespoon mix with 8oz water PRN: Constipation	<input type="checkbox"/> Citrucel (Methylcellulose) 2g PO 1 tablespoon mix with 8oz water PRN: Constipation
<input type="checkbox"/> Imodium (Loperamide) 2 caplets after the first loose stool, 1 caplet after ea subsequent stool PRN: Diarrhea	<input type="checkbox"/> Other: _____

OTHER: (Please list medication, dose, instructions)

Other:

Provider Signature: _____ **Date:** _____

Appendix C: CCL needs assessment requirements.

[Physician's Report including TB test results available in pdf fillable report format]

Regulations SOCIAL REHABILITATION FACILITIES 81068.2 (81068.2 NEEDS AND SERVICES PLAN 81068.2

(a) Prior to admission, the licensee shall determine whether the facility's program can meet the prospective client's service needs.

(b) For each client admitted, the licensee shall ensure that a written Needs and Services Plan is started prior to admission, and completed prior to or within 72 hours of admission, that must include:

(1) A written assessment as required in California Code of Regulations, Title 9, Division 1, Chapter 3, Article 3.5, Section 532.2(b).

There shall be a written assessment of each client on admission which includes at least:

- (1) Health and psychiatric histories;
- (2) Psycho-social skills;
- (3) Social support skills;
- (4) Current psychological, educational, vocational and other functional limitations;
- (5) Medical needs, as reported; and
- (6) Meal planning, shopping and budgeting skills.

(2) Any needs appraisal or individual program plan completed by a placement agency or consultant.

(3) A written treatment/rehabilitation plan as required by California Code of Regulations, Title 9, Subchapter 3, Article 3.5, Section 532.2(c).

Appendix D: Regulations for Prohibited and Restricted Health conditions, and Restricted Health Condition Care Plans

[Templates for completing Health Condition Care Plans are provided under admission documents]

Community Care Licensing GENERAL LICENSING REQUIREMENTS

80091 PROHIBITED HEALTH CONDITIONS 80091

(a) In adult CCFs clients who require health services or have a health condition including, but not limited to, those specified below shall not be admitted or retained.

(1) Naso-gastric and naso-duodenal tubes.

(2) Active, communicable TB.

(3) Conditions that require 24-hour nursing care and/or monitoring.

(4) Stage 3 and 4 dermal ulcers.

(5) Any other condition or care requirements which would require the facility to be licensed as a health facility as defined by Sections 1202 and 1250 of the Health and Safety Code.

(b) Repealed by Manual Letter No. CCL-98-05, effective 10/1/98.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1530, 1531, and 1557.5, Health and Safety Code.

Regulations GENERAL LICENSING REQUIREMENTS 80092

80092 RESTRICTED HEALTH CONDITIONS 80092

Section 1502(a) of the Health and Safety Code defines a Community Care Facility (CCF) as providing nonmedical residential and day care. Clients who require nursing care and/or monitoring generally may not be in CCFs, though there are exceptions. The exceptions include hospice care in RCFEs, medical care in residential care facilities for the chronically ill (RCF-CIs), and medically fragile children receiving specialized care in Foster Family Homes.

(a) Adult CCFs may accept or retain clients who have the conditions listed in this section only if all requirements of Article 8 are met.

(b) Care for the following health conditions must be provided only as specified in Sections 80092.1 through 80092.11.

(1) Use of inhalation-assistive devices as specified in Section 80092.3.

(2) Colostomy/ileostomies as specified in Section 80092.4.

(3) Requirement for fecal impaction removal, enemas, suppositories only as specified in Section 80092.5.

(4) Use of catheters as specified in Section 80092.6.

(5) Staph or other serious, communicable infections as specified in Section 80092.7.

(6) Insulin-dependent Diabetes as specified in Section 80092.8.

(7) Stage 1 and 2 dermal ulcers as specified in Section 80092.9.

(8) Wounds as specified in Section 80092.9.

(9) Gastrostomies as specified in Section 80092.10.

(10) Tracheostomies as specified in Section 80092.11.

80092.1 GENERAL LICENSING REQUIREMENTS Regulations

80092.1 GENERAL REQUIREMENTS FOR RESTRICTED 80092.1 HEALTH CONDITIONS

(a) A client with a restricted health condition specified in Section 80092 may be admitted or retained in an adult CCF if all requirements in Sections 80092.1(b) through (c) are met.

(b) The licensee is willing to provide the needed care.

