TRANSMITTAL LETTER

Data entry cells are highlighted

Submission Date:

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

RE: Legal Entity Name:

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

Contractor Certification:

Enclosed herewith is the completed Contract Negotiation Package for the organization and fiscal year(s) period(s) shown on Form 2 *Contract Application*. 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

Department of Mental Health Program Certification:

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

Signed Program/Bureau District Chief Approval Date

Type/Print Name of Signer

Signed Deputy Director Approval Date

Type/Print Name of Signer

Department of Mental Health Contracts Development and Administration Certification:

We have reviewed the proposed Maximum Contract Amount and it complies with the Department's proposed allocation for the Contract:

Signed CDAD Contract Administrator (including Supervisor's Initials) Date

Type/Print Name of Signer

Signed Approved by Chief of Contracts for Department of Mental Health Date

Type/Print Name of Signer

LEGAL ENTITY CONTRACT INFORMATION SHEET Attach to Form 1

Cell instructions: Data entry cells are highlighted.
(unprotect pass word is dmh in small case)

1 Submission Date: January 0, 1900

2 County Fiscal Year(s): _____ FY(s) applicable for the Neg. Pkg

3 Reason for Proposal (check the following for Contract Renewal, Contract Amendment or Solicitation Proposal:

4 Contract Renewal (√): _____ Contract Amendment (√): _____ Solicitation (√): _____

Contract Supersession (√): _____

5 Request Period (check the following for Full Fiscal Year or Mid-Year/Partial Year Change:

6 Full Fiscal Year (✓): _____

7 Mid-Year/Partial Year Change (Enter effective period of change (mm/dd/yy to June 30, yyyy)):

8 Legal Entity Name (As appears on the organization's Articles of Incorporation):
0

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

10 Legal Entity Number (if assigned by County, otherwise enter TBD (To be Determined): _____

11 Federal Nine-Digit Tax Identification Number for the organization: _____

12 Address of administrative headquarters or main office:

13 a Street Number and Name: _____

14 b Room or Suite Number (if any): _____

15 c City/State/Zip Code: _____

16 Organization status is: Not For Profit (check): _____ For Profit (check): _____

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

18 Contact Person: _____ Responsible to communicate with DMH

19 a Title: _____

20 b Telephone No.: _____ Fax No.: _____

21 c e-mail Address: _____

22 d Website: _____

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

24 Please list contracts with other Los Angeles County departments:

Department Name:	Contract Term:	Contract Type/Service:

Please check if the Legal Entity is:

25 ☐ consumer owned and operated

26 ☐ provider of primary health care

27 ☐ provider of substance abuse services

28 ☐ FQHC

29 ☐ FQHC Look-alike

LEGAL ENTITY PROVIDER SITES OPERATING DAYS AND HOURS

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

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

Cell format for columns e through ff is h:mm so enter the hour followed by a colon followed by the minutes (i.e., 8:15)

(If the facility is open 24 hours per day and 7 days a week enter a check (√ or x) in column d and do not complete columns e through ff for that facility)

	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	bb	cc	dd	ee	ff
5	SERVICE FACILITY BY PROVIDER SITE (Report the facility's open hours in columns e - ff. Check column b if the facility is a satellite site. Check column c if the facility is ADA compliant. Check column d if the facility is open 24/7 and do not complete e - ff)		Check if facility is a Satellite Site	Check if facility is ADA compliant	Check if facility is open 24/7	MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY				SUNDAY			
						OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE	
	PROV #	FACILITY NAME				AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
6																																	
7																																	
8																																	
9																																	
10																																	
11																																	
12																																	
13																																	
14																																	
15																																	
16																																	
17																																	
18																																	
19																																	
20																																	
21																																	
22																																	
23																																	
24																																	
25																																	
26																																	
27																																	

LEGAL ENTITY PROVIDER SITES SERVICE CAPACITY

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

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

This Schedule is to report various service site capacities including language, age-group, target population, and other specialty service capabilities by provider number location(s) funded under the County mental health contract.
For each provider site, enter a check (√ or x) under columns d - xx if the site has the capacity to provide said provision/service. Use extra space (e.g., col. s - u) to list additional capacity.

