LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
CONTRACT MANAGEMENT AND MONITORING DIVISION

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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LEGAL ENTITY CONTRACT
SERVICE DELIVERY PLAN (SDP)
INSTRUCTIONS

FISCAL YEAR 2022-2023

Effective July 1, 2022

Deadlines for Submission:

1. Initial SDP: Renewal and any Amendments for FY 22-23 indicating changes through July 30, 2022	July 30, 2022
2. Mid-year SDP: Change(s) through December 31, 2022	January 31, 2023
3. Closing SDP: FY 2022-23 Final Changes	October 31, 2023 or 30 days after Cost Report due, whichever is later
Additional submission of SDP	As Needed

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I. OVERVIEW OF THE SERVICE DELIVERY PLAN

1. Role of the Contract Management and Monitoring Division

   a. In 2017, the Department of Mental Health (DMH) embarked on an extensive internal reorganization that included the creation of a new division. The Contract Management and Monitoring Division (CMMD) of DMH is tasked with providing oversight of the mental health services and supports provided under the Department's Legal Entity (LE) and other unique service agreements. Specifically, CMMD works with agencies to ensure that services under the LE and other unique service agreements is delivered effectively and efficiently while producing a measurable impact on the individuals, families, and communities of Los Angeles County and increasing access to care. Oversight activities include clinical programmatic monitoring (to ensure effective mental health services and supports are delivered), fiscal and budget monitoring, and administrative monitoring.

   b. Our mission is to promote comprehensive, effective and efficient management of our network of providers, maximize fiscal strength, continuously improve program performance, foster open and honest communication, and deliver high quality services to our clients and community.

2. Revision of the Negotiation Package and Name Change to Service Delivery Plan

   In 2018, CMMD conducted meetings with DMH staff that had been utilizing the Negotiation Package (NP) to monitor DMH services, as well as with LE providers and other stakeholders that completed the NP forms. As a result, significant changes were made to the NP, including the name change to Service Delivery Plan.

3. Purpose of DMH Contract Service Delivery Plan (SDP)

   a. The purpose of the SDP is to gather agency information and annual service projections (Initial and Mid-Year SDP) and actual service delivery (Closing SDP) data for DMH Short-Doyle Medi-Cal (SDMC) contract providers that are a part of the DMH's client care network. DMH contracts with SDMC providers to offer Specialty Mental Health Services (SMHS) to DMH clients countywide using the Legal Entity (LE) Contract. DMH SDMC contract providers referred to as LE providers.
   b. The DMH SDP is a Microsoft Excel (Excel) File comprised of seven (7) schedules (i.e. worksheets).

c. The SDP schedules are intended to be tools used for LE providers and DMH for the following purposes:

i. Planning – Planning the allocation distributed to provider site(s)/Provider Number(s) (PN) in Los Angeles County (LAC) (i.e.: types of services, funding amounts, and number of clients).

ii. Communication – Identifying provider service provision trends that require discussion and resolution between DMH and LE providers.

iii. Monitoring – Tracking and reviewing ongoing program and service provisions.

iv. Evaluation – Evaluating LE providers' compatibility with the County's service delivery system and integration with the DMH's claims processing information and claims reimbursement systems.

4. How SDP is Utilized

The SDP, by reference, is an extension of the LE Contract. It is used for monitoring, but not for reimbursement, negotiation and/or bidding purposes. ***Any requests for changes to the LE Contract must be reviewed and approved by the Contract Lead and Deputy Director. After approval of a change in the Contract, a written amendment by the Chief of Contracts Development and Administration Division (CDAD) will be executed. Approved and executed changes shall be reflected in the updated SDP prepared for the designated time period.***

5. Purpose of Schedules

The purpose of each schedule is indicated in the chart on the next page and on the top page of each individual schedule.

Chart I. PURPOSE OF THE SDP SCHEDULES		
Schedule Number	**Name of Schedule**	**Purpose**
1	Legal Entity Transmittal Form	Provide DMH with LE's contract updates/changes
2	Legal Entity Information Form	Provide up-to-date LE information used for contract monitoring and management.
3	Legal Entity Covered Services by Provider Number	Report services/activities rendered at each provider site (provider number location).
4	Provider Site Staffing and Budget Allocation	Identify staffing and budget allocation at each provider site.
4a	Urgent Care Center (UCC) Provider Site Staffing and Budget Allocation	Identify staffing and budget allocation at each UCC provider site.
4b.	24 Hr. Resid. Program Site Staffing and Budget Allocation	Identify staffing and budget allocation at each 24 Hr Residential Program site(s): Subacute (IMD) (MHRC and SNF-STP), PHF (Psychiatric Health Facility), ERS (Enriched Residential Service), and CRTP (Crisis Residential Treatment Program).
4c.	Legal Entity Indirect Cost (One 4c form completed for each LE)	Identify the indirect cost at the Legal Entity level.
5	Legal Entity Mental Health Service Plan	Provide projection of services by IBHIS Plan, MC status, and Age Group for all provider sites for current fiscal year.
6	Legal Entity Subprogram Schedule	Verification of allocation changes. The LE provider is responsible for updating this schedule (Subprogram Schedule) for review and approval of the Contract Lead.
7	Legal Entity Budget Summary by Provider Number	Summary the LE providers funded programs and allocated amounts by provider site.

6. Right to Request Additional Documents and Information

At any time, DMH may request, additional information to support a submitted SDP prior to approving the document. Additional documentation may include, but is not limited to program descriptions, staffing documentation, site lease information, line-item budget detail, program specific documentation (such as those needed for CalWORKs), and/or copies of subcontract agreements.

7. Public Record

a. When the DMH Director recommends a contract of any type to the Board of

Supervisors, and such recommendation appears on the Board agenda, all SDP material submitted shall become a matter of public record. With exception of those elements in each SDP that are defined by the contractor as business or trade secrets and plainly marked as "Trade Secret", "Confidential", or "Proprietary."

b. The County shall not be liable or responsible for the disclosure of any such records or any part thereof. Unless disclosure is required or permitted under the California Public Records Act or otherwise by law.

8. No Funds Disbursed by DMH Until the Board of Supervisors Has Approved the Contract

Disbursements of funds in accordance with the Terms and Conditions of the LE Contract and in no case can disbursements exceed the contract's Maximum Contract Amount (MCA) and/or the total for each respective **Funded Program** identified in the LE contract's **Financial Summary**.

II. SDP SUBMISSION PROCESS AND PROCEDURES

1. Required Submission of SDP

Financial Exhibit A, paragraph K of the LE Contract states that monitoring of services and claiming for the requested period based on the approved LE SDP (formerly known as NP) and other information outlined in the LE providers' Financial Summary and Service Exhibit. Therefore, timely completion, submission, and approval of the SDP are required. Per Urgent Care Center Cost-Based Payment Policy 801.10, Procedure Section 4.1 Negotiation Package and Program Budget Approval Section 4.1.1

2. SDP Schedules for FY 2022-23

a. There are seven (7) required schedules in the SDP for Fiscal Year (FY) 2022-23. All schedules are in Excel format and saved as Excel 1997- 2003 to avoid compatibility issues for agencies that have not updated their Microsoft Office software. All schedules are to be completed and submitted for each SDP submission: Initial, Mid-Year, Closing, and Additional.

b. Schedules 1, 2, 4, (4a), (4b), 6, and 7 are electronically emailed to all LE providers, along with instructions and a letter from the DMH highlighting pertinent information for the current fiscal year SDP process.

c. Schedules 3 and 5 are made available to agencies through download in NGA Reports File using agency's assigned C# and/or from the Contract Lead/Analyst and updated prior to each SDP submission period. These schedules are populated with each agency's FY 2020-21 and/or FY 2021-22 actual data. Providers are encouraged to review their data for the previous fiscal year and use it as a basis for revising/completing the schedule with estimates for

FY 2022-23.

3. Submitting the SDP

a. After completing the entire SDP, providers must submit a signed electronic version of the packet to their Contract Lead as listed in Exhibit E – County's Administration in the LE Agreement.
b. The original SDP to be printed and bound separately prior to submission with wet signature.