(c) Care is provided as specified in this article.

(d) Either the client's medical condition is chronic and stable, or is temporary in nature and is expected to return to a condition normal for that client, and

(e) The client must be under the medical care of a licensed professional.

(f) Prior to admission of a client with a restricted health condition specified in Section 80092, the licensee shall:

(1) Communicate with all other persons who provide care to that client to ensure consistency of care for the medical condition.

(2) Ensure that facility staff who will participate in meeting the client's specialized care needs complete training provided by a licensed professional sufficient to meet those needs.

(A) Training shall include hands-on instruction in both general procedures and client-specific procedures.

(g) All new facility staff who will participate in meeting the client's specialized care needs shall complete the training prior to providing services to the client.

(h) The licensee shall ensure that facility staff receive instruction from the client's physician or other licensed professional to recognize objective symptoms, observable by a lay person, and how to respond to that client's health problems, including who to contact.

(i) The licensee shall monitor the client's ability to provide self-care for the restricted health condition, document any change in that ability, and inform the persons identified in Section 80092.2(a)(1) of that change.

(j) Should the condition of the client change, all staff providing care and services shall complete any additional training required to meet the client's new needs, as determined by the client's physician or a licensed professional designated by the physician.

(k) If the licensed health professional delegates routine care, the following requirements must be met for health conditions specified in Sections 80092.3, 80092.4 and 80092.6 through 80092.11:

Regulations GENERAL LICENSING REQUIREMENTS 80092.1

80092.1 GENERAL REQUIREMENTS FOR RESTRICTED 80092.1 HEALTH CONDITIONS (Continued)

(1) The licensee shall obtain written documentation from the licensed professional outlining the procedures and the names of the facility staff who have been trained in those procedures.

(2) The licensee ensures that the licensed professional reviews staff performance as often as necessary, but at least annually.

(l) All training shall be documented in the facility personnel files.

(m) The licensee of an ARF shall develop and maintain, as part of the Needs and Services Plan, a Restricted Health Condition Care Plan as specified in Section 80092.2.

(1) The care plan shall neither require nor recommend that the licensee or any facility personnel or any other person providing care, other than a physician or licensed professional, implement any health care procedure that may legally be provided only by a physician or licensed professional.

(n) The licensee shall ensure that the client's health-related service needs are met and shall follow the approved plan for each client.

(o) The licensee shall document any significant occurrences that result in changes in the client's physical, mental and/or functional capabilities and report these changes to the client's physician and authorized representative.

(p) The licensee shall demonstrate compliance with the restricted health condition care plan by maintaining in the facility all relevant documentation.

(q) The licensee shall report any substantive deviation from the care plan to the client's authorized representative.

(r) The duty established by this section does not infringe on a client's right to receive or reject medical care or services, as allowed in Section 80072.

(1) If a client refuses medical services specified in the care plan, the licensee shall immediately notify all persons identified in Section 80092.2(a)(1) and shall participate in developing a plan for meeting the client's needs.

(2) *If unable to meet the client's needs, the licensee shall issue an eviction notice as specified in Section 80068.5.*

80092.2 GENERAL LICENSING REQUIREMENTS Regulations

80092.2 RESTRICTED HEALTH CONDITION CARE PLAN 80092.2

(a) If the licensee of an ARF chooses to care for a client with a restricted health condition, as specified in Section 80092, the licensee shall develop and maintain, as part of the Needs and Services Plan, a written Restricted Health Condition Care Plan. The plan must include all of the following:

- (1) Documentation that the client and the client's authorized representative, if any, the client's physician or a licensed professional designated by the physician, and the placement agency, if any, participated in the development of the plan.
- (2) Documentation by the client's physician or a licensed professional designated by the physician, of the following:
 - (A) Stability of the medical condition.
 - (B) Medical conditions that require services or procedures.
 - (C) Specific services needed.
 - (D) Client's ability to perform the procedures.
 - (E) The client does not require 24-hour nursing care and/or monitoring.
- (3) Identification of a licensed professional who will perform procedures if the client needs medical assistance.
- (4) Identification of the person(s) who will perform incidental medical assistance that does not require a licensed professional.
- (5) Name and telephone number of emergency medical contacts.
- (6) A date specified by the client's physician or designee, who is also a licensed professional, when the plan must be reviewed by all parties identified in Section 80092.2(a)(1).
- (7) A signed statement from the client's attending physician that the plan meets medical scope of practice requirements.
- (8) For clients of a placement agency, a signed statement from a representative of the placement agency that they have reviewed and approved the plan and that the placement agency will monitor implementation of the plan.