	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
					THRESHOLD LANGUAGES													NON-THRESHOLD LANGUAGES					AGE-GROUP				
5	PROV NO.	FACILITY NAME	Service Area	Supervisor Dist	Armenian	Arabic	Cantonese	Other Chinese	Cambodian	English	Farsi	Korean	Mandarin	Russian	Spanish	Tagalog	Vietnamese	American /Other Sign Language					0 - 5	5 - 15	16 - 25	26 - 59	60 +
6																											
7																											
8																											
9																											
10																											
11																											
12																											
13																											
14																											
15																											
16																											
17																											
18																											
19																											
20																											
21																											
22																											
23																											
24																											
25																											
26																											

LEGAL ENTITY PROVIDER SITES SERVICE CAPACITY

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

1 Submission Date: 1/0/1900

2 County Fiscal Year: 0

3 Legal Entity Name: 0

4 Legal Entity Number: 0

	a		aa	bb	cc	dd	ee	ff	gg	hh	ii	jj	kk	ll	mm	nn	oo	pp	qq	rr	ss	tt	uu	vv	ww	xx
			SPECIALTY POPULATION										SPECIALTY SERVICES										OTHER			
5	PROV NO.	FACILITY NAME																								
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
16																										
17																										
18																										
19																										
20																										
21																										
22																										
23																										
24																										
25																										
26																										

LEGAL ENTITY COVERED SERVICES BY PROVIDER SITE/NUMBER

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

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

This Schedule is to report services/activities rendered at the provider site (provider number location) funded under the County mental health contract.
For each provider site, enter a check (√ or x) under columns d - rr to indicate the services/activities provided at the site. Use extra space in columns ss - vv to list additional capacity.

	a		b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x
					OUTPATIENT SERVICES							OUTREACH		SUPPORT SVCS				DAY SERVICES							
5	PROV NO.	FACILITY NAME	Service Area	Supervisor District	Targeted Case Management	Collateral	Psychological Testing	Mental Health Services	Therapeutic Behavioral Svc	Medication Support Svc	Crisis Intervention	Mental Health Promotion	Community Client Svc	Public Guardian Investigation	Public Guardian Admin	Life Support	Case Mgmt Support	Crisis Stabilization(ER)	Crisis Stabilization(UC)	Vocational	Socialization Day Svc	Day Treatment Int, Half Day	Day Treatment Int, Full Day	Day Rehab, Half Day	Day Rehab, Full Day
					15/4	15/10	15/34	15/40-59	15/58	15/62	15/77	45/10	45/20	60/20	60/30	60/40	60/60	10/24	10/25	10/31	10/41	10/82	10/85	10/92	10/98
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
16																									
17																									
18																									
19																									
20																									
21																									
22																									
23																									
24																									
25																									

LEGAL ENTITY COVERED SERVICES BY PROVIDER SITE/NUMBER

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted

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

	a		y	z	aa	bb	cc	dd	ee	ff	gg	hh	ii	jj	kk	ll	mm	nn	oo	pp	qq	rr	ss	tt	uu	vv
			24 HOUR SERVICES																				OTHER			
5			Acute Gen. Hospital	Psych Hosp Forensic	Psych Hosp 21 or under	Admin Day	Psychiatric Health Facility	SNF Acute Intensive	IMD w/o Patch	IMD w/ Patch	IMD w/ Patch MIO	IMD w/ Patch Indigent MIO	IMD Forensic Ind/Pass Day	Crisis Residential	Forensic Inpatient	Trans Res Non Medi-Cal	Residential Pass Day	Transitional Residential	Trans Res Long Term	Semi-Sup Living	Independent Living	MH Rehab Center				
	PROV NO.	FACILITY NAME	5/10-18			5/19	5/20	5/30	5/35	5/36-39				5/43	5/50	5/60	5/62	5/65	5/70	5/80	5/89	5/90				
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
16																										
17																										
18																										
19																										
20																										
21																										
22																										
23																										
24																										
25																										

PROVIDER SITE BUDGET

(unprotect pass word is dmh in small case)
Cell instructions: → Data entry cells are highlighted.

