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INSTRUCTIONS

The following instructions are provided for your reference. Please contact the Behavioral Health and Recovery Services Division if you have any questions or need further assistance to complete the Self-Audit.

Note: the Agency Information section must contain original signatures.

All sections, including the Agency Information with original signatures, are due to Behavioral Health and Recovery Services by 3:00pm, Friday, February 12, 2021.

Instructions
1. Before you begin, please review each page of the Provider Self-Audit. Ensure that you understand each of the questions/items and that each objective for the respective program or service is complete and consistent with your agency’s current Agreement with the County of Marin.

Complete each Section according to the instructions. Please respond to narrative questions thoroughly and completely. Do not enter any information in the "Reviewed" Column on each page. The County will use this action to verify review of relevant documentation.

After the Provider Self-Audit is completed, please be sure that the Executive Director/Agency Leader and the Chair of your agency’s Board of Directors, as well as the staff member who is responsible for providing the data/information for the Self-Audit, signs the ‘Assurances’ on the ‘Agency Information’ portion of the Self-Audit. These signatures will assure that the information contained in this Self-Audit is complete and correct.

2. Copies of all documents referenced herein must be made available at the Site Visit, as requested, during the follow-up Site Visit that is scheduled to take place in February or March of 2020.

This year, the Provider Self-Audit consists of the following sections:
RESOURCES INFORMATION

Agency Information
This section includes general Professional Services Contract information, State Department of Health Care Services Information, additional key staffing and significant changes, and assurance signatures for each Agreement with the County. All providers are required to complete this section. For agencies with multiple contracts or programs, please submit the ‘Agency Information’ portion for EACH contract. You may complete and submit one (1) copy of the remaining Sections of the Self-Audit as long as the information is the same across programs/contracts.

County of Marin Professional Services Contract (PSC), Applicable Laws and Regulations Compliance
All providers are required to complete this section. This section includes a number of questions and statements that correspond with the County of Marin’s Professional Services Contract, applicable laws and regulations.

Drug/Medi-Cal (D/MC) or Substance Abuse Prevention and Treatment Block Grant (SABG) Treatment Regulation Compliance
Providers that offer substance use treatment services are required to complete this section. This section includes information on DMC and SABG treatment services, certifications, access, assessments, care coordination, EBPs, utilization review, clinical documentation, claims, data collection, etc.

Staff Certification and Training Log
Treatment Providers are required to complete this section.

Medication Assisted Treatment (MAT)
All providers except for prevention providers are required to complete this section.

Perinatal Services Compliance
Providers that receive Residential Women & Children, and SABG Block Grant Perinatal Set-Aside Funds are required to complete this section. If you are uncertain if you are required to complete this section, please contact your contract manager.
Adolescent Services Compliance
Providers that receive funding to provide Adolescent Treatment services are required to complete this section. If you are uncertain if you are required to complete this section, please contact your contract manager.

Tobacco Policy Checklist
Treatment and Sober Living Environment Providers are required to complete this section.

Primary Prevention Regulation Compliance
Providers that receive primary prevention funds are required to complete this section.

Sober Living Environments
Sober Living Environment Providers are required to complete this section.

Policies and Procedures
All providers are required to complete this section, as applicable. See section for additional information.

Self-Audit Checklist
This is a summary intended to assist with Self-Audit submission.
PROVIDER SELF-AUDIT SECTIONS

Providers are to complete the following sections:

Note: Treatment providers are defined as agencies or individuals who provide the following services: outpatient, intensive outpatient, withdrawal management, residential, or opioid treatment / narcotic treatment services.

A. All Providers
   i. Agency Information
   ii. Professional Services Contract
      a. Service Standards
      b. Equity and Inclusion
   iii. Policies and Procedure (as applicable)

B. Treatment Providers
   i. Drug/Medi-Cal and SABG Treatment Regulation Compliance
   ii. Medication Assisted Treatment
   iii. Perinatal Services Compliance (if applicable)
   iv. Adolescent Services Compliance (if applicable)
   v. Staff Certification and Training
   vi. Tobacco Policy Checklist

C. Sober Living Environments
   i. Sober Living Environment Compliance
   ii. Medication Assisted Treatment
   iii. Tobacco Policy Checklist