CALIFORNIA-DSS-MANUAL-CCL MANUAL LETTER NO. CCL-16-04 Effective 1/5/16

Regulations GENERAL LICENSING REQUIREMENTS 80092.3 (Cont.)

80092.2 RESTRICTED HEALTH CONDITION CARE PLAN 80092.2 (Continued)

(b) The Restricted Health Condition Care Plan shall neither require nor recommend that the licensee or any facility personnel or any other person providing care, other than a physician or licensed professional, implement any health care procedure that may legally be provided only by a physician or licensed professional.

80092.3 INHALATION-ASSISTIVE DEVICES 80092.3

(a) A licensee of an adult CCF may accept or retain a client who requires the use of an inhalation-assistive device if all of the following conditions are met:

- (1) The licensee is in compliance with Section 80092.1.
- (2) The licensee monitors the client's ongoing ability to operate and care for the device in accordance with the physician's instructions.
- (3) The licensee ensures that either:
 - (A) The device is operated and cared for by a licensed professional when the client is unable to operate the device, or determine his/her own need.
 - (B) The device can legally be operated by an unlicensed person and is cared for by facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).
- (4) The licensee ensures that:
 - (A) The device is functional.

(B) The device is removed from the facility when no longer prescribed for use by the client.

(5) The licensee ensures that the room containing the device is large enough both to accommodate it and to allow easy passage of clients and staff.

(6) The licensee ensures that facility staff have the knowledge of and ability to care for the device.

80092.4 COLOSTOMY/ILEOSTOMY 80092.4

(a) A licensee of an adult CCF may accept or retain a client who has a colostomy or ileostomy if all of the following conditions are met:

(1) The client is mentally and physically capable of providing all routine care for his/her ostomy, and the physician has documented that the ostomy is completely healed.

(2) A licensed professional provides assistance in the care of the ostomy.

(3) The licensee is in compliance with Section 80092.1.

(4) The licensee monitors the client's ongoing ability to provide care for his/her ostomy in accordance with the physician's instructions.

(5) The licensee ensures that:

(A) A licensed professional provides ostomy care when the client is unable to provide selfcare.

(B) The ostomy bag and adhesive may be changed by facility staff who receive training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

(6) The licensee ensures that used bags are discarded as specified in Section 80088(f)(2).

(7) The licensee ensures privacy when ostomy care is provided.

80092.5 FECAL IMPACTION REMOVAL, ENEMAS, OR SUPPOSITORIES 80092.5

(a) A licensee of an adult CCF may accept or retain a client who requires manual fecal impaction removal, enemas, or use of suppositories if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The licensee monitors the client's ongoing ability to provide his/her own routine care in accordance with the physician's instructions.

(3) The licensee ensures that a licensed professional administers the fecal impaction removal, the enemas, or suppositories when the client is unable to do so for himself/herself.

(4) The licensee ensures that a licensed professional performs manual fecal impaction removal whenever it is necessary.

(5) The licensee ensures privacy when care is being provided.

80092.6 INDWELLING URINARY CATHETER/CATHETER PROCEDURE 80092.6

(a) A licensee of an adult CCF may accept or retain a client who requires an indwelling catheter if all of the following conditions are met:

(1) The client is physically and mentally capable of caring for all aspects of the condition except insertion, removal and irrigation.

(A) Irrigation shall only be performed by a licensed professional in accordance with the physician's orders.

(B) Insertion and removal shall only be performed by a licensed professional.

(2) The licensee is in compliance with Section 80092.1.

(3) The licensee monitors the client's ongoing ability to care for his/her catheter in accordance with the physician's instructions.

(4) The licensee ensures that either catheter care is provided by a licensed professional when the client is unable to provide self-care, or the catheter bag and tubing are changed and bags are emptied by facility staff who receive training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

(5) The licensee ensures that insertion, removal and irrigation of the catheter, or any other required catheter care other than that specified in Section 80092.6(a)(4) are performed by a licensed professional.

(6) The licensee ensures that waste materials are disposed of as specified in Section 80088(f)(2).

(7) The licensee ensures privacy when care is provided.

80092.7 STAPH OR OTHER SERIOUS, COMMUNICABLE INFECTIONS 80092.7

(a) A licensee of an adult CCF may accept or retain a client who has a staph or other serious communicable infection if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The licensee has obtained a statement from the client's physician that the infection is not a risk to other clients.