1 SUBMISSION DATE: January 0, 1900 2 COUNTY FISCAL YEAR(s): 0

3a LEGAL ENTITY NAME: 0 3b LEGAL ENTITY NUMBER: 0

4a PROVIDER NUMBER: 4b FACILITY NAME:

5a PROVIDER SITE ADDRESS: 5b CITY:

5c STATE: 5d ZIP CODE: 6 TELEPHONE #:

Enter only one Provider Number description into the highlighted cell. Schedule 6 is the budget for the identified Provider Site (Provider Number) including Satellite Site(s), if applicable. Use a separate Schedule 6 for each Provider Site.

7 HEAD OF SERVICE: 8 SERVICE AREA: 9 SUPERVISOR DISTRICT:

10	AN ERROR HAS OCCURRED IF A NUMBER APPEARS IN ANY OF THE ADJACENT THREE (3) CELLS. THE BUDGET EXPENSES AND REVENUES MUST BE EQUAL FOR A BALANCED BUDGET. IF NOT EQUAL AN AMOUNT OTHER THAN "-" WILL APPEAR.	-	-	-

EXPENSES:

	a	b	c	d	e	f	g	h
11	**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 cell as a percent of the Total Direct program Budget (col g line cells divided by col g, line 31)
	Budgeted Positions by License/Degree	FTE	AMOUNT	FTE	AMOUNT	FTE (b+d)	AMOUNT (c+e)	
12	Physician (MD)/Psychiatrist/MH Nurse Practitioner (NP)					-	-	-
13	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.)/MH Clinical Nurse Specialist (CSN)					-	-	-
14	RN, LVN, Psych. Tech.					-	-	-
15	MH Rehabilitation Specialist					-	-	-
16	Mental Health Related B.A. or 2 yrs. MH Experience - not licensed					-	-	-
17	No B.A. or 2 yrs Exp & Student					-	-	-
18	Other Non-Administrative Program Staff					-	-	-
19	Administrative Support Program Staff (exclude indirect staff)					-	-	-
20	**Total Salaries and Wages** (lines 12:19)		-		-		-	-
21	Employee Benefits						-	-
22	**TOTAL PERSONNEL EXPENSE & FTEs** (lines 20 + 21)	-	-	-	-	-	$ -	-
23	**PROGRAM SERVICES AND SUPPLIES**							
24	Equipment, Purchased with a Unit Value $5,000 or more						-	-
25	Facilities and/or Improvements, Purchased with a Unit Value $5,000 or more						-	-
26	One-Time Expenses						-	-
27	Professional Services - Clinical/Program						-	-
28	Subcontracts (program/clinical personnel)						-	-
29	All Other Services and Supplies						-	-
30	**TOTAL SERVICES AND SUPPLIES** (sum lines 24:29)		-		-		$ -	-
31	**TOTAL PERSONNEL & SERVICES/SUPPLIES EXPENSES** (lines 22 + 30)		-		-		$ -	
32	**INDIRECT ADMINISTRATIVE OVERHEAD** (Attributed to the general administration.						$ -	-
33	**TOTAL GROSS PROVIDER SITE and INDIRECT EXPENSES** (line 22 for FTE count and lines 31 + 32 for dollar amounts)	-	-	-	-	-	$ -	

PROVIDER SITE BUDGET

(unprotect pass word is dmh in small case)
Cell instructions: → Data entry cells are highlighted.

1 SUBMISSION DATE: January 0, 1900 2 COUNTY FISCAL YEAR(s): 0

3a LEGAL ENTITY NAME: 0 3b LEGAL ENTITY NUMBER: 0

4a PROVIDER NUMBER: 4b FACILITY NAME:

5a PROVIDER SITE ADDRESS: 5b CITY:

5c STATE: 5d ZIP CODE: 6 TELEPHONE #:

Enter only one Provider Number description into the highlighted cell. Schedule 6 is the budget for the identified Provider Site (Provider Number) including Satellite Site(s), if applicable. Use a separate Schedule 6 for each Provider Site.