D. Prevention Providers
   i. Primary Prevention

E. Other
   i. Contact your Contract Manager
## SELF-AUDIT CHECKLIST

### Agency Information Section

**Signed Assurances**
- N/A
- Completed

### Professional Services Contract Section

**Service Standards Subsection**
- N/A
- Completed

**Equity and Inclusion Subsection**
- N/A
- Completed

### DMC and SABG Treatment Regulation

- N/A
- Completed

### Staff Certification and Training Section

**Staff Certification and Training Log**
- N/A
- Completed

### Medication Assisted Treatment Section (MAT)

**Medication Assisted Treatment**
- N/A
- Completed

### Perinatal Service Compliance

- N/A
- Completed

### Adolescent Treatment Service Compliance

- N/A
- Completed

### Tobacco Policy Checklist

- N/A
- Completed

### Sober Living Environments (SLE) Section

**Sober Living Environments**
- N/A
- Completed

**Recovery Residence (RR) Only**
- N/A
- Completed

### Primary Prevention Section

**Primary Prevention**
- N/A
- Completed

### Policies and Procedure Section

**Policies and Procedures (attachments)**
- N/A
- Completed
AGENCY INFORMATION

GENERAL INFORMATION

Agency Name:  
Program Name:  
Contract Number: BHRS-AD- xx -20-21
Contractor Type (check one):
☐ Non-Profit Agency
☐ Private For-Profit Agency
☐ Independent Contractor
☐ Religious Provider
☐ Other

STATE DEPARTMENT OF HEALTH CARE SERVICES INFORMATION

Provider Number:  
Date of Last DHCS Site Visit:  
Certification Date:  
License Date:  
Drug/Medi-Cal Certification Date:  
☐ Copy of License/Certifications Attached

KEY STAFFING AND SIGNIFICANT CHANGES

In FY 2020--21 were there any key staffing and/or significant changes that have not been reported to the County, Behavioral Health and Recovery Services?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
If yes, please list the details of the change.

Is your agency, its Executives, or its Board of Directors in process of any organizational changes or restructuring that would materially change the manner in which services are provided, or the agency's ability to meet any contractual requirements as prescribed in your agreement(s) with the County of Marin?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
ASSURANCES

ALL PROVIDERS

We testify that all of the information provided to the Marin County Behavioral Health and Recovery Services Division Self-Audit form is true, complete and accurate and that the information is submitted without errors or omissions.

Click or tap here to enter text.

Executive Director/Agency Leader  
Print Name  
Date

Click or tap here to enter text.

Chair, Board of Directors  
Print Name  
Date

Click or tap here to enter text.

Staff Responsible for Self-Audit Data  
Print Name  
Date
PROFESSIONAL SERVICES CONTRACT (PSC) & APPLICABLE LAWS AND REGULATION

CONFIDENTIALITY AND HIPAA

ALL PROVIDERS – EXCLUDING PREVENTION

PSC Exhibit I: Contractor and County mutually agree to maintain the confidentiality of Contractor's participant records, including billings, pursuant to Sections 11812 (c) and 11879, Health and Safety Code, and Federal Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, dated June 9, 1987), the federal Health Insurance Portability and Accountability Act (HIPAA), and all other applicable State and Federal laws and any amendments. Contractor shall inform all its officers, employees, and agents of the confidentiality provisions of said regulations, and provide all necessary policies and procedures and training to ensure compliance. [Reference PSC, Exhibit I and State/County SABG Block Grant Contract, Exhibit B, Section O]

PSC Exhibit M: If Contractor is a Business Associate under HIPAA, Exhibit M, Business Associate Agreement Addendum, shall be applicable to Contractor and included as an essential term of this Agreement. Contractor's failure to comply with the terms and conditions of this Business Associate Agreement Addendum Exhibit is a material breach of this Agreement. [Reference PSC, Exhibit M]

Does your agency maintain the confidentiality of participant records, including billing as required by all local, state and federal regulations?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does your agency inform all of its officers, employees and agents of the confidentiality provisions of said regulations?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does your agency comply with the Business Associate Agreement Terms and Conditions set forth in Exhibit M of the PSC?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
SERVICES TO BE PERFORMED

ALL PROVIDERS

PSC Exhibit I: Services and work provided by Contractor at the County’s request under this Agreement will be performed in a timely manner, and in accordance with applicable federal and state statutes and regulations, including, but not limited to, sections 96.126, 96.127, 96.128, 96.131 and 96.132, and all references therefrom, of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310, the State of California Alcohol and/or Other Drug Program Certification Standards (2017 version), Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; 42 CFR Part 438 Managed Care, Minimum Quality Drug Treatment Standards for SABG and any and all guidelines promulgated by the State Department of Health Care Services’ (DHCS) Alcohol and Drug Programs and the Marin County Department of Health and Human Services to serve special populations and groups, as applicable; County laws, ordinances, regulations and resolutions; and in a manner in accordance with the standards and obligations of Contractor's profession. Contractor shall devote such time to the performance of services pursuant to this Agreement as may be reasonably necessary for the satisfactory performance of Contractor’s obligations.  [Reference PSC, Exhibit I]