4. Submission Deadlines for FY 2022-23

a. For FY 2022-23, LE providers are required to submit three (3) annualized SDPs: July 30, 2022, January 31, 2023, and closing date October 31, 2023 or 30 days after Cost Report whichever is later. Each submission reflects provider contract changes and service estimates at different intervals within the FY, including the time of contract renewal or beginning of the year amendment and after the close of the FY. SDPs must be submitted by LE providers on or before 5:00PM of the date specified by DMH as follows:

1. Initial SDP: Renewal and any Amendments for FY 22-23 indicating changes through July 30, 2022	July 30, 2022
2. Mid-year SDP: Change(s) through December 31, 2022	January 31, 2023
3. Closing SDP: FY 2022-23 Final Changes	October 31, 2023 or 30 days after Cost Report, whichever is later
Additional submission of SDP	As Needed

b. DMH may request additional submission(s) of SDP as necessary. If additional submissions requested from the LE providers, the DMH Contract Lead will determine the submission deadline(s). In addition, LE providers may be asked to submit a SDP if participating in an open solicitation process.

c. The submission due date for the closing SDP will be a date to be determined based on 30 days after the Cost Report due date, which is generally in October after the end of the preceding FY.

d. The deadline dates for FY 2022-23 are also on the cover page of the SDP instructions.

5. Late Submissions

a. Must notify CMMD and obtain permission.

b. Failure to submit – processing of financial, program and other requests will be

on hold until the SDP is submitted and approved.

6. Failure to Complete the SDP

   a. Incomplete and incorrect SDPs will return to the sender/LE provider for correction and/or additional information.

   b. The LE provider may experience a significant delay in the execution of their related contract action/approval due to failure to complete their SDP.

7. Finalizing the SDP

   a. To finalize the SDP, please be sure to:

      i. Complete Schedules 1-7 as outlined in "Section III - Instructions for Completing the Schedules" by the due date indicated in this document and on the cover sheet, or as notified by DMH if the due date indicated as TBD.

      ii. Submit the completed SDP to the DMH CDAD at the address indicated in the "Instructions for Completing the Service Delivery Plan".

      iii. Provide responses and/or additional documentation requested by the Contract Leads (or their designee) within the weeks following your submission.

      iv. Provide on a timely basis the revised schedules or additional information requested by the Contract Lead (or their designee).

8. Approval of the SDP

   a. Upon approval of all information, the Contract Lead and Deputy Director will sign and date Schedule 1 and LE provider will receive notification via email that your SDP submission is accepted and approved.

   b. CDAD will approve and file the SDP.

III. INSTRUCTIONS FOR COMPLETING THE SCHEDULES

1. General Instructions

   a. The use of standardized templates permits the use of the schedules for multiple combinations of budget preparation, thereby allowing the roll-up of data from lower levels of reporting to higher levels (i.e. Service Site to Legal Entity).

However, except for the header information the cells on one schedule may or may not link to another schedule.

b. It is the LE preparers' responsibility to make and validate any links.

c. LE Providers should mark any requirements in any of the schedules that do not apply as N/A (Not Applicable).

d. Complete Schedules 1, 2, 4, 4a for UCCs only, 4b for 24 Hr. Residential Services, 6, and 7 using the FY 2022-23 Excel Worksheet.

e. Download Schedule 3 and 5 in NGA Reports File using agency's assigned C# or request the file from the Contract Lead or Analyst. Print, review and confirm the accuracy of the information or hand annotate requested changes.

f. Provide information in all the yellow highlighted areas.

2. Schedule Instructions

The instructions for each schedule are indicated in the following charts:

SCHEDULE 1. LEGAL ENTITY TRANSMITTAL FORM	
• Click on Tab 1: "Schedule 1-LE Transmittal". • This form is also referred to as the "Cover Sheet" • Schedule 1 provides a brief description of summary of changes, e.g., specifics of an amendment. • Schedule 1 requires signatures from the provider's authorized signer, Contract Lead, and Deputy Director before it is finalized and sent to CDAD.	
Line 1	Enter the submission date in the respective highlighted cell. This cell is linked to the Schedule 2 Legal Entity Information entry for "Submission Date."
Line 2	Enter your agency's LE name (as it appears on the organization's Articles of Incorporation) in the respective highlighted cell. This cell is linked to the Schedule 2 Legal Entity Information for "Legal Entity Name."
Line 3	Check (√) the appropriate SDP submission period.
Line 4	Check (√) whether the SDP is for a Contract Renewal, Contract Amendment, Solicitation, Schedule 5 Only, or Contract Modification with Amendment.
Line 5	List changes for the submission period in the "Summary of Changes" section. Include only changes from the last approved SDP. Attach another sheet if needed.
Line 6	In the Contractor Certification Box, enter the date signed. Type/print name of the individual in your agency authorized to sign contracts on behalf of the LE and that will sign the Transmittal Letter upon completion of the SDP. Signer is to sign in the indicated "Signed" space. The authorized signer should not sign this form until the SDP is ready to submit to DMH. Agency should leave all other sections blank.
Line7	Do not complete any of the information under the "Department of Mental Health Program Certification" section.

SCHEDULE 2. LEGAL ENTITY INFORMATION FORM	
• Click on Tab 2: "Schedule 2-LE Info Form". • New information not previously included in the FY 2017-18 Negotiation Package include listing of 1) all contracts with other government, non-profit and other funding sources and 2) subcontracts.	
Line 1	The "Submission Date" cell will be prepopulated with the information keyed in this section in Schedule 1 Legal Entity Transmittal Form.
Line 2	The "Legal Entity Name" cell will be prepopulated with the information keyed in this section in Schedule 1 Legal Entity Transmittal Form.
Line 3	Enter the fiscal year(s) for which the Service Delivery Plan proposal is applicable.
Line 4	If the organization has a "Doing Business as" (DBA) Name, enter the DBA Name in this section.
Line 5	If DMH has assigned a "Legal Entity Number" enter the number. If no number has been assigned enter "TBD" (To be Determined). DMH will assign a "Legal Entity Number" later if a contract/contract amendment is awarded.
Line 6	Enter the organization's nine-digit Federal Tax Identification Number.
Line 7	Enter the organization's Vendor Identification Number.
Lines 8-11	Enter the address for the organization's administrative headquarters or main office.
Line 12	Check the appropriate organization status: Not For Profit or For Profit.
Line 13	Indicate the correct LAC Supervisorial District where the organization headquarters/central office is located.
Lines 14-17	Enter the requested contact information for the person designated as the primary lead to communicate with DMH in regard to SDP matters.
Line 18	Enter the organization's website address.
Line 19	Enter current or prior DMH contract number. If the agency does not have a prior/current contract, and has indicated a Legal Entity Number "TBD" then enter N/A on Line 19.

Line 20	List all existing contracts the agency has with other LAC Departments, including other information requested. If additional space is required, attach a separate sheet to the Service Delivery Plan to complete the agency's list.
Line 21	List all existing contracts the agency has with other counties in California and other information requested. If additional space is required, attach a separate sheet to the SDP to complete the agency's list.
Line 22	List all existing contracts the agency has with other government, non-profit- and other funding sources and other information requested. If additional space is required, attach a separate sheet to the SDP to complete the agency's list.
Line 23	List all existing subcontract(s) the agency has and other information requested. Copies of subcontract(s) must be submitted to CDAD per the LE Contract. If additional space is required, attach a separate sheet to the SDP to complete the agency's list.

SCHEDULE 3. LEGAL ENTITY COVERED SERVICES BY PROVIDER NUMBER BY STAFF CLASSIFICATION

- Click on Tab 3: "Schedule 3-Covered Svcs by PN".
- The Schedule provides staff classification information for the monitoring of appropriate job classifications for contracted services and for rate-setting purposes.
- Providers should access the prior FY covered services data through download in NGA Reports File using agency's assigned C# and/or from the Contract Lead/Analyst. Providers should review their data to ensure accuracy. For example, FTEs of each clinical classification entered by service mode/service function range should be consistent with the covered services reflected in the download. If inconsistencies are found, providers should note them in this Schedule, and inform the Contract Lead/Analyst.

Lines 1 thru 4	Submission Date, County Fiscal Year, Legal Entity Name, and Legal Entity Number fields are linked to other cells from Schedule 1 and Schedule 2
Lines 8 thru 98, column a	Enter Provider Number and clinical staff classification(s) assigned to the Provider Number entered.
Lines 8 thru 98, column b thru c	Enter the corresponding Service Area and Supervisorial District for the Provider Number entered in column a.

Lines 8 thru 98, column d thru y	Enter the Full-Time Equivalent (FTE) of the clinical staff classification entered in corresponding row by the service mode/service function range listed on line 5. (See lines 6-7 for example.)
Line 5, column z thru ac	Enter other service mode/service function range not listed in columns d-y, if applicable.
Lines 8 thru 98, column z thru ac	Enter the Full-Time Equivalent (FTE) of the clinical staff classification entered in corresponding row by the service mode/service function range noted on line 5, columns z thru ac, if applicable.