(3) The licensee monitors the client's ongoing ability to care for his/her own condition by complying with the instructions of the licensed professional who is managing the client's care.

(A) The licensed professional may delegate certain aspects of the care providing the facility staff responsible for providing the care receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2) prior to providing care.

(4) The licensee ensures that a licensed professional assesses the infection and evaluates the treatment at intervals set by the physician or a licensed professional designated by the physician.

(5) The licensee ensures that prior to providing care, staff are trained in and follow Universal Precautions and any other procedures recommended by the licensed professional for protection of the client who has the infection, other clients and staff.

(6) The licensee ensures that all aspects of care performed in the facility by the licensed professional and facility staff are documented in the client's file.

80092.8 DIABETES 80092.8

(a) A licensee of an adult CCF may accept or retain a client who has diabetes if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

2) The client is mentally and physically capable of administering his/her own medication and performing his/her own glucose testing if applicable, or a licensed professional administers the tests and injections.

(A) The licensed professional may delegate to trained facility staff glucose testing provided all of the following conditions are met:

1. The blood glucose-monitoring test is performed with a blood glucose-monitoring instrument that has been approved by the federal Food and Drug Administration for over-the-counter sale.

2. The licensee ensures that facility staff responsible for glucose testing receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

3. Facility staff comply with the instructions of the licensed professional regarding the performance of the test and the operation of the blood glucose-monitoring instrument.

4. Facility staff immediately notify the client's physician if the results are not within the normal range for the client.

5. The licensee ensures that the results of each blood glucose test performed by facility staff are documented and maintained in the client's record in the facility.

(3) The licensee ensures that sufficient amounts of medicines, testing equipment, syringes, needles, and other supplies are maintained and stored in the facility.

(4) The licensee ensures that injections are administered immediately after a syringe is filled unless the client is using prefilled syringes prepared by a registered nurse, pharmacist or drug manufacturer.

(5) The licensee ensures that syringes and needles are disposed of in accordance with California Code of Regulations, Title 8, Section 5193.

(A) California Code of Regulations, Title 8, Section 5193(d)(2) is paraphrased in pertinent part:

Contaminated needles and other contaminated sharps shall not be bent, recapped or removed. Shearing or breaking of contaminated needles is prohibited.

Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

1. Puncture resistant;
2. Labeled in accordance with this section;
3. Leakproof on the sides and bottom; and
4. Repealed by Manual Letter No. CCL-07-01, effective 1/12/07.

(6) The licensee provides a modified diet as prescribed by a client's physician, as specified in Section 80076(a)(6). Any substitutions shall be made by the facility dietitian or in consultation with a registered dietician or the client's physician or medical provider.

(A) Repealed by Manual Letter No. CCL-07-01, effective 1/12/07.

(7) The licensee ensures that all facility staff who provide care receive training in recognizing the signs and symptoms of hyperglycemia and hypoglycemia and in taking appropriate action for client safety.

(b) For clients who provide self-care, the licensee shall:

(1) Monitor the client's ongoing ability to perform his/her glucose testing and administer his/her medication in accordance with the physician's instructions.

(2) Assist clients with self-administered medication, as specified in Section 80075.

80092.9 WOUNDS 80092.9

(a) A licensee of an adult CCF may accept or retain a client who has a serious wound if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The wound is either an unhealed, surgically closed incision or wound, or determined by the physician or a licensed professional designated by the physician to be a Stage 1 or 2 dermal ulcer and is expected by the physician or designated professional to completely heal.

(3) The licensee ensures that a licensed professional in accordance with the physician's instructions provides the wound care.

(A) The licensed professional may delegate simple dressing to facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

(B) Repealed by Manual Letter No. CCL-07-01, effective 1/12/07.

(4) The licensee ensures that a licensed professional assesses the wound at intervals set by the physician, or a licensed professional designated by the physician, to evaluate treatment and progress toward healing.

(5) The licensee ensures that all aspects of care performed by the licensed professional and facility staff are documented in the client's file.

(b) Non-serious wounds, which include but are not limited to minor cuts, punctures, lacerations, abrasions, and first-degree burns are not affected by this section.

80092.10 GASTROSTOMY FEEDING, HYDRATION, AND CARE 80092.10

(a) A licensee of an adult CCF may accept or retain a client who requires gastrostomy care, feeding, and/or hydration if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The physician has documented that the gastrostomy is completely healed.