7 HEAD OF SERVICE: 8 SERVICE AREA: 9 SUPERVISOR DISTRICT:

FUND/REVENUE SOURCES (gross dollar amounts by Funded Programs from LE Agreement Financial Summary):

	a	b	c	d	e	f	g	h
34	**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 33)
35	Enter Funded Program Name/Gross Amount						-	-
36	Enter Funded Program Name/Gross Amount						-	-
37	Enter Funded Program Name/Gross Amount						-	-
38	Enter Funded Program Name/Gross Amount						-	-
39	Enter Funded Program Name/Gross Amount						-	-
40	Enter Funded Program Name/Gross Amount						-	-
41	Enter Funded Program Name/Gross Amount						-	-
42	Enter Funded Program Name/Gross Amount						-	-
43	Enter Funded Program Name/Gross Amount						-	-
44	Enter Funded Program Name/Gross Amount						-	-
45	Enter Funded Program Name/Gross Amount						-	-
46	Enter Funded Program Name/Gross Amount						-	-
47	Enter Funded Program Name/Gross Amount						-	-
48	Enter Funded Program Name/Gross Amount						-	-
49	Enter Funded Program Name/Gross Amount						-	-
50	Enter Funded Program Name/Gross Amount						-	-
51	Enter Funded Program Name/Gross Amount						-	-
52	Enter Funded Program Name/Gross Amount						-	-
53	Enter Funded Program Name/Gross Amount						-	-
54	Enter Funded Program Name/Gross Amount						-	-
55	Enter Funded Program Name/Gross Amount						-	-
56	Enter Funded Program Name/Gross Amount						-	-
57	Enter Funded Program Name/Gross Amount						-	-
58	Enter Funded Program Name/Gross Amount						-	-
59	Enter Funded Program Name/Gross Amount						-	-
60	Enter Funded Program Name/Gross Amount						-	-
61	Enter Funded Program Name/Gross Amount						-	-
62	Enter Funded Program Name/Gross Amount						-	-
63	**Total Proposed Maximum Amount** (sum lines 35:62)		-		-		$ -	-
64	**Client, Third Party and Other Non-County Revenues:**							
65	Client Fees						-	-
66	Insurance						-	-
67	Interest (on any funds associated with any of the funds lines 35:62)						-	-
68	Medicare						-	-
69	Enter Other Revenues						-	-
70	Enter Other Revenues						-	-
71	Enter Other Revenues						-	-
72	**Total Client, Third Party and Other Revenue** (sum lines 65:71)		-		-		$ -	-
73	**TOTAL GROSS REVENUES** (lines 63 + 72)		-		-		$ -	-

LEGAL ENTITY BUDGET SUMMARY

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

This schedule is to report funded programs and amounts by provider site (provider number location) funded under the County mental health contract.

Enter the provider number in columns b - r on row 5. Then using the dropdown menu in column A, indicate the funded program and amount funding such provider site.

	a	b	c	d	e	f	g	h	i	j
5	Provider Number / Funded Program (Drop down)									
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35	Total by Provider Number	-	-	-	-	-	-	-	-	-

LEGAL ENTITY BUDGET SUMMARY

Submission Date: 1/0/1900
County Fiscal Year: 0
Legal Entity Name:
Legal Entity Number: 0

a	k	l	m	n	o	p	q	r	s
Provider Number / Funded Program (Drop down)									Funded Prog Total
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
									-
Total by Provider Number	-	-	-	-	-	-	-	-	-

LEGAL ENTITY MENTAL HEALTH SERVICES PLAN

1 Submission Date: 1/0/1900
2 County Fiscal Year(s): 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

5	A. Legal Entity Level	Srvc Area	Sup. District	Non-Medi-Cal[1]	Row Percent	Non-EPSDT MC[2]	Row Percent	MCE[3]	Row Percent	EPSDT MC[4]	Row Percent	SCHIP[5]	Row Percent	Total	Row Percent
6	Unique Clients Served	N/A	N/A		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
7	Units				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
8	Dollars				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!

9	B. Provider Level	Srvc Area	Sup. District	Non-EPSDT/ Non- MC[1]	Row Percent	Non-EPSDT MC[2]	Row Percent	MCE[3]	Row Percent	EPSDT MC & SCHIP[4]	Row Percent	SCHIP[5]	Row Percent	Total	Row Percent
10	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
11				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
12				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
13	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
14				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
15				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
16	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
17				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
18				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
19	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
20				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
21				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
22	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
23				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
24				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
25	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
26				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
27				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######
28	(Provider No.) Provider Site Name			Clients	######	Clients	######	Clients	######	Clients	######	Clients	######	#VALUE!	######
29				Units	######	Units	######	Units	######	Units	######	Units	######	#VALUE!	######
30				Dollars	######	Dollars	######	Dollars	######	Dollars	######	Dollars	######	#VALUE!	######