SCHEDULE 4. PROVIDER SITE STAFFING AND BUDGET ALLOCATION

- Click on Tab 4: "Prov Site Budget".
- Schedule 4 is to be filled out for each provider location (as identified with a DMH/State assigned Provider Number). Budget and funding for all programs operated within the same PN are to be included in the same Schedule 4. If a LE provider has more than one (1) Provider Number, then create Schedule 4 for as many Provider Site Budgets as necessary. If a LE provider has additional UCC provider site(s) or 24 Hr. Residential program(s), complete Schedule 4a and Schedule 4b accordingly.
- DMH Funds to be reported in Schedule 4 should be reported based on the following:
    1. Existing funding: Contractors will need to have received from DMH a planning notification of the initial and/or revised funded program allocations to prepare the SDP budget.
    2. Prospective funding: Contractors or prospective contractors will need to have received a solicitation notice from DMH, which will provide the necessary information for the preparation of a proposed budget in response to the solicitation.

	Submission Date, County Fiscal Year, Legal Entity Name, and Legal Entity Number fields are linked to other cells from Schedule 1 and Schedule 2.
Lines 1 and 2	Enter the four-digit provider number and provider name.
Lines 3 and 4	Enter the provider site address.
Line 5	Enter the telephone number of the provider site.
Line 6	Enter the Service Area for which the Schedule 4 is applicable.

Line 7	Enter the LAC Supervisorial District for which the Schedule 4 is applicable.
Line 8	Enter hours of operation
Line 9	Enter the name of the Head of Service or contact person.
Line 10	Enter the name of the Program Director or Manager.
Line 11	Enter the email address of the Program Director or Manager.
Line 12	Enter the telephone number of the Program Director or Manager.
Lines 13 thru 29, columns b thru e	Enter the FTEs, and Salaries/Wages associated with the personnel identified on lines 13 thru 21, column a.
Lines 32 through 40, columns c and e	Enter the employee benefits associated with the personnel identified on lines 13 thru 29.
Lines 43 thru 49, columns c and e	Enter expenses for the respective expense categories listed in column a. (DMH may require Contractor to submit a budget narrative to explain and/or provide detail of certain expenses if deemed necessary). For closing SDP, enter actual costs.
Line 52, columns c and e	If an indirect administrative overhead is allocated to a provider site/number, enter the organization's indirect administrative overhead. Generally accepted cost accounting allocation principles must be used.
Lines 55 thru 87, column a	Enter the revenue description that the organization proposes to receive from DMH from the dropdown menu (lines 36-63) or by typing in the funded program name (lines 64-67). The DMH revenue descriptions were provided in the DMH LE Contract's Financial Summary and/or solicitation documents released by DMH.
Lines 55 thru 87, columns c and e.	Enter estimated revenue amounts. All amounts are to be in gross dollar amounts.
Lines 90 thru 97, column a	Enter the descriptions of revenue that the organization expects to receive reimbursement from third parties for mental health services (for example, reimbursement/revenue from client, insurance, Medicare, and interest..)
Lines 90 thru 97, columns c and e.	Enter the estimated revenue amounts

SCHEDULE 4a. UCC PROVIDER SITE STAFFING AND BUDGET ALLOCATION

- Click on Tab 4a: "UCC Provider Site".
- The Program Budget shall be based upon the UCCs Maximum Capacity.
- LACDMH reserves the right to 1) review the SDPs for accuracy and reasonableness, 2) approve or reject SDPs or Program Budgets, and 3) provide instructions for remedying any rejected SDPs or Program Budgets.

SCHEDULE 4b. 24 Hr. RESIDENTIAL AGREEMENT STAFFING AND BUDGET ALLOCATION

- Click on Tab 4b: "24 Hr. Residential Agreement".
- The Program Budget shall be based upon the Provider's Maximum Capacity.
- LACDMH reserves the right to 1) review the SDPs for accuracy and reasonableness, 2) approve or reject SDPs or Program Budgets, and 3) provide instructions for remedying any rejected SDPs or Program Budgets.

SCHEDULE 4c. LEGAL ENTITY INDIRECT COST

- Click on Tab 4c: "LE Indirect Cost".
- Complete the LE Indirect Cost worksheet by filling out the yellow highlighted cells as applicable.
- The Indirect Cost Budget shall be at the Legal Entity level.
- On line 50, column b, enter the Total Direct Cost by adding total direct cost (line 51, column g) from all Schedule 4s.

SCHEDULE 5. LEGAL ENTITY MENTAL HEALTH SERVICE PLAN

- Click on Tab 5: “Schedule 5-LE MH Svcs Plan.”
    - Schedule 5 is blank in the Service Delivery Plan Excel file. This schedule must be downloaded in NGA Reports File using agency's assigned C# and/or requested through the Contract Lead.
- The downloaded schedule will populate with FY 2020-21 and FY 2021-22 actual service provision data. Providers are encouraged to review their data for the previous fiscal year(s) and use it as a basis for projecting their annual service provision for FY 2022-23.
- Providers should note that actual data provided as a resource and additional or different sources of information can be for use in completing the current fiscal years provision projections.
- Depending on the type of SDP to be submitted – initial, mid-year, or closing – the requested information (indicated in the headers of columns) will change accordingly, to reflect actual (closing) vs. projected (initial and mid-year) data.
- Download Schedule 5 from the NGA Reports File using agency's assigned C# and/or from the Contract Lead/Analyst. Review actual service data for your agency for the last two FYs. Provide annual service projections for your agency for the current FY. Print completed schedule.

SCHEDULE 6. LEGAL ENTITY SUBPROGRAM SCHDEULE

- Click on Tab 6: "Schedule 6-LE Subprogram"
- At the time of the LE Contract Renewal/Supersession, DMH will provide Contractor with a completed Schedule 6 (**Subprogram Schedule**) consistent with the Renewal/Supersession contract amount.
- Contractor is responsible for updating Schedule 6 (**Subprogram Schedule**) with applicable executed financial amendments for review and approval of the Contract Lead.
- DMH Funds to be reported in Schedule 6 (**Subprogram Schedule**) should be reported based on the following:
- Existing funding: Contractors will need to have received from DMH a planning notification of the initial and/or revised funded program allocations to prepare the SDP budget.
- Prospective funding: Contractors or prospective contractors will need to have received a solicitation notice from DMH providing the necessary information for the preparation of a proposed budget in response to the solicitation.

SCHEDULE 7. LEGAL ENTITY BUDGET SUMMARY BY PROVIDER NUMBER

- Click on Tab 7: "Schedule 7-Budget Summary by PN."
- Schedule 7 provides an overview of the *Fund/Revenue Sources* section in Schedule 4 (Provider Site Staffing and Budget Allocation) and Legal Entity level subtotal by Funded Programs.

Line 5, columns b through r (as applicable).	Enter Provider Number.
Lines 6 thru 33, column a	Select from the dropdown menu, appropriate Fund/Revenue Source(s) (or Funded Program(s)) proposed to fund the provider site(s) associated with the Provider Number(s) entered in columns b thru r. Lines 34 and 35 are blank cells (without dropdown menu) in case a new funding that is not included in the dropdown menu needs to be included.
Line 37, column a	Enter Non-County Revenue. This amount should equal Line 74, Total Client, Third Party and Other Revenue, of Schedule 4 (Provider Site Staffing & Budget Allocation) for the same Provider Number.
Lines 6 thru 35,	Enter the dollar amount for each appropriate Funded Program

column b thru r.	proposed to fund each provider site entered in columns b thru r. Line 36, Subtotal by Provider Number, should equal Line 64, Total Proposed Maximum Amount, of Schedule 4 (Provider Site Staffing & Budget Allocation) for the same Provider Number.
Line 38	Total by Provider Number should equal Line 75, Total Gross Revenues, of Schedule 4 (Provider Site Staffing & Budget Allocation) for the same Provider Number.