(3) The licensee monitors the client's ongoing ability to provide all routine feeding, hydration and care for his/her gastrostomy in accordance with the physician's instructions.

(4) The licensee ensures that gastrostomy feeding, hydration, medication administration through the gastrostomy, and stoma cleaning are provided by a licensed professional when the client is unable to provide his/her own feeding, hydration and care.

(A) The licensed professional may delegate the following tasks to facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2):

1. Gastrostomy feeding, hydration, and stoma cleaning.
2. For routine medications, trained staff may add medication through the gastrostomy per physician's or nurse practitioner's orders.
3. For PRN medications, trained staff may add medications through the gastrostomy in accordance with Sections 80075(b) through (e).

80092.11 TRACHEOSTOMIES 80092.11

(a) A licensee of an adult CCF may accept or retain a client who has a tracheostomy if all of the following conditions are met:

- (1) The licensee is in compliance with Section 80092.1.
- (2) Either the client is mentally and physically capable of providing all routine care for his/her tracheostomy and the physician has documented that the tracheostomy opening (stoma) is completely healed, or assistance in the care of the tracheostomy is provided by a licensed professional.

(A) The licensed professional may delegate routine care for the tracheostomy to facility staff who receive supervision and training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

1. Suctioning shall not be delegated to facility staff.
- (3) The licensee monitors the client's ongoing ability to provide all routine care for his/her tracheostomy in accordance with the physician's instructions.
- (4) The licensee ensures that tracheostomy care is provided by a licensed professional when the client is unable to provide self-care.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, and 1530, Health and Safety Code.

Regulations GENERAL LICENSING REQUIREMENTS 80093

80093 DEPARTMENT REVIEW OF HEALTH-RELATED CONDITIONS 80093

(a) The Department may review actual or suspected health-related conditions, including those specified in Section 80092 to determine if a client is appropriately placed in the facility and if the client's health related needs are being met. The Department will inform the licensee that the client's health-related condition requires review and will specify documentation that the licensee shall submit to the Department.

(1) Documentation includes, but is not limited to, the following:

- (A) Restricted Health Condition Care Plan, if applicable.
- (B) Needs and Services Plan.
- (C) Copies of prescriptions for medical services and/or medical equipment.

(2) The licensee shall submit the documentation to the Department within 10 working days.

(b) If the Department determines that the client has a restricted health condition, as specified in Section 80092, the licensee shall provide care to the client in accordance with conditions specified in Sections 80092.1 and applicable requirements in Sections 80092.3 through 80092.11. If the licensee is not able to provide adequate care, the client shall be relocated.

(c) If the Department determines that the client has a prohibited health condition, as specified in Section 80091 or a health condition that cannot be cared for within the limits of the license or within the abilities of that specific facility, the Department will order relocation of the client as specified in Section 80094.

(1) The notification to the licensee will include notice of all appeal rights, as specified in Section 80094.

(d) This section does not entitle the licensee to a full evidentiary hearing, state hearing, or any other administrative review beyond that set forth in this section.

80094 GENERAL LICENSING REQUIREMENTS Regulations

80094 HEALTH CONDITION RELOCATION ORDER 80094

(a) In an adult CCF the Department will order relocation of a client if the Department makes any of the following determinations:

(1) The client has a prohibited health condition, as specified in Section 80091.

(2) The licensee has not met all requirements in Sections 80092.1 and applicable requirements in Sections 80092.3 through 80092.11.

(3) The client has a health condition that cannot be cared for within the limits of the license or within the abilities of that specific facility.

(b) The Department will give written notice to the licensee ordering the relocation of the client and informing the licensee of the client's right to an IDT review of the relocation order.

(1) Concurrently the Department will give the notice of the health condition relocation order and information about the client's right to request review of the relocation order to the client. The Department will mail, by certified mail, or deliver a copy within one working day to the client's authorized representative, if any and responsible person.

(A) If the client has no authorized representative, as defined in Section 80001, the relocation order shall be sent to the responsible person and representative payee, if any.

(2) The health condition relocation order will state the reason for the relocation order and cite the regulation(s) requiring the relocation.

(3) Upon receipt of the relocation order, the licensee shall prepare a written relocation plan in compliance with Section 80078.