Insert as many as needed

[1]Individuals who are not eligible for Short-Doyle/Medi-Cal, Medi-Cal Expansion, EPSDT or State Children's Health Insurance Program.
[2]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.
[3]Beneficiaries eligible for Medi-Cal coverage expansion under the Affordable Care Act
[4]Beneficiaries eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
[5]Title XXI State Children's Health Insurance Program (formerly Healthy Families)

Schedule 9 - Subprogram Schedule

Contractor Name:
Legal Entity Number:
Fiscal Year:

DMH Legal Entity Agreement
The Financial Summary -
Amendment Number -

A	B	C	D	E	F		G				H
					Non-Medi-Cal Funds		Medi-Cal Funds (Gross)				
Rank	Funded Program	Subprogram	IS Plan	Medi-Cal Reimbursable (Y/N)[1]	Direct/ Indirect Srvcs (IS)	Manual Invoice	EPSDT Medi-Cal	Non-EPSDT Medi-Cal	SCHIP (Healthy Families)	Medicaid Expansion (MCE)	Subprogram Amount (Gross Dollars)
CATEGORICALLY FUNDED PROGRAMS (100-399)											
100N	Family Preservation Program	Family Preservation Program	2011	N							$ -
		Healthy Way LA	NA	N							$ -
130N	Specialized Foster Care - DCFS MAT (Non Full Scope Medi-Cal)	Specialized Foster Care - Child Welfare Services DCFS MAT (Non Medi-Cal)	2077	N							$ -
130M	Specialized Foster Care - Child Welfare Services (Medi-Cal)	Enhanced Mental Health Services	2064	Y							$ -
		MAT	2072	Y							$ -
		Wraparound	2079	Y							$ -
131N	Group Home Aftercare Services (Non Medi-Cal)	Group Home Aftercare Services (Non Medi-Cal)	2135	N							$ -
131M	Group Home Aftercare Services (Medi-Cal)	Group Home Aftercare Services (Medi-Cal)	2135	Y							$ -
132N	First 5 (Non Medi-Cal)	First 5 (Non Medi-Cal)	2137	N							$ -
132M	First 5 (Medi-Cal)	First 5 (Medi-Cal)	2137	Y							$ -
140N	Comprehensive SOC Program (SAMHSA, CFDA #93.958)	Comprehensive SOC Program (SAMHSA, CFDA #93.958)	2035	N							$ -
141N	Child MH Initiative-Project ABC (SAMHSA, CFDA #93.104)	Child MH Initiative-Project ABC (SAMHSA, CFDA #93.104)	None	N							$ -
142N	Family Wellness Network (SAMHSA, CFDA #93.243)	Family Wellness Network (SAMHSA, CFDA #93.243)	None	N							$ -
150N	Juvenile Justice Program (STOP)	Juvenile Justice Program (STOP)	2027	N							$ -
151N	Juvenile Justice Program (JJCPA -- MHSAT)	Juvenile Justice Program (JJCPA -- MHSAT)	2024	N							$ -
152N	Juvenile Justice Program (JJCPA -- MST)	Juvenile Justice Program (JJCPA -- MST)	2049	N							$ -
153N	Juvenile Justice Program (Co-occurring Disorder)	Juvenile Justice Program (Co-occurring Disorder)	2081	N							$ -
154N	Juvenile Justice Program (FFT) Non Medi-Cal	Second Chance FFT Program	2123	N							$ -
		Juvenile Justice Program (FFT)	2071	N							$ -