IV. TERMS, ACRONYMS AND DEFINITIONS

TERMS & ACRONYMS	DEFINITION
Beneficiary Types:	• Non-Medi-Cal: Individuals who are not eligible for Short-Doyle/Medi-Cal, Medi-Cal Expansion, EPSDT or State Children's Health Insurance Program (MCHIP). • EPSDT Medi-Cal: beneficiaries eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. • Non-EPSDT Medi-Cal: beneficiaries eligible for Short-Doyle/Medi-Cal program for certain individuals with low incomes and resources such as children and families, pregnant women, seniors, and persons with disabilities. • MCHIP (includes Healthy Families transition to Medi-Cal program): Expanded Medicaid Children's Health Insurance Program under Title XXI of the Social Security Act. • MCE (Medicaid Expansion): beneficiaries eligible for Medi-Cal coverage expansion under the Affordable Care Act.
CDAD	Los Angeles County DMH Contract Development Administration Division
CMMD	Los Angeles County DMH Contract Management and Monitoring Division
Department of Mental Health (DMH)	Los Angeles County Department of Mental Health.
Direct Costs	Costs identified specifically with a final cost objective (i.e. a particular financial award, project, service or other direct activity of the organization).
NGA Reports File (No longer EFT)	NGA Reports File (Replacement of EFT) to download Schedule 3 & 5 reports using agency's assigned C#
Equipment (Major)	Major means movable personal property of a relatively permanent nature and of significant value meaning $5,000 or more. Allowable to the extent the equipment costs are capitalized and captured through depreciation, unless the County contract specifically approves outright purchase in which case the lower of the contract authorized purchase

TERMS & ACRONYMS	DEFINITION
	amount or the equipment actual costs is allowable. No further depreciation is allowed for lump-sum outright purchases. (Ref. Centers for Medicare and Medicaid Services (CMS), The Provider Reimbursement Manual – Part 1, Chapter 1 Depreciation; County of Los Angles Fiscal Manual, Chapter 6 Fixed Assets, and California Code of Regulations (CCR) Title 9 Division 1, Section 552 Equipment Expense).
Equipment (Minor)	Minor means portable equipment items costing less than $5,000 per unit. Allowable and expensed under the services and supplies category.
Funded Program	Set of services paid through a particular funding source for the benefit of a specific beneficiary (e.g., Medi-Cal or Non-Medi-Cal). The Funded Program Amount is the basis for the provisional payment to the Contractor per Paragraph E of the Financial Exhibit A of LAC-DMH LE Contract. A Funded Program is one or more Subprograms.
FY	Fiscal Year
Indirect costs	Costs incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified under a particular final cost objective without effort disproportionate to the results received.
Lead Contract Program Manager	The DMH person that is designated to be the primary DMH liaison with the LE.
Legal Entity (LE)	Mental health provider whose legal Schedule may be an association, corporation, partnership, sole proprietorship, or other legal Schedule of organization recognized by the State of California. The terms “organization”, “agency”, “company”, “provider”, and “contractor” may be used interchangeably with “LE”.
Licensed clinical/treatment staff.	See the California Code of Regulations, Title 9, Division 1 – Mental Health, Article 8, Professional and Technical Standards, Section 620 – 632 for information regarding the license/degree categories that are used in the program personnel sections of this Service Delivery Plan.
Maximum Contract Amount (MCA)	Maximum reimbursement from DMH possible under the Terms and Conditions of a LE Contract. MCA control applies to the grand total of all programs within the entire LE Contract and also to the respective “Funded Programs” within the LE Contract as defined in the LE Contract’s

TERMS & ACRONYMS	DEFINITION
	Financial Summary.
Mid-Year/Partial Year Change	Specific portions of the SDP document that the DMH requires be submitted when amending a LE Contract during the LE Contract's Term.
Service Delivery Plan (SDP)	Document that the DMH requires a service provider to submit when requesting a contract renewal, or a contract award under a solicitation, or a mid-year change to a current contract. Formerly known as Negotiation Package.
Provider Number	Four-character numeric or alpha-numeric code assigned by DMH in collaboration with the State Department of Health Care Services. Generally, the provider number is assigned to a specific geographic four-wall facility site; however, in certain circumstances there could be more than one provider number assigned to the same site. In the case of solicitations involving a site for which there is no currently assigned provider number the service provider is to use TBA (to be assigned) followed by a – (dash) 1 (number consecutively) for each proposed new site (i.e. TBA-1, TBA-2, etc.).
Provider Site	Physical facility at which the services/activities will be rendered and/or coordinated if such services/activities will be rendered in the field.
Service Area (SA)	Geographically defined area used by DMH to divide the County of Los Angeles into smaller units for the operation of the public mental health system. There are eight (8) SA's which are identified in the DMH's County web page.
Service provider/provider	Non-government organization (NGO) that proposes to or currently does render mental health services and/or activities.
SIFT	Secure Internet File Transfer
Solicitation	DMH issued Request for Proposal (RFP), Request for Information (RFI), or Request for Statement of Qualifications (RFSQ).
Subprogram	Set of services for a specific purpose. The Subprogram Amounts are allocated and/or awarded based on Contractors' areas of expertise and their ability to provide specific services and/or serve specific populations. The Subprogram Amounts will be used to monitor the provision of mental health services within the Funded Program and

TERMS & ACRONYMS	DEFINITION
	will not be used at cost settlement.
Unique Number of Clients	Unique number of clients are total clients served.
Unduplicated Number of Clients	Unduplicated number of clients are those clients served by name, but does not count more than once even if they had been open and closed a number of times.

SCHEDULE 1. LEGAL ENTITY TRANSMITTAL FORM

1 Submission Date:

This Schedule provides DMH with the Legal Entity's timely Service Delivery Plans to DMH and updates on contractual changes.
Please indicate Amendment # in Summary of Changes when MCA is adjusted.

TO: Department of Mental Health,
Contract Development and Administration Division

2 RE: Legal Entity Name:

(As appears on the organization's Articles of Incorporation)

3 Service Delivery Plan Submission Period (check (√) the appropriate submission period):

Renewal and any Amendments for FY 22-23 for changes up to July 1, 2022 (due 07/30/2022)
Mid-year change(s) up to December 31, 2022 (due 1/31/2023)
Other change(s) Describe the period:
Closing: Final Changes due October 31, 2023 or 30 days after Cost Report, whichever is later

4 Contract Renewal (√): Contract Amendment (√): Solicitation (√):
Schedule 5 Only (√): Contract Modification without Amendment (√):

5 Summary of Changes: include only changes from the last approved FY 2021-22 Service Delivery Plan (if additional space is needed, attach another sheet)

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

6

CONTRACTOR CERTIFICATION

Enclosed herewith is the completed Contract Service Delivery Plan for the organization and fiscal year(s) period(s) shown above. It is correct to the best of my knowledge and represents my organization's proposal for the provision of mental health services/activities for the County.

I certify that services proposed herein meet or exceed the applicable program standards as set forth in the Welfare and Institutions Code and the California Code of Regulations:

Signed (Legal Entity person authorized to sign contracts) | Date

Type/Print Name of Signer | Email Address

7

DEPARTMENT OF MENTAL HEALTH PROGRAM CERTIFICATION

I certify that I have reviewed the content of this Contract Service Delivery Plan and that it meets DMH standards and policies:

Signed Contract Lead Approval | Approval Date

Name of Signer

Signed Deputy Director Approval | Approval Date

Name of Signer

Cell instructions:
Enter responses in highlighted cells

The signed contract Service Delivery Plan (SDP) packet must be sent electronically to:
The Contract Lead as listed in Exhibit E - County's Administration in the LE Agreement

SCHEDULE 2. LEGAL ENTITY INFORMATION FORM

Cell instructions: Data entry cells are highlighted.

This Schedule provides up-to-date Legal Entity information used for contract monitoring and management.

1 Submission Date: January 0, 1900

2 Legal Entity Name: 0

3 County Fiscal Year(s): FY(s) applicable for the Service Delivery Plan

4 Legal Entity DBA (Doing Business As) name, if applicable:

5 Legal Entity Number:

6 Federal Nine-Digit Tax Identification Number for the organization:

7 Vendor Identification Number for the Organization:

8 Address of administrative headquarters or main office (may not be a provider site):

9 a Street Address:

10 b Room or Suite Number (if any):

11 c City/State/Zip Code:

12 Organization status is: Not For Profit (check): For Profit (check):

13 Supervisorial District in which headquarters is located (1st, 2nd, 3rd, 4th or 5th):

14 Contact Person: Responsible to communicate with DMH

15 a Title:

16 b Telephone No. & Ext.: Fax No.:

17 c Email Address:

18 d Website:

19 If applicable, current or prior County DMH contract number: which expires/expired on (enter date):

20 Please list all contracts with other Los Angeles County departments (if applicable):

Department Name:	*Contract Term:*	*Contract Type/Service:*

21 Please list all contracts with other California County(ies) (if applicable):

County/Department Name:	*Contract Term:*	*Contract Type/Service:*

22 Please list all contracts with other government, non-profit, and other funding sources:

Name:	*Contract Term:*	*Contract Type/Service:*

23 Please list all subcontracts (note: copies of subcontracts should be submitted to CDAD):

Subcontractor Name:	*Contract Term:*	*Contract Type/Service:*

SCHEDULE 3. LEGAL ENTITY COVERED SERVICES BY PROVIDER NUMBER BY STAFF CLASSIFICATION

Cell instructions: Data entry cells are highlighted.

