

Plan and Budget Required Documents Checklist

MODIFIED FY 2018-2019

County/City: <u>San Benito</u>		Fiscal Year: 2018-2019
	Document	Page Number
1.	Checklist	Yes
2.	Agency Information Sheet	Yes
3.	Certification Statements	
	A. Certification Statement (CHDP) – Original and one photocopy	Yes
	B. Certification Statement (CCS) – Original and one photocopy	Yes
4.	Agency Description	
	A. Brief Narrative	Yes
	B. Organizational Charts for CCS, CHDP, and HCPCFC	Retain locally
	C. CCS Staffing Standards Profile	Retain locally
	D. Incumbent Lists for CCS, CHDP, and HCPCFC	Yes
	E. Civil Service Classification Statements – Include if newly established, proposed, or revised	N/A
	F. Duty Statements – Include if newly established, proposed, or revised	N/A
5.	Implementation of Performance Measures – Performance Measures for FY 2017—2018 are due November 30, 2018.	N/A
6.	Data Forms	
	CHDP Program Referral Data	N/A
7.	Memoranda of Understanding and Interagency Agreements List	
	A. MOU/IAA List	Yes
	B. New, Renewed, or Revised MOU or IAA	Yes
	C. CHDP IAA with DSS biennially	Retain locally
	D. Interdepartmental MOU for HCPCFC biennially	Retain locally
8.	Budgets	
	A. CHDP Administrative Budget (No County/City Match)	
	1. Budget Summary	Yes

County/City: San Benito

Fiscal Year: 2018-2019

Document		Page Number
2.	Budget Worksheet	Yes
3.	Budget Justification Narrative	Yes
B.	CHDP Administrative Budget (County/City Match) - Optional	
1.	Budget Worksheet	N/A
2.	Budget Justification Narrative	N/A
3.	Budget Justification Narrative	N/A
C.	CHDP Foster Care Administrative Budget (County/City Match) - Optional	
1.	Budget Summary	N/A
2.	Budget Worksheet	N/A
3.	Budget Justification Narrative	N/A
D.	HCPCFC Administrative Budget	
1.	Budget Summary	Yes
2.	Budget Worksheet	Yes
3.	Budget Justification Narrative	Yes
E.	CCS Administrative Budget	
1.	Budget Summary	Yes
2.	Budget Worksheet	Yes
3.	Budget Justification Narrative	Yes
G..	Other Forms	
1.	County/City Capital Expenses Justification Form	N/A
2.	County/City Other Expenses Justification Form	N/A
9.	Management of Equipment Purchased with State Funds	
1.	Contractor Equipment Purchased with DHCS Funds Form (DHCS1203)	N/A
2.	Inventory/Disposition of DHCS Funded Equipment Form (DHCS1204)	N/A
3.	Property Survey Report Form (STD 152)	N/A

Agency Information Sheet

County/City: San Benito

Fiscal Year: 2018-2019

Official Agency

Name:	Health and Human Service Agency, Public Health Services	Address:	1111 San Felipe Road Hollister, CA 95023
Health Officer	Gail Newel, MD, MPH		

CMS Director (if applicable)

Name:	N/A	Address:	
Phone:			
Fax:		E-Mail:	

CCS Administrator

Name:	Melissa Schilling	Address:	1111 San Felipe Road
Phone:	831-637-5367		Hollister, CA 95023
Fax:	831-637-9073	E-Mail:	mschilling@cosb.us

CHDP Director

Name:	N/A	Address:	
Phone:			
Fax:		E-Mail:	

CHDP Deputy Director

Name:	Melissa Schilling	Address:	1111 San Felipe Road
Phone:	831-637-5367		Hollister, CA 95023
Fax:	831-637-9073	E-Mail:	mschilling@cosb.us

Clerk of the Board of Supervisors or City Council

Name:	Janet Slibsager	Address:	481 Fourth Street
Phone:	831-636-4000		Hollister, CA 95023
Fax:	831-636-4010	E-Mail:	jslibsager@cosb.us

Director of Social Services Agency

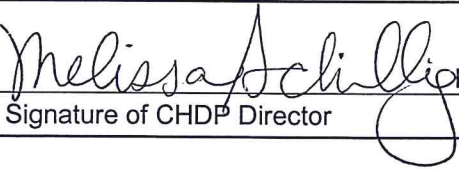
Name:	Tracey Belton, Int. Dir.		111 San Felipe Road
Phone:	831-636-4190		Hollister, CA 95023
Fax:	831-637-2910	E-Mail:	tbelton@cosb.us


Chief Probation Officer

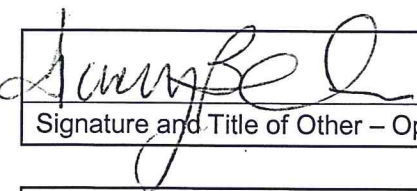
Name:	Chief Joe Frontella		400 Monterey Street
Phone:	831-636-4070		Hollister, CA 95023
Fax:	831-636-5682	E-Mail:	jfrontella@cosb.us

Certification Statement - Child Health and Disability Prevention (CHDP) Program**County/City: San Benito County****Fiscal Year: 2018-2019**

I certify that the CHDP Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 6 (commencing with Section 124025), Welfare and Institutions Code, Division 9, Part 3, Chapters 7 and 8 (commencing with Section 14000 and 14200), Welfare and Institutions Code Section 16970, and any applicable rules or regulations promulgated by DHCS pursuant to that Article, those Chapters, and that section. I further certify that this CHDP Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9, Federal Financial Participation. I further certify that this CHDP Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). I further agree that this CHDP Program may be subject to all sanctions or other remedies applicable if this CHDP Program violates any of the above laws, regulations and policies with which it has certified it will comply.

	Melissa Schilling, RN	3/11/19
Signature of CHDP Director		Date Signed

	Gail Newel, MD, MPH	3/22/19	um, DON/DD
Signature of Director or Health Officer		Date Signed	

	Tracey Belton, Interim Director, HHSA	3/11/19
Signature and Title of Other – Optional		Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson

Date

Certification Statement - California Children's Services (CCS)**County/City:** San Benito**Fiscal Year:** 2018-2019

I certify that the CCS Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 5, (commencing with Section 123800) and Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000-14200), and any applicable rules or regulations promulgated by DHCS pursuant to this article and these Chapters. I further certify that this CCS Program will comply with the Children's Medical Services (CMS) Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CCS Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Services Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. Section 701 et seq.). I further agree that this CCS Program may be subject to all sanctions or other remedies applicable if this CCS Program violates any of the above laws, regulations and policies with which it has certified it will comply.



Signature of CCS Administrator

3/22/19

Date Signed



Signature of Director or Health Officer

3/22/19

Date Signed

mks-

Signature and Title of Other – Optional

Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson

Date