CALIFORNIA-DSS-MANUAL-CCL MANUAL LETTER NO. CCL-98-05 Effective 10/1/98



MANZANITA ADMISSION AGREEMENT

Appendix E:

WELCOME TO INTERIM! Manzanita is a short-term crisis program. Our hope is that you will have an opportunity to address the issues or concerns that led you to come to Manzanita. We want to help you avoid recurrent crisis situations. During your stay you will be provided with tools in different areas to equip you to manage a future crisis. These tools include ways to cope with mental illness, manage your medication, improve your relationships, and/or help you strengthen your existing support systems.

Manzanita Services include

- *Structured, Non-institutional Environment:* Staff supports residents with daily living skills, personal hygiene, and daily house maintenance. Breakfast, lunch, dinner, and snacks are provided.
- *Individual and Group Counseling:* Staff works with residents to develop strategies to avoid reoccurrence of crisis situations. Residents are assisted in formulating and following through on client-centered goals, which often focus on obtaining housing, coping with mental illness, improving interpersonal relationships, and strengthening the resident's existing support system.
- *Medication Support:* All medications are stored in the medication room. Staff assists residents with self-administration of medications and symptom awareness and education. Each resident will meet with a Psychiatric provider once per week (or as needed).
- *Onsite Structured Day Program:* Groups and weekend activities are offered.

Individual Responsibilities and Program Agreements

1. I agree that my participation is the most important aspect of successful treatment.
2. I agree to develop a workable counseling program as part of my treatment plan.
3. I agree to actively pursue my goals.
4. I agree to attend all daily program groups, morning meetings and activities, and counseling sessions.
5. I agree to meet and discuss safe discharge with my Interim and MCBH support team weekly.
6. I agree that I have a responsibility to the Manzanita household.
7. I agree to volunteer for a chore during morning meeting.
8. I agree to meet with the County Psychiatric Physician's Assistant and remain in the house until after I have met with the PA.
9. I agree to maintain an appropriate level of personal and room hygiene.
10. I agree to be present for evening meals.
11. I agree to check-in with staff before leaving the house.
12. I agree that I will sign in and out and obtain staff initials whenever I leave and return to the program.
13. I agree to allow staff to search my personal belongings before I bring them into the house.
14. I agree not to harass, proposition, or request others for physical intimate contact.

Personal Rights, Privacy Rights, and Confidentiality

To ensure you receive quality care and services and to maintain the continuum of care, Manzanita House medical staff such as the Registered Nurse and Psychiatric Technician reserves the right to share treatment and medical information with all program staff, County Behavioral Health, and as directed in any Releases of Information that you authorize. Staff will inform you of your personal rights, complaint procedures, and exceptions to confidentiality by reviewing the following forms with the resident prior to admission: Voluntary Consent for Rehabilitation, Notice of Interim's Privacy Practices, Client Grievance and Appeal Procedure, Room Search Policy, Personal Rights (LIC 613), and the Resident Handbook. Staff will inform clients of their Personal Rights as outlined by Community Care Licensing. Clients' Personal Rights will not be violated. Upon admission, clients are provided with a copy of "Personal Rights: Adult Community Care Facilities." Clients sign the Personal Rights LIC 613 form indicating clients have received a copy of Personal Rights. Security/surveillance cameras are operating inside and outside of the facility for your safety and security. These cameras are *not* placed in the private areas such as bedrooms or bathroom areas.

Fees

Program fees are calculated daily according to income and qualifying expenses on a case-by-case basis. The Program Fee Agreement specifies how fees are determined and is individualized to accommodate individual circumstances. Please refer to the separate Program Fee Agreement for details on your individualized fee agreement. If you are a San Benito County client, San Benito is paying your fees, and you will need to settle the fees with them.

Room Search Policy

Manzanita staff reserve the right to search your room and locker if there is a strong cause to believe that there is alcohol, non-prescribed drugs, stockpiled prescribed or non-prescribed drugs, weapons, other items that could threaten the health and safety of you and/or others, or stolen property on the premises.

General Policies

Resident acknowledges that s/he has been provided with *the Resident Handbook* (Patient's Rights, Safety & House Agreements, Visitor Policy, Complaint Procedure, Personal Rights, services provided) prior to admission. Resident acknowledges that Manzanita staff have reviewed each section of the *Resident Handbook* and resident agrees to abide by and observe these policies and expectations.