1 Submission Date: January 0, 1900

2 Legal Entity Name: 0

3 County Fiscal Year: 0

4 Legal Entity Number: 0

This Schedule reports services/activities rendered by each clinical/direct service staff classification at each Provider Site (provider number location). For each site, enter a FTE under columns d - y to indicate the direct services/activities provided. Use extra space in columns z - ac to list additional capacity. Only the staff time allocated to providing direct service should be allocated on this schedule. *Please download in NGA Reports File using agency's assigned C# to confirm covered services.

	a		b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	ab	ac	ad
					OUTPATIENT SERVICES					OUTREACH		SUPPORT SVCS		DAY SERVICES						24 HOUR SERVICES							OTHER				Total
5	PROV NO.	Staff Classification (e.g., clinical psychologist, nurse practitioner, pharmacist, psychiatric social worker)	Service Area	Supervisor District	Targeted Case Management	Mental Health Services	Therapeutic Behavioral Svc	Medication Support Svc	Crisis Intervention	Mental Health Promotion	Community Client Svc	Life Support	Case Mgmt Support	Crisis Stabilization (ER)	Crisis Stabilization (UC)	Day Treatment Int, Half Day	Day Treatment Int, Full Day	Day Rehab, Half Day	Day Rehab, Full Day	Hospital Inpatient	Admin Day	Psychiatric Health Facility	Adult Crisis Residential	Residential (Other)	Transitional Residential	Semi-Sup Living					
					15/01-09	15/10-19 & 30-59	15/58	15/60-69	15/70-79	45/10-19	45/20-29	60/40-49	60/60-69	10/20-24	10/25-29	10/81-84	10/85-89	10/91-94	10/95-99	5/10-18	5/19	5/20-29	5/40-49	5/60-64	5/65-79	5/80-84					
6	Example	MH Psychiatrist				1.25		0.50	0.25																						2.0
7	Example	Psychiatric Social Worker			6.50	11.00			2.50	1.00																					21.0
8																															0.0
9																															0.0
10																															0.0
11																															0.0
12																															0.0
13																															0.0
14																															0.0
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	a		b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	ab	ac	ad
					OUTPATIENT SERVICES					OUTREACH		SUPPORT SVCS		DAY SERVICES						24 HOUR SERVICES							OTHER				Total
5	PROV NO.	Staff Classification (e.g., clinical psychologist, nurse practitioner, pharmacist, psychiatric social worker)	Service Area	Supervisor District	Targeted Case Management	Mental Health Services	Therapeutic Behavioral Svc	Medication Support Svc	Crisis Intervention	Mental Health Promotion	Community Client Svc	Life Support	Case Mgmt Support	Crisis Stabilization (ER)	Crisis Stabilization (UC)	Day Treatment Int, Half Day	Day Treatment Int, Full Day	Day Rehab, Half Day	Day Rehab, Full Day	Hospital Inpatient	Admin Day	Psychiatric Health Facility	Adult Crisis Residential	Residential (Other)	Transitional Residential	Semi-Sup Living					
					15/01-09	15/10-19 & 30-59	15/58	15/60-69	15/70-79	45/10-19	45/20-29	60/40-49	60/60-69	10/20-24	10/25-29	10/81-84	10/85-89	10/91-94	10/95-99	5/10-18	5/19	5/20-29	5/40-49	5/60-64	5/65-79	5/80-84					
49																															0.0
50																															0.0
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97																															0.0

SCHEDULE 4. PROVIDER SITE STAFFING & BUDGET ALLOCATION

Cell instructions: → Data entry cells are highlighted.

PROVIDER SITE INFORMATION			
1 PROVIDER NUMBER:		**2** PROVIDER NAME:	
3 PROVIDER SITE ADDRESS:		**4** CITY/ZIP CODE	
5 TELEPHONE #:	**6** SERVICE AREA:	**7** SUPERVISORIAL DISTRICT:	
8 HOURS OF OPERATION (e.g., Mon - Fri 8am to 5pm):		**9** HEAD OF SERVICE:	
10 PROGRAM DIRECTOR NAME:	**11** EMAIL:	**12** TELEPHONE #:	

*This schedule identifies the staffing level at each Provider Site and the budget allocated for the Provider Site. *Complete one Schedule 4 for each Provider Site.

Submission Date: January 0, 1900
Legal Entity Name: 0
County Fiscal Year: 0
Legal Entity Number: 0

EXPENSES

	a	b	c	d	e	f	g	h
13	**PROVIDER SITE STAFFING** (from each respective Provider Number)	PROPOSED BUDGET OR LAST APPROVED BUDGET		MID/PARTIAL-YEAR CHANGE/SOLICITATION REQUEST - ( ) denotes negative amount		PROPOSED NEW/REVISED BUDGET		Column g as a percent of the total Direct program budget (col g line cells divided by col g, line 51)
	Budgeted Positions by License/Degree	FTE	AMOUNT	FTE	AMOUNT	FTE (b+d)	AMOUNT (c+e)	
14	Physician (MD)/Psychiatrist/MH Nurse Practitioner (NP)					-	-	-
15	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.)/MH Clinical Nurse Specialist (CSN)					-	-	-
16	RN, LVN, Psych. Tech.					-	-	-
17	MH Rehabilitation Specialist					-	-	-
18	MH Related B.A. or 2 yrs. MH Experience - not licensed					-	-	-
19	No B.A. or 2 yrs Exp & Student					-	-	-
20	Other Non-Administrative Program Staff - specify below							
21						-	-	-
22						-	-	-
23						-	-	-
24	Clinical Admin Staff - specify below (exclude indirect staff)							
25						-	-	-
26						-	-	-
27						-	-	-
28						-	-	-
29						-	-	-
30	**Total Program Salaries and Wages** (lines 14:29)	-	-	-	-	-	-	-
31	Employee Benefits (itemize below)							
32	Health Insurance						-	-
33	Other Insurances						-	-
34	Reitrement Plans						-	-
35	Payroll Taxes						-	-
36							-	-
37								-
38							-	-
39	Total Employee Benefits (lines 32:38)		-		-		-	-
40	Professional Services - Clinical (i.e. subcontracted Psychiatrist)					-	-	-
41	**TOTAL PERSONNEL EXPENSE & FTEs** (lines 30 + 39 + 40)	-	-	-	-	-	$ -	-
42	**PROGRAM SERVICES AND SUPPLIES (Use Schedule 4b for Indirect Cost)**							
43	Equipment, Purchased with a Unit Value $5,000 or more						-	-
44	Facilities/Improvements, Purchased with a Unit Value $5,000 or more						-	-
45	One-Time Expenses						-	-
46	Professional Services - Non-Clinical						-	-
47	Subcontracts						-	-
48	Invoice/Flex Funds (as reflected in the LE Contract Financial Summary)						-	-
49	All Other Direct Services and Supplies						-	-
50	**TOTAL SERVICES AND SUPPLIES** (sum lines 43:49)		-		-		$ -	-
51	**TOTAL PERSONNEL & SERVICES/SUPPLIES EXPENSES** (lines 41 + 50)		-		-		$ -	
52	**INDIRECT ADMINISTRATIVE OVERHEAD** Attributed to the general administration (Complete Schedule 4b).						$ -	-
53	**TOTAL GROSS PROVIDER SITE and INDIRECT EXPENSES** (line 41 for FTE count and lines 51 + 52 for dollar amounts)	-	-	-	-	-	$ -	

SCHEDULE 4. PROVIDER SITE STAFFING & BUDGET ALLOCATION

Cell instructions: → Data entry cells are highlighted.

PROVIDER SITE INFORMATION

1 PROVIDER NUMBER:		**2** PROVIDER NAME:	
3 PROVIDER SITE ADDRESS:		**4** CITY/ZIP CODE	
5 TELEPHONE #:	**6** SERVICE AREA:	**7** SUPERVISORIAL DISTRICT:	
8 HOURS OF OPERATION (e.g., Mon - Fri 8am to 5pm):		**9** HEAD OF SERVICE:	
10 PROGRAM DIRECTOR NAME:	**11** EMAIL:	**12 TELE**PHONE #:	