154M	Juvenile Justice Program (FFT) Medi-Cal	Juvenile Justice Program (FFT)	2071	Y							$ -
160N	PATH McKinney, CFDA #93.150	PATH McKinney, CFDA #93.150	2023	N							$ -
170N	Homeless Services (Non Medi-Cal)	Homeless Services (Non Medi-Cal)	2089	N							$ -
		Healthy Way LA	NA	N							$ -
170M	Homeless Services (Medi-Cal)	Homeless Services (NCC) Medi-Cal	2089	Y							$ -
171N	Post-Release Community Supervision-Community Reintegration (PRCSCR) Program (Non Medi-Cal)	PRCSCR Program (Non Medi-Cal)	2134	N							$ -
		Healthy Way LA	NA	N							$ -
171M	Post-Release Community Supervision-Community Reintegration (PRCSCR) Program (Medi-Cal)	PRCSCR Program (Medi-Cal)	2134	Y							$ -
180N	CalWORKs	CalWORKs Mental Health Services	2006	N							$ -
		Community Outreach Services	2006	N							$ -
181N	CalWORKs Homeless Family Project	CalWORKs Homeless Family Project	2040	N							$ -
		Community Outreach Services	2040	N							$ -
182N	GROW	GROW	2013	N							$ -
190N	PES Relief Plan (Non Medi-Cal)	PES Relief Plan (Non Medi-Cal)	2045	N							$ -
		Healthy Way LA	NA	N							$ -
190M	PES Relief Plan (Medi-Cal)	PES Relief Plan (Medi-Cal)	2045	Y							$ -
300N	DCFS Medical Hubs (VIP)	DCFS Medical Hubs	2044	N							$ -
301M	DCFS Starview PHF	DCFS Starview PHF	2038	Y							$ -
302N	DCFS Independent Living (Hillview)	DCFS Independent Living (Hillview)	2039	N							$ -
303N	DCFS THP (HFLF)	DCFS THP (HFLF)	2039	N							$ -
304M	DCFS - 2011 Realignment	DCFS - 2011 Realignment	new	Y							$ -
310N	DHS Social Model (Dual Diagnosis)	DHS Social Model (Dual Diagnosis)	2010	N							$ -
311N	DHS LAMP (Dual Diagnosis)	DHS LAMP (Dual Diagnosis)	2010	N							$ -
312N	DHS BHS (Dual Diagnosis)	DHS BHS (Dual Diagnosis)	2010	N							$ -
		Healthy Way LA	NA	N							$ -
320N	Juvenile Justice Program/Title IV-E - MST (Non Medi-Cal)	Juvenile Justice Program/Title IV-E - MST (Non-Medi-Cal)	2127	N							$ -
320M	Juvenile Justice Program/Title IV-E - MST (Medi-Cal)	Juvenile Justice Program/Title IV-E - MST (Medi-Cal)	2127	Y							$ -
330N	Other Employment Services/CCJCC (SSG)	Other Employment Services/CCJCC (SSG)	None	N							$ -
340N	CGF IMD Step Down (Non Medi-Cal)	CGF IMD Step Down (Non Medi-Cal)	2119	N							$ -
340M	CGF IMD Step Down (Medi-Cal)	CGF IMD Step Down (Medi-Cal)	2119	Y							$ -
FEDERAL/STATE (360)											
360M	Federal/State Revenue	Federal/State Revenue	2082	Y							$ -
CGF FUNDED PROGRAMS (400-499)											
400N	DMH (Non Medi-Cal Services)	DMH Mental Health Services (Non Medi-Cal)	1000	N							$ -
		Healthy Way LA	NA	N							$ -
400M	DMH (Medi-Cal Services)	DMH Mental Health Services (Medi-Cal)	1000	Y							$ -