Appendix G: Medical Necessity Definition

Medical Necessity are the conditions necessary for receiving Specialty Mental Health Services through Medi-Cal. In deciding if a client meets medical necessity, the client must have a serious mental illness, i.e., schizophrenia, bipolar disorder, schizoaffective disorder, severe anxiety disorder, or major depression. In addition, the client has at least one of the following problems as a result of the diagnosis: 1) Significant difficulty in an important area of the functioning or 2) A probability of significant deterioration in an important area of life functioning.

The expectation is that the proposed treatment will significantly reduce the problem or prevent significant deterioration in an important area of life functioning. Also, the condition would not be responsive to physical healthcare-based treatment.

Appendix H: CDSS/CCL and DHCS staffing regulations for Short Term Crisis Residential Facility:

§ 531. Program Standards and Requirements (Title 9, Division 1, Chapter 3).

Scheduling of staff provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week with exception of overnight shifts based on the number of residents in facility. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the nighttime hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served.

Appendix H: CDSS/CCL and DHCS staffing regulations for Short Term Crisis Residential Facility:

§ 531. Program Standards and Requirements (Title 9, Division 1, Chapter 3).

Scheduling of staff provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week with exception of overnight shifts based on the number of residents in facility. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the nighttime hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served.

**ATTACHMENT E
SAN BENITO COUNTY
BUSINESS ASSOCIATE ADDENDUM**

- (a) Contractor shall comply with, and assist the County in complying with, the privacy requirements of the Health Insurance Portability and Accountability Act (including but not limited to 42 U.S.C. 1320d et seq.; "HIPAA") and its implementing regulations (including but not limited to 45 CFR Parts 142, 160, 162 and 164), hereinafter collectively referred to as the "Privacy Rule." Terms used but not otherwise defined in this Addendum shall have the same meaning as those terms are used in the Privacy Rule.
- (b) Except as otherwise limited in this Addendum, Contractor may use or disclose Protected Health Information to perform functions, activities, or services for or on behalf of the County as specified in this Addendum, provided that such use or disclosure would not violate the Privacy Rule with which the County complies.
- (c) Contractor shall not use or further disclose Protected Health Information other than as permitted or required by this Addendum, or as required by law.
- (d) Contractor shall use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Addendum.
- (e) Contractor shall report to the County any use or disclosure of the Protected Health Information not provided for by this Addendum.
- (f) Contractor shall mitigate, to the extent practicable, any harmful effect that is known to Contractor as a result of a use or disclosure of Protected Health Information by Contractor which is in violation of the requirements of this Agreement.
- (g) Contractor shall ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, created, or received by Contractor on behalf of the County, agrees to the same restrictions and conditions that apply through this Agreement to Contractor with respect to such information.
- (h) Contractor shall provide access, at the request of the County, and in the time and manner designated by the County, to Protected Health Information in a Designated Record Set; this Protected Health Information will be released to the County or, as directed by the County, to an Individual, in order to meet the requirements under 45 CFR Section 164.524.
- (i) Contractor shall make any amendment(s) to Protected Health Information in a Designated Record Set that the County directs, pursuant to 45 CFR Section 164.526, at the request of the County or an Individual, and in the time and manner designated by the County.
- (j) Contractor shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for the County, to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Section 164.528.

- (k) Contractor shall provide to the County or an Individual, in the time and manner designated by the County, information collected in accordance with subsection (j), to permit the County to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Section 164.528.
- (l) Contractor shall make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Contractor on behalf of the County, available to the County; or at the request of the County, to the Secretary of the United States Department of Health and Human Services (“Secretary”), in a time and manner designated by the County or the Secretary, for purposes of the Secretary determining the County’s compliance with the Privacy Rule.
- (m) A breach by Contractor of any provision of this Addendum, as determined by County, shall constitute a material breach of the contract and shall provide grounds for immediate termination of the Contract by the County.
 - (1) Except as provided in subparagraph (2) of this section, upon termination of this Addendum for any reason, Contractor shall return or destroy all Protected Health Information received from the County, or created or received by Contractor on behalf of the County. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Contractor. Contractor, its agents and subcontractors shall retain no copies of the Protected Health Information.
 - (2) In the event that Contractor determines that returning or destroying the Protected Health Information is infeasible, Contractor shall provide to the County notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Contractor shall extend the protections of this Addendum to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Contractor, or any of its agents or subcontractors, maintains such Protected Health Information.
- (n) The Parties agree to take action to amend this Agreement from time to time as is necessary for the County to comply with the requirements for the Privacy Rule or any other requirements of HIPAA and its implementing regulations.

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