REVENUE - LACDMH FUNDING (gross dollar amounts by Funded Programs from LE Agreement Financial Summary):

	a	c	d	e	f	g	h
54	**FUND/REVENUE REIMBURSEMENT SOURCES PROPOSED TO BE CONTRACTED WITH COUNTY (The County's contractual and reimbursement control will be the Maximum Contract Amount (MCA) by Funded Program Allocation):**	LAST APPROVED BUDGET		MID-YEAR, PARTIAL YEAR CHANGE OR SOLICITATION REQUEST		PROPOSED NEW/REVISED BUDGET (c+e)	PERCENT OF TOTAL BUDGET (col g cells ÷ column g, line 53)
55	Choose from the dropdown list					-	-
56	Choose from the dropdown list					-	-
57	Choose from the dropdown list					-	-
58	Choose from the dropdown list					-	-
59	Choose from the dropdown list					-	-
60	Choose from the dropdown list					-	-
61	Choose from the dropdown list					-	-
62	Choose from the dropdown list					-	-
63	Choose from the dropdown list					-	-
64	Choose from the dropdown list					-	-
65	Choose from the dropdown list					-	-
66	Choose from the dropdown list					-	-
67	Choose from the dropdown list					-	-
68	Choose from the dropdown list					-	-
69	Choose from the dropdown list					-	-
70	Choose from the dropdown list					-	-
71	Choose from the dropdown list					-	-
72	Choose from the dropdown list					-	-
73	Choose from the dropdown list					-	-
74	Choose from the dropdown list					-	-
75	Choose from the dropdown list					-	-
76	Choose from the dropdown list					-	-
77	Choose from the dropdown list					-	-
78	Choose from the dropdown list					-	-
79	Choose from the dropdown list					-	-
80	Choose from the dropdown list					-	-
81	Choose from the dropdown list					-	-
82	Choose from the dropdown list					-	-
83	Choose from the dropdown list					-	-
84	Enter Funded Program Name/Gross Amount					-	-
85	Enter Funded Program Name/Gross Amount					-	-
86	Enter Funded Program Name/Gross Amount					-	-
87	Enter Funded Program Name/Gross Amount					-	-
88	**Total Proposed Maximum Amount** (sum lines 55:87)	-		-		$ -	-
89	**REVENUE - Client, Third Party and Other Non-County Sources:**						
90	Client Fees					-	-
91	Insurance					-	-
92	Interest (on any funds associated with any of the funds on lines 55:87)					-	-
93	Medicare					-	-
94	Enter Other Revenues					-	-
95	Enter Other Revenues					-	-
96	Enter Other Revenues					-	-
97	Enter Other Revenues					-	-
98	**Total Client, Third Party and Other Revenue** (sum lines 90:97)	-		-		$ -	-
99	**TOTAL GROSS REVENUES** (lines 88 + 98)	-		-		$ -	-

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
NEGOTIATION PACKAGE

URGENT CARE CENTER BUDGET

ATTACHMENT I
SCHEDULE 4-A

PROVIDER SITE INFORMATION					
1 PROVIDER NUMBER:		**2** PROVIDER NAME:			
3 PROVIDER SITE ADDRESS:				**4** CITY/ZIP CODE:	
5 TELEPHONE #:		**6** SERVICE AREA:		**7** SUPERVISORIAL DISTRICT:	
8 HOURS OF OPERATION (e.g., Mon - Fri 8am to 5pm):			**9** HEAD OF SERVICE:		
10 PROGRAM DIRECTOR NAME:		**11** EMAIL:		**12 TELE**PHONE #:	

Submission Date: January 0, 1900
County Fiscal Year: 0
Legal Entity Name: 0
Legal Entity Number: 0

*This schedule identifies the staffing level at each Urgent CareProvider Site and the budget allocated for the Urgent Care Provider Site.

*Complete one Schedule 4a for each Urgent Care Provider Site.

13 NOTES/EXPLANATION (press ALT+Enter to create a new line):

14

15	EXPENSES		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
16	a	b	c	d	e	f	g	h
17	**DIRECT COST - PROGRAM STAFFING**		**FTE**	**AMOUNT**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**
18	Physician (MD)/Psychiatrist/MH Nurse Practitioner (NP)						0	0
19	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.)/MH Clinical Nurse Specialist (CNS)						0	0
20	RN, LVN, Psych. Tech.						0	0
21	Mental Health Rehabilitation Specialist						0	0
22	MH Related B.A. or 2 yrs. MH Experience - not licensed						0	0
23	No B.A. or 2 yrs Exp & Student						0	0
24	Other Non-Administrative Program Staff						0	0
25	Administrative Support Program Staff (exclude indirect staff)						0	0
26	Other (Specify)						0	0
27	Other (Specify)						0	0
28	Other (Specify)						0	0
29	**Total Salaries and Wages** (lines 18 - 28)		0	$ -	0	$ -	0	$ -
30	Employee Benefits							0
31	**TOTAL PERSONNEL EXPENSE & FTEs** (lines 29 + 30		0	$ -	0	$ -	0	$ -

32	**DIRECT COST - SERVICES & SUPPLIES**	**NOTE**		**AMOUNT**		**AMOUNT**		**AMOUNT**
33	Conferences							0
34	Client Support Services (provide detail separately)							0
35	Education and Training							0
36	Equipment Leases (not lease purchase)							0
37	Equipment, Purchased and with a Unit Value Under $5,000							0
38	Furniture							0
39	Information Technology/Data Processing							0
40	Insurance-Workers Compensation							0
41	Insurance-Other (Specify)							0
42	Laboratory Services							0
43	Medications							0
44	Office Supplies							0
45	Professional Services - Accounting							0
46	Professional Services - Legal							0
47	Professional Services - Other (Specify)							0
48	Professional Services - Other (Specify)							0
49	Publications							0
50	Subcontracts (provide detail separately)							0
51	Telecommunications							0
52	Travel/Transportation							0
53	Utilities							0
54	Other (Specify)							0
55	Other (Specify)							0
56	Other (Specify)							0
57	**TOTAL SERVICE & SUPPLIES** (lines 33 - 56)			$ -		$ -		$ -
58	**TOTAL DIRECT COST (PERSONNEL, SERVICE, AND SUPPLIES)** (lines 31 + 57)		0	$ -	0	$ -	0	$ -

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
NEGOTIATION PACKAGE

URGENT CARE CENTER BUDGET

ATTACHMENT I
SCHEDULE 4-A

PROVIDER SITE INFORMATION					
1 PROVIDER NUMBER:		**2** PROVIDER NAME:			
3 PROVIDER SITE ADDRESS:				**4** CITY/ZIP CODE:	
5 TELEPHONE #:		**6** SERVICE AREA:		**7** SUPERVISORIAL DISTRICT:	
8 HOURS OF OPERATION (e.g., Mon - Fri 8am to 5pm):		**9** HEAD OF SERVICE:			
10 PROGRAM DIRECTOR NAME:		**11** EMAIL:		**12 TELE**PHONE #:	

Submission Date: January 0, 1900
County Fiscal Year: 0
Legal Entity Name: 0
Legal Entity Number: 0

*This schedule identifies the staffing level at each Urgent CareProvider Site and the budget allocated for the Urgent Care Provider Site.

*Complete one Schedule 4a for each Urgent Care Provider Site.

56	EXPENSES		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
57	a	b	c	d	e	f	g	h
58	**INDIRECT COST**	**NOTE**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**
59	Salaries/Wages and Employee Benefits							
60	Executive Manager						0	0
61	Clinic Manager						0	0
62	Program Manager						0	0
63	Support Staff (clerical/reception)						0	0
64	Other (Specify)						0	0
65	Other (Specify)						0	0
66	Employee Benefits							0
67	Executive/Administrative Office Costs (Specify)							0
68	Advertising/Promotional Expenses							0
69	Capital Equipment (Purchased and with a Unit Value of $5,000 or more) Depreciation							0
70	Capital Equipment (Lease Purchases with a Unit Value of $5,000 or more) Amortization							0
71	Conferences							0
72	Consultants (provide detail separately)							0
73	Education and Training							0
74	Equipment Leases (not lease purchase)							0
75	Equipment, Purchased and with a Unit Value Under $5,000							0
76	Facility Rent/Lease Costs							0
77	Facility (Owned) Costs							0
78	Furniture							0
79	Information Technology/Data Processing							0
80	Insurance-Workers Compensation							0
81	Insurance-Other (Specify)							0
82	Office Supplies							0
83	Professional Services - Accounting							0
84	Professional Services - Legal							0
85	Professional Services - Other (Specify)							0
86	Professional Services - Other (Specify)							0
87	Publications							0
88	Subcontracts (provide detail separately)							0
89	Telecommunications							0
90	Travel/Transportation							0
91	Utilities							0
92	Other (Specify)							0
93	Other (Specify)							0
94	**TOTAL INDIRECT COST** (lines 60 - 93)		0	$ -	0	$ -	0	$ -
95	**INDIRECT COST PERCENTAGE** (lines 94/55%)			#DIV/0!				#DIV/0!
96	**TOTAL COST (DIRECT AND INDIRECT)** (lines 55 + 94)		0	$ -	0	$ -	0	$ -