LIVING WAGE ORDINANCE

ALL PROVIDERS

The Board of Supervisors approved a 2.5% CPI adjustment to Marin County Living Wage Ordinance (LWO) rates. The updated rates, effective January 1, 2021, are presented below (with reference to the previous rates):

<table>
<thead>
<tr>
<th>New Marin County LWO Rates Effective January 1, 2020</th>
<th>With Benefits</th>
<th>Without Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised LWO Wage Rate (Effective January 1, 2021)</td>
<td>$13.55</td>
<td>$15.40</td>
</tr>
<tr>
<td>Previous LWO Wage Rate (Through December 31, 2020)</td>
<td>$13.40</td>
<td>$15.25</td>
</tr>
</tbody>
</table>

Is your agency in compliance with the Living Wage Ordinance?
☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed
Marin County Living Wage Ordinance Declaration

What the Ordinance does. For new, continued, extended or otherwise amended contracts beginning January 1, 2021, the Living Wage Ordinance (LWO) requires County contractors and subcontractors to provide the following to their employees covered by the Ordinance on County contracts and subcontracts for direct services: (1) wages of at least $13.55 per hour with health benefits; or (2) the payment of at least $15.40 per hour if no health benefits are provided.

These rates may be adjusted annually, effective the 1st of each January, to reflect the increase during the preceding year in the Consumer Price Index for all urban consumers in the San Francisco-Oakland-San Jose area, as published in October by the U.S. Department of Labor, Bureau of Labor Statistics. New, continued, extended or otherwise amended contracts are required to incorporate the living wage in effect at the time of the contract change.

The LWO applies only if you have in excess of $25,000 in cumulative annual business with a County department or departments. The County may require contractors to submit reports on the number of employees affected by the LWO, and may require at any time that contractors furnish to the County for services rendered a certification(s), under penalty of perjury, that the contractor and any subcontractor is in full compliance with the provisions of the LWO.

Effect on County of Marin contracting. For contracts and amendments signed on or after January 1, 2021, the LWO has the following effect:

- In each contract, the contractor will agree to abide by the LWO and to provide its employees the minimum benefits the LWO requires, and to require its subcontractors subject to LWO to do the same.

- If a contractor does not provide the LWO’s minimum benefits, the County can award a contract to that contractor only if the contract is exempt under the LWO, or if the contract has received an approved waiver. The contract will not contain the agreement to abide by the LWO if there is an exemption or waiver on file.

What this form does. If you can assure the County that, beginning with the first County contract or amendment you receive after January 1, 2021, and until further notice, you will provide the minimum benefit levels specified in the LWO to your covered employees, and will ensure that your subcontractors also subject to the LWO do the same, this will help the County’s contracting process.

For more information, (1) see our Website, including the complete text of the ordinance: www.marincounty.org/lwo, (2) e-mail us at: dellerman@marincounty.org, or (3) phone us at (415) 473-6358.

Routing. Return this form to the County department that sent it to you.

DECLARATION

In order to be a certified vendor with the County of Marin, this company will provide, if applicable, the minimum benefit levels specified in the LWO to our Covered Employees, and will ensure that our subcontractors also subject to the LWO do the same, until further notice. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Signature

Company: Click or tap here to enter text.

Federal Employer ID Number Click or tap here to enter text.

Print Name: Click or tap here to enter text.

County Vendor Number: Click or tap here to enter text.
(if known)

Date: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.
ACCOUNTING REQUIREMENTS AND PROCEDURE

ALL PROVIDERS

PSC Exhibit I “Contractor shall provide the County an annual Cost Report no later than sixty (60) days after the termination of this Agreement. In addition to the annual Cost Report, contractor shall furnish the County, within one hundred and eighty (180) days of close of contractor fiscal year, a certified copy of an Audit Report from an independent CPA firm. [Reference PSC, Exhibit I]

Contractor is in compliance with the regulations that state that no part of any federal funds provided under the State contract shall be used to pay the salary of an individual in excess of $210,700. www.opm.gov [Reference State/County SABG Block Grant Contract, Exhibit A, Attachment I, Section 2, Paragraph A]

Contractors that expend more than $750,000 in total federal funds in a year must comply with the 45 CFR 75.501 audit requirements. [Reference: State/County SABG Block Grant Contract, Exhibit D, Section 16, Paragraph c., section (3)]

What are the dates of your agency's fiscal year? Click or tap here to enter text.