A	B	C	D	E	F		G				H
					Non-Medi-Cal Funds		Medi-Cal Funds (Gross)				
Rank	Funded Program	Subprogram	IS Plan	Medi-Cal Reimbursable (Y/N)[1]	Direct/ Indirect Srvcs (IS)	Manual Invoice	EPSDT Medi-Cal	Non-EPSDT Medi-Cal	SCHIP (Healthy Families)	Medicaid Expansion (MCE)	Subprogram Amount (Gross Dollars)
MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS (500-899)											
500N	Full Service Partnerships (Non Medi-Cal)	Child FSP - Family Support Services	2050	N							$ -
		Child FSP (Non Medi-Cal)	2047	N							$ -
		TAY FSP (Non Medi-Cal)	2051	N							$ -
		Adult FSP (Non Medi-Cal)	2054	N							$ -
		Older Adult FSP (Non Medi-Cal)	2057	N							$ -
		Healthy Way LA	NA	N							$ -
500M	Full Service Partnerships (Medi-Cal)	Child FSP (Medi-Cal)	2047	Y							$ -
		TAY FSP (Medi-Cal)	2051	Y							$ -
		Adult FSP (Medi-Cal)	2054	Y							$ -
		Older Adult FSP (Medi-Cal)	2057	Y							$ -
		Child Wraparound (Medi-Cal)	2107	Y							$ -
		TAY Wraparound (Medi-Cal)	2114	Y							$ -
510N	Field Capable Clinical Services (FCCS) Non Medi-Cal	Child FCCS (Non Medi-Cal)	2058	N							$ -
		TAY FCCS (Non Medi-Cal)	2078	N							$ -
		Adult FCCS (Non Medi-Cal)	2052	N							$ -
		Adult FCCS - Service Extenders	None	N							$ -
		Older Adult FCCS (Non Medi-Cal)	2070	N							$ -
		Older Adult FCCS - Service Extenders	None	N							$ -
		Healthy Way LA	NA	N							$ -
510M	Field Capable Clinical Services (FCCS) Medi-Cal	Child FCCS (Medi-Cal)	2058	Y							$ -
		TAY FCCS (Medi-Cal)	2078	Y							$ -
		Adult FCCS (Medi-Cal)	2052	Y							$ -
		Older Adult FCCS (Medi-Cal)	2070	Y							$ -
520N	Wellness Centers (Non Medi-Cal)	Wellness/Client-Run Centers (Non Medi-Cal)	2068	N							$ -
		Healthy Way LA	NA	N							$ -
520M	Wellness Centers (Medi-Cal)	Wellness/Client-Run Centers (Medi-Cal)	2068	Y							$ -
530N	Alternative Crisis Services (Non Medi-Cal)	Enriched Residential Services (Non Medi-Cal)	2060	N							$ -
		Urgent Care Center (Non Medi-Cal)	2062	N							$ -
		Healthy Way LA	NA	N							$ -
530M	Alternative Crisis Services (Medi-Cal)	Enriched Residential Services (Medi-Cal)	2060	Y							$ -
		Urgent Care Center (Medi-Cal)	2062	Y							$ -
540N	IMD Step-Down (Non Medi-Cal)	IMD Step Down (Non Medi-Cal)	2056	N							$ -
		Healthy Way LA	NA	N							$ -
540M	IMD Step-Down (Medi-Cal)	IMD Step Down (Medi-Cal)	2056	Y							$ -
600N	Prevention & Early Intervention Programs (PEI) Non Medi-Cal	PEI - Children (Non Medi-Cal)	2098	N							$ -
		PEI - TAY (Non Medi-Cal)	2101	N							$ -
		PEI - Adult (Non Medi-Cal)	2092	N							$ -
		PEI - Older Adult (Non Medi-Cal)	2093	N							$ -
		PEI - Training	None	N							$ -
		PEI - Technical Assistance	None	N							$ -
		PEI - Special Programs (Non Medi-Cal)	2091	N							$ -
600M	Prevention & Early Intervention Programs (PEI) Medi-Cal	PEI - Children (Medi-Cal)	2098	Y							$ -
		PEI - TAY (Medi-Cal)	2101	Y							$ -
		PEI - Adult (Medi-Cal)	2092	Y							$ -
		PEI - Older Adult (Medi-Cal)	2093	Y							$ -
		PEI - Special Programs (Medi-Cal)	2091	Y							$ -
700N	Innovation (Non Medi-Cal)	Integrated Mobile Health Team (IMHT)	2130	N							$ -
		Integrated Services Management Model (ISM)	2129	N							$ -
		Integrated Clinic Model (ICM)	2128	N							$ -
		Integrated Peer-Run Model - Community Outreach Services	2132	N							$ -
		Healthy Way LA	NA	N							$ -
700M	Innovation (Medi-Cal)	Integrated Mobile Health Team (IMHT)	2130	Y							$ -
		Integrated Services Management Model (ISM)	2129	Y							$ -
		Integrated Clinic Model (ICM)	2128	Y							$ -
800N	Probation Camps	Probation Camp Program	2053	N							$ -
810N	Jail Transition & Linkage	Jail Transition & Linkage	None	N							$ -
820N	Planning, Outreach & Engagement	Planning, Outreach & Engagement	2084	N							$ -
	Maximum Contract Amount				0	0	0	0	0	0	$ -

[1]Medi-Cal reimbursable reflects DMH program guidelines in addition to applicable state and federal regulation

v11/21/13