97	FUNDING/REVENUE PROJECTION		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
98	a	b	c	d	e	f	g	h
99	**REVENUE**	**NOTE**		**AMOUNT**		**AMOUNT**		**AMOUNT**
100	UCC-MHSA Non-MC							0
101	UCC-MHSA MC							0
102	Enter Funded Program or Other Revenue							0
103	Enter Funded Program or Other Revenue							0
104	Enter Funded Program or Other Revenue							0
105	Enter Funded Program or Other Revenue							0
106	Enter Funded Program or Other Revenue							0
107	Enter Funded Program or Other Revenue							0
108	Enter Funded Program or Other Revenue							0
109	**TOTAL GROSS REVENUE** (lines 100 - 108)			$ -		$ -		$ -

PROVIDER SITE INFORMATION					
1 PROVIDER NUMBER:		**2** PROVIDER NAME:			
3 PROVIDER SITE ADDRESS:				**4** CITY/ZIP CODE:	
5 TELEPHONE #:		**6** SERVICE AREA:		**7** SUPERVISORIAL DISTRICT:	
8 HOURS OF OPERATION (e.g., Mon - Fri 8am to 5pm):			**9** HEAD OF SERVICE:		
10 PROGRAM DIRECTOR NAME:		**11** EMAIL:		**12 TELE**PHONE #:	

Submission Date: January 0, 1900
County Fiscal Year: 0
Legal Entity Name: 0
Legal Entity Number: 0

***This schedule identifies the staffing level at each 24 Hr. Residential Program site and the budget allocated for the 24 Hr. Residential Program Site. Indicate below by marking "X" the type of program being reported. Complete one Schedule 4b for each 24 Hr. Residential Program Site.**

Subacute (IMD) (MHRC and SNF-STP)	
PHF (Psychiatric Health Facility)	
ERS (Enriched Residential Service)	
CRTP (Crisis Residential Treatment Program)	

13 NOTES/EXPLANATION (press ALT+Enter to create a new line):

14

15	EXPENSES		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
16	a	b	c	d	e	f	g	h
17	**DIRECT COST - PROGRAM STAFFING**		**FTE**	**AMOUNT**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**
18	Physician (MD)/Psychiatrist/MH Nurse Practitioner (NP)						0	0
19	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.)/MH Clinical Nurse Specialist (CNS)						0	0
20	RN, LVN, Psych. Tech.						0	0
21	Mental Health Rehabilitation Specialist						0	0
22	MH Related B.A. or 2 yrs. MH Experience - not licensed						0	0
23	No B.A. or 2 yrs Exp & Student						0	0
24	Other Non-Administrative Program Staff						0	0
25	Administrative Support Program Staff (exclude indirect staff)						0	0
26	Other (Specify)						0	0
27	Other (Specify)						0	0
28	Other (Specify)						0	0
29	**Total Salaries and Wages** (lines 18 - 28)		0	$ -	0	$ -	0	$ -
30	Employee Benefits							0
31	**TOTAL PERSONNEL EXPENSE & FTEs** (lines 29 + 30		0	$ -	0	$ -	0	$ -

32	**DIRECT COST - SERVICES & SUPPLIES**	**NOTE**		**AMOUNT**		**AMOUNT**		**AMOUNT**
33	Conferences							0
34	Client Support Services (provide detail separately)							0
35	Education and Training							0
36	Equipment Leases (not lease purchase)							0
37	Equipment, Purchased and with a Unit Value Under $5,000							0
38	Furniture							0
39	Information Technology/Data Processing							0
40	Insurance-Workers Compensation							0
41	Insurance-Other (Specify)							0
42	Laboratory Services							0
43	Medications							0
44	Office Supplies							0
45	Professional Services - Accounting							0
46	Professional Services - Legal							0
47	Professional Services - Other (Specify)							0
48	Professional Services - Other (Specify)							0
49	Publications							0
50	Subcontracts (provide detail separately)							0
51	Telecommunications							0
52	Travel/Transportation							0
53	Utilities							0
54	Other (Specify)							0
55	Other (Specify)							0
56	Other (Specify)							0
57	**TOTAL SERVICE & SUPPLIES** (lines 33 - 56)			$ -		$ -		$ -
58	**TOTAL DIRECT COST (PERSONNEL, SERVICE, AND SUPPLIES)** (lines 31 + 57)		0	$ -	0	$ -	0	$ -

56	EXPENSES		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
57	a	b	c	d	e	f	g	h
58	**INDIRECT COST**	**NOTE**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**
59	Salaries/Wages and Employee Benefits							
60	Executive Manager						0	0
61	Clinic Manager						0	0
62	Program Manager						0	0
63	Support Staff (clerical/reception)						0	0
64	Other (Specify)						0	0
65	Other (Specify)						0	0
66	Employee Benefits							0
67	Executive/Administrative Office Costs (Specify)							0
68	Advertising/Promotional Expenses							0

69	Capital Equipment (Purchased and with a Unit Value of $5,000 or more) Depreciation							0
70	Capital Equipment (Lease Purchases with a Unit Value of $5,000 or more) Amortization							0
71	Conferences							0
72	Consultants (provide detail separately)							0
73	Education and Training							0
74	Equipment Leases (not lease purchase)							0
75	Equipment, Purchased and with a Unit Value Under $5,000							0
76	Facility Rent/Lease Costs							0
77	Facility (Owned) Costs							0
78	Furniture							0
79	Information Technology/Data Processing							0
80	Insurance-Workers Compensation							0
81	Insurance-Other (Specify)							0
82	Office Supplies							0
83	Professional Services - Accounting							0
84	Professional Services - Legal							0
85	Professional Services - Other (Specify)							0
86	Professional Services - Other (Specify)							0
87	Publications							0
88	Subcontracts (provide detail separately)							0
89	Telecommunications							0
90	Travel/Transportation							0
91	Utilities							0
92	Other (Specify)							0
93	Other (Specify)							0
94	**TOTAL INDIRECT COST** (lines 60 - 93)		0	$ -	0	$ -	0	$ -
95	**INDIRECT COST PERCENTAGE** (lines 94/55%)			#DIV/0!				#DIV/0!

96	**TOTAL COST (DIRECT AND INDIRECT)** (lines 55 + 94)		0	$ -	0	$ -	0	$ -

97	FUNDING/REVENUE PROJECTION		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
98	a	b	c	d	e	f	g	h
99	**REVENUE**	**NOTE**		**AMOUNT**		**AMOUNT**		**AMOUNT**
104	Enter Funded Program or Other Revenue							0
105	Enter Funded Program or Other Revenue							0
106	Enter Funded Program or Other Revenue							0
107	Enter Funded Program or Other Revenue							0
108	Enter Funded Program or Other Revenue							0
109	**TOTAL GROSS REVENUE** (lines 104 - 108)			$ -		$ -		$ -

SCHEDULE 4c. LEGAL ENTITY INDIRECT COST

Cell instructions: → Data entry cells are highlighted.

LEGAL ENTITY INFORMATION			
Legal Entity Name:	0	Legal Entity Number:	0
Submission Date:	January 0, 1900	County Fiscal Year:	0

*This schedule identifies the indirect cost at the Legal Entity level. *Complete one Schedule 4c for the Legal Entity.

	EXPENSES		Proposed or Last Approved Budget		Mid/Partial Year Change + or -		Proposed New/Revised Budget	
	a	b	c	d	e	f	g	h
3	**INDIRECT COST**	**NOTE**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**	**FTE**	**AMOUNT**
4	Salaries/Wages and Employee Benefits							
5	Executive Managers/CEO/COO/CFO/CIO						0	0
6	Other Managers						0	0
7	IT Staff						0	0
8	Accounting Staff						0	0
9	Support Staff (clerical/reception)						0	0
10	Other (Specify)						0	0
11	Other (Specify)						0	0
12	Other (Specify)						0	0
13	Employee Benefits							
14	Health Insurance							0
15	Other Insurances							0
16	Reitrement Plans							0
17	Payroll Taxes							0
18	Other (Specify)							0
19	Other (Specify)							0
20	Other (Specify)							0
21	Executive/Administrative Office Costs (Specify)							0
22	Advertising/Promotional Expenses							0
23	Capital Equipment (Purchased and with a Unit Value of $5,000 or more) Depreciation							0
24	Capital Equipment (Lease Purchases with a Unit Value of $5,000 or more) Amortization							0
25	Conferences							0
26	Consultants (provide detail separately)							0
27	Education and Training							0
28	Equipment Leases (not lease purchase)							0
29	Equipment, Purchased w/ a Unit Value Under $5,000							0
30	Facility Rent/Lease Costs							0
31	Facility (Owned) Costs							0
32	Furniture							0
33	Information Technology/Data Processing							0
34	Insurance-Workers Compensation							0
35	Insurance-Other (Specify)							0
36	Office Supplies							0
37	Professional Services - Accounting							0
38	Professional Services - Legal							0
39	Professional Services - Other (Specify)							0
40	Professional Services - Other (Specify)							0
41	Publications							0
42	Subcontracts (provide detail separately)							0
43	Telecommunications							0
44	Travel/Transportation							0
45	Utilities							0
46	Other (Specify)							0
47	Other (Specify)							
48	Other (Specify)							0
49	**TOTAL INDIRECT COST** (lines 4 - 48)		0	$ -	0	$ -	0	$ -

50	**TOTAL DIRECT COST (from Total of Schedule 4's)**		**INDIRECT COST % (Total Indir Cost/Dir Cost %)**	#DIV/0!