Does any of your agency’s staff have salaries comprised of federal funds that exceed $210,700?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

To be completed by Providers that expends Federal funds in excess of $750,000 in a year. This includes $750,000 in federal funds from all sources, not just from Behavioral Health and Recovery Services.

Is your agency in compliance with the 45 CFR 75.501 audit requirements?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Has your agency submitted an independent agency audit to the County, through the Behavioral Health and Recovery Services Division?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, when was the independent agency audit submitted? Click or tap here to enter text.

If no, please attach the most recent independent audit with Self-Audit.
TRAINING

ALL PROVIDERS

Contractors are required to have all applicable staff adhere to PSC Standard Terms and Conditions by participation in the following trainings.

**All Providers**
- Cultural Competence
- Non-Discrimination

**Treatment Providers**
- Information Privacy and Security – Including 42 CFR and HIPAA/Law and Ethics
- ASAM (E-Training 1 & 2)
- CPR and First Aid HIV/AIDS
- CalOMS Treatment/Marin WITS Electronic Health Record
- DMC-ODS Requirements

**Adolescent Case Managers Only**: Training in AOD treatment, community resources, physical and sexual abuse, family dynamics and legal issues.

**Prevention Providers**
- PPSDS Prevention

**Recommended Trainings**
- Medication Assisted Treatment ASAM A, B, & C, are highly recommended In-Person Trainings
- ASAM Coaching

Is your agency in compliance with providing required training (as applicable) to staff?

☐ N/A ☐ Yes ☐ No ☐ Reviewed

*If no, why and please describe your plan to address, including timeframe for completion.* Click or tap here to enter text.

Complete the Staff Training and Certification Log on page 75.
CONFLICT OF INTEREST

Contractor agrees at all times in performance of this Agreement to comply with all laws of the United States, the State of California and all local ordinances regarding conflicts of interest, including, but not limited to, Article 4 of Chapter 1, Division 4, Title 1 of the California Government Code, commencing with Section 1090, and Chapter 7 of Title 9 of said Code, commencing with Section 87100, including regulations promulgated by the California Fair Political Practices Commission, reference to the Hatch Act (Title 5 USC, Sections 1501-1508.

If any actual or potential conflict of interest arises during the term of this Agreement, Contractor shall promptly notify the County of such conflict or potential conflict of interest so that the County may determine whether to terminate this Agreement.”

Does your agency affirm that it has no interest in other projects or independent agreements that would conflict in any manner or degree with the performance of services required to be performed under the current Agreement(s) with the Behavioral Health and Recovery Services Division?

☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

Does your agency have a written policy prohibiting Conflict of Interest by any employee or agent assigned, on any basis, to this/these Agreement(s)?

☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

When was your agency's Conflict of Interest policy established?  Click or tap here to enter text.

If the policy has been revised, date of last revision: Click or tap here to enter text.

Does this policy carry the signatures of the Agency Leader/Executive Director and the Chair of the agency’s Board of Directors?

☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

Is your agency in compliance with the Hatch Act?

☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed
# AUTHORITY OF CONTRACT

## ALL PROVIDERS

If Contractor is a corporation or public agency, each individual executing this Agreement on behalf of said corporation or public agency represents and warrants that he or she is duly authorized to execute and deliver Agreement on behalf of said corporation, in accordance with a duly adopted resolution of the Board of Directors of said corporation or in accordance with the by-laws of said corporation or Board or Commission of said public agency, and that this Agreement is binding upon said corporation in accordance with its terms. If Contractor is a corporation, Contractor shall, within thirty (30) days after execution of this Agreement, deliver to County a certified copy of a resolution of the Board of Directors of said corporation authorizing or ratifying the execution of this agreement. [Reference PSC, and contract resolution authorization]

<table>
<thead>
<tr>
<th>Has your agency’s Board of Directors authorized or ratified the execution of this Agreement?</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a copy of the resolution or Board minutes that verify this authorization or ratification submitted to the County within thirty (30) days of execution of this Agreement?</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
</tbody>
</table>

If no, please explain:
ASSIGNABILITY
ALL PROVIDERS

PSC Exhibit I "Contractor will have an MOU in place with all approved subcontractors that defines the services to be provided by the subcontractors and is consistent with and fully reflects the services and conditions described in this contract. Such MOUs will be made available to County within a reasonable time upon request." [Reference PSC, Exhibit I]

<table>
<thead>
<tr>
<th>Has your agency entered into any sub-contracts with organizations, agents, or consultants to provide any of the services outlined in this Agreement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ Yes □ No □ Reviewed</td>
</tr>
<tr>
<td>If yes, have sub-contracts been approved, in writing, by the County?</td>
</tr>
<tr>
<td>□ N/A □ Yes □ No □ Reviewed</td>
</tr>
<tr>
<td>If applicable, have the subcontractors that are performing federally reimbursable services been debarred?</td>
</tr>
<tr>
<td>□ N/A □ Yes □ No □ Reviewed</td>
</tr>
</tbody>
</table>
OUTREACH ACTIVITIES

ALL PROVIDERS

Contractor agrees to conduct outreach activities for the purpose of encouraging individuals in need of treatment and recovery services for alcohol and drug problems, as appropriate, to undergo such treatment and recovery services. [Reference Reauthorization Act, Public Law 102-321]

Does your agency actively conduct outreach activities in an effort to encourage entry into treatment and recovery services to persons experiencing problems with alcohol and drugs?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, please list and describe the type(s) of outreach activities your agency conducts: Click or tap here to enter text.

Does your agency have a written policy that outlines responsibilities, methods and populations that are the focus of outreach activities?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

When was the outreach activities policy established? Click or tap here to enter text.

Is the policy signed by the Executive Director and the Chair of the agency’s Board of Directors?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Date of the last revision? (If applicable) Click or tap here to enter text.
ALCOHOL AND OTHER DRUG USE REQUIREMENTS

All contractors are required to comply with the provisions set forth in the Drug-Free Workplace Act of 1990. [Reference State/County SABG Block Grant C Contract, Exhibit B, Section R and Exhibit I]

Is your agency in compliance with all of the provisions of the Drug Free Workplace Act of 1990?  
☐ N/A □ Yes □ No □ Reviewed  
If no, why not: Click or tap here to enter text.

Does your agency have a written policy pertaining to the use of alcohol and other drugs on and off the premises for staff members?  
☐ N/A □ Yes □ No □ Reviewed  
If no, please describe your plans for developing a written policy: Click or tap here to enter text.

If yes, please answer the following questions:  

Does the agency’s policy include language on preventing and addressing staff relapses?  
☐ N/A □ Yes □ No □ Reviewed  
Please describe how staff members are informed of the agency’s policy:  
Click or tap here to enter text.

Does your agency have a written policy pertaining to the use of alcohol and other drugs on and off the premises for people receiving services?  
☐ N/A □ Yes □ No □ Reviewed  
If no, please describe your plans for developing a written policy:  
Click or tap here to enter text.
If yes, please answer the following questions:

Does your agency’s policy include language on preventing and addressing client relapses?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Please describe how clients are informed of the agency’s policy:

Click or tap here to enter text.

Does your agency have a written policy to ensure the following:

No Unlawful Use or Unlawful Use Messaging Regarding Drugs

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Restriction on Distribution of Sterile Needles

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Limitation on Use of Funds for Promotion of Legalization of Controlled Substances

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.”); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law. Is your agency in compliance with these requirements?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
SMOKING REQUIREMENTS

ALL PROVIDERS

Contractor shall comply, and require that any subcontractors comply, with “Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children’s services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.” [Reference State/County SABG Block Grant Contract Exhibit D(F), Section 21, Paragraph a]

To be completed by all providers.

<table>
<thead>
<tr>
<th>Is your agency in compliance with the Smoking Prohibition set forth in the State/County SABG Block Grant Contract Exhibit D(F), Section 21, Paragraph a?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A                  ☐ Yes                  ☐ No                   ☐ Reviewed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are pregnant women allowed to smoke on your premises?</th>
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<tbody>
<tr>
<td>☐ N/A                  ☐ Yes                  ☐ No                   ☐ Reviewed</td>
</tr>
</tbody>
</table>
PSC Exhibit I “Contractor shall charge participant fees. No one shall be denied services based solely on ability or inability to pay.” [Reference PSC, Exhibit I]

PSC Exhibit I “Contractor shall perform eligibility and financial determinations in accordance with a fee schedule approved by the County Alcohol and Drug Program Administrator for this purpose. Individual income, expenses, and the number of dependents shall be considered in formulating the fee schedule and in its utilization” [Reference PSC, Exhibit I]

Title 45, CFR, Part 96, Section 137 SABG is the funding of last resort for services for Pregnant and Parenting Women, Tuberculosis and HIV. [Reference 45CFR, 96.137]

PSC Exhibit I “Contractor shall conduct community centered fundraising activities, as appropriate.” [Reference PSC, Exhibit I]

Does the agency have a current fee schedule that has been approved by the County Alcohol and Drug Program Administrator?
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Does the agency assess and collect participant fees?
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Are collected fees credited to your agency’s Professional Services Contract with the County?
☐ N/A ☐ Yes ☐ No ☐ Reviewed

With the exception of share of cost, are you in compliance with Drug/Medi-Cal funds being considered payment in full?
☐ N/A ☐ Yes ☐ No ☐ Reviewed

How does your agency ensure that the County is only billed for services for Marin residents assessed at below 138% FPL? In your response, describe if any fees are charged to participants or if payment from the County is considered payment in full.

Click or tap here to enter text.
| Does the agency ensure that SABG is the funding of last resort for services for Pregnant and Parenting Women, TB and HIV? |
|---|---|---|---|
| ☐ N/A | ☐ Yes | ☐ No | ☐ Reviewed |

*If yes, how does your agency make this determination? Also describe how you are ensuring compliance with all other SABG Block Grant funding requirements?*
LICENSURE

TREATMENT PROVIDERS ONLY

PSC Item 14 “The contractor shall maintain the appropriate licenses, certifications, and/or necessary permits throughout the life of this Agreement. Contractor shall also obtain any and all permits which might be requested by the work to be performed herein.” [Reference PSC, Section 14]

<table>
<thead>
<tr>
<th>Are all necessary licenses, permits and certifications required to provide services as outlined in this Agreement, current and in good standing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has your agency made a listing of all personnel assigned to this Agreement, at any level, available to the County?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

*If yes, does the listing include each person’s name, title, professional degree, state license, number, if applicable, and experience?*

| ☐ N/A | ☐ Yes | ☐ No | ☐ Reviewed |

<table>
<thead>
<tr>
<th>Have all assigned personnel been continuously active during the reporting period at the levels prescribed in Agreement budget documents?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the agency notify BHRS using the form(s) and timeframes noted in the Contractor Manual and MHSUS-ADP-08 of any changes to staff or Board of Directors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you attach copies of your current license(s) and certification(s)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

If you answered “No” to any of the above questions, please summarize exceptions and provide additional clarification as necessary. Click or tap here to enter text.
PSC Exhibit I “The contractor and/or any permitted sub-contractor shall not discriminate in the provision of services because of race, color, religion, national origin, sex, sexual orientation, age or mental or physical handicap as provided by State and Federal law.

For the purpose of this contract, distinctions on the grounds of race, color, religion, national origin, age or mental or physical handicap include but are not limited to the following: denying a Medi-Cal beneficiary any service or benefit which is different, or is provided in a different way manner or at a different time from that provided to other beneficiaries under this contract; subjecting a beneficiary to segregation or separate treatment in any matter related to receipt of any service; restricting a beneficiary in any way in the enjoyment, advantage or privilege enjoyed by others receiving ant service or benefit; treating a beneficiary differently from others in determining whether the beneficiary satisfied any admission, eligibility, other requirement or condition which individuals must meet in order to be provided any benefit; the assignment of times or places for the provision of services on a basis of the race, color, religion, national origin, sexual orientation, age or mental or physical handicap of the beneficiaries to be served” [Reference PSC, Exhibit I]

"Contractor shall develop and implement policies and procedures that ensure non-discrimination in access to or the provision of services because of the prescribed use of or need for Medication Assisted Treatment for substance use disorders." [Reference PSC, Exhibit I]

"County BHRS and its contractors shall take affirmative action to ensure that applicants are employed and that employees are treated fairly during employment without regard to their race, sex, sexual orientation, HIV status, color, religion, ancestry, national origin, age, or disability. Such action shall include, but not be limited to, employment, upgrading, demotion or transfer, recruitment or recruitment advertising, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship." [Reference Nondiscrimination - MHSUS - ADP-13]
Contractor shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. Contractor shall not unlawfully discriminate against any person pursuant to the following. [Reference State/County SABG Block Grant Contract, Exhibit A]

- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972 (regarding education and programs and activities
- The Age Discrimination Act of 1975
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act

<table>
<thead>
<tr>
<th>Does the agency have a current written policy that specifically prohibits discrimination of employees and applicants for employment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

Does this policy directly address each of the following: race, religious creed, color, national origin, ancestry