SCHEDULE 5. LEGAL ENTITY MENTAL HEALTH SERVICE PLAN

Cell instructions: Data entry cells are highlighted.

This schedule provides projections of services by IBHIS Plan, MC status, and Age Group for all Provider Sites under the LE for the current fiscal year.
*Please download in NGA Reports File using agency's assigned C# to assist in developing projections along with agency's internal data/records.

1 Submission Date: January 0, 1900

2 County Fiscal Year: 0

3 Legal Entity Name: 0

4 Legal Entity Number 0

Op Code	Provider Name	Provider Number	IS/IBHIS PLAN	Total Unique Clients Served			Unduplicated Client Counts (Use to Determine Non-Medi-Cal & Medi-Cal %s)							FY 21-22 Clients Served by Age Group (Use to Determine FY 22-23 Age Group %s)							Projected Clients by Age Group							
							FY 20-21		FY 21-22		Projected FY 22-23										FY 22-23							
				FY 20-21	FY 21-22 (counts)	FY 22-23 (counts)	Medi-Cal Clients	Non-Medi-Cal Clients	Medi-Cal Clients	Non-Medi-Cal Clients	Medi-Cal Clients (%)	Non-Medi-Cal Clients (%)	Total (should be 100%)	0-15	16-25	26-59	60 and older	UOS	Cost	Cost per Client	0-15 (%)	16-25 (%)	26-59 (%)	60 and older (%)	TOTAL (should be 100%)	UOS	Cost	Cost per Client
			For example:										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program A*	*2001*	*1000 CGF*										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program B*	*2002*	*1000 CGF*										0%							#DIV/0!					0%			#DIV/0!
NGA			*1000 CGF TOTAL*										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program A*	*2001*	*2066 MHSA - FSP*										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program B*	*2002*	*2066 MHSA - FSP*										0%							#DIV/0!					0%			#DIV/0!
NGA			*2066 MHSA - FSP TOTAL*										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program A*	*2001*	*2072 MAT - DMH*										0%							#DIV/0!					0%			#DIV/0!
NGA	*Program B*	*2002*	*2072 MAT - DMH*										0%							#DIV/0!					0%			#DIV/0!
NGA			*2072 MAT - DMH TOTAL*										0%							#DIV/0!					0%			#DIV/0!
NGA			*…*										0%							#DIV/0!					0%			#DIV/0!
NGA			*…*										0%							#DIV/0!					0%			#DIV/0!
NGA			*…*										0%							#DIV/0!					0%			#DIV/0!
NGA													0%							#DIV/0!					0%			#DIV/0!
NGA													0%							#DIV/0!					0%			#DIV/0!
NGA													0%							#DIV/0!					0%			#DIV/0!
NGA													0%							#DIV/0!					0%			#DIV/0!
NGA													0%							#DIV/0!					0%			#DIV/0!
			LE TOTAL										0%							#DIV/0!					0%			#DIV/0!

LE Name: | Subprogram Schd No: | LE No:
Agreement No: | Fin Sum No: | Fiscal Year:
Agreement Period: | Amendment No: | Amendment Date:

A	B	C	D	E	F	G	H	I	J	K
CIOB Rank	**Funded Programs/Subprograms**	**Non-Medi-Cal Funds**			**Medi-Cal (MC) Funds**					
		Direct/ Indirect Service	Manual Invoice	**Non-MC Total (Gross Dollars)**	EPSDT Medi-Cal	Non-EPSDT Medi-Cal	MCHIP	Medicaid Expansion	SB 75	**Medi-Cal Total (Gross Dollars)**
Categorically Funded Programs										
100N	Family Preservation Program			-						-
130N	Specialized Foster Care - DCFS MAT			-						
130.1M	Specialized Foster Care Enhanced MH Svcs									-
130.2M	Specialized Foster Care MAT									-
130.4M	Specialized Foster Care TFC									-
130.3N,M	Specialized Foster Care Wraparound			-						-
300N	DCFS Medical Hub			-						
301M	DCFS PHF									-
140N	Comprehensive SOC Prog (SAMHSA,CFDA#93.958)			-						
142.1N	Project ABC South LA (SAMHSA, CFDA#93.104)			-						
150N	Juvenile Justice Program (STOP)			-						
151N	Juvenile Justice Program (JJCPA-MHSAT)			-						
152N	Juvenile Justice Program (JJCPA - MST)			-						
152.2N,M	Juvenile Justice Program (JJCPA - New Directions)			-						-
153N	Juvenile Justice Program (COD)			-						
154M	Juvenile Justice Program (FFT)			-						-
170N,M	Homeless Program			-						-
172.1N,M	ODR Diversion Programs			-						-
180N	CalWORKs MHS			-						
183N	CalWORKs Homeless Family Solution System			-						
182N	GROW			-						
171N,M	Post-Release Community Supervision-CRP			-						-
310N	DPH Dual Diagnosis			-						
350N	DCSS Forensic Center Services			-						
210N,M	DHS EPIC Program			-						-
220N,M	Measure H Housing Supportive Services Program			-						-
230N,M	Children's Outreach & Triage Team (COTT)			-						-
231N,M	Outreach & Triage Team (OTT)			-						-
240N	CARES Act Invoice (CFDA #21.019)			-						-
Federal/State Revenue										
360M	Federal/State Revenue									-
Realignment Funded Programs										
400N,M	DMH Mental Health Services			-						-
	DMH MH Services - STRTP			-						-
	DMH MH Services - Aftercare			-						-
	DMH MH Services - TSCF			-						-
	DMH MH Services - ISFC			-						-
340N,M	DMH IMD Step Down			-						-
MHSA Funded Programs										
500N,M	MHSA Full Service Partnership (FSP)			-						-
	MHSA FSP Incentive			-						-
511N,M	MHSA Outpatient Care Services			-						-
531N,M	MHSA Alternative Crisis Services			-						-
540N,M	MHSA OCS -Housing Supportive Services Program			-						-
810N	MHSA Linkage Services Invoice			-						
820N	MHSA Planning, Outreach, & Engagement			-						
600N,M	MHSA Prevention & Early Intervention (PEI)									
	MHSA PEI Special Programs									
	MHSA PEI Flex Funds			-						-
	MHSA PEI Training									
	MHSA PEI Court Diversion									
	Subtotal	-	-	-	-	-	-	-	-	-
Maximum Contract Amount		**$0**								

*FY19-20 PHF allocation included in Rank 400N,M DMH Mental Health Services

v3/9/2020

SCHEDULE 7. LEGAL ENTITY BUDGET SUMMARY BY PROVIDER NUMBER

1 Submission Date: January 0, 1900
2 County Fiscal Year: 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

This Schedule summarizes and provides the Legal Entity's funded programs and allocated amounts by Provider Site.

*Enter the provider number in columns b - r on row 5. Then using the dropdown menu in column A to indicate the funded programs and allocated budgets for each Provider Site.

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o
5	**Provider Number** / **Funded Program (Drop down)**														
6	Choose from the dropdown list														
7	Choose from the dropdown list														
8	Choose from the dropdown list														
9	Choose from the dropdown list														
10	Choose from the dropdown list														
11	Choose from the dropdown list														
12	Choose from the dropdown list														
13	Choose from the dropdown list														
14	Choose from the dropdown list														
15	Choose from the dropdown list														
16	Choose from the dropdown list														
17	Choose from the dropdown list														
18	Choose from the dropdown list														
19	Choose from the dropdown list														
20	Choose from the dropdown list														
21	Choose from the dropdown list														
22	Choose from the dropdown list														
23	Choose from the dropdown list														
24	Choose from the dropdown list														
25	Choose from the dropdown list														
26	Choose from the dropdown list														
27	Choose from the dropdown list														
28	Choose from the dropdown list														
29	Choose from the dropdown list														
30	Choose from the dropdown list														
31	Choose from the dropdown list														
32	Choose from the dropdown list														
33	Choose from the dropdown list														
34															
35															
36	Subtotal (DMH)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
37	Client, Third Party and Other Non-County Revenue														
38	Total by Provider Number	-	-	-	-	-	-	-	-	-	-	-	-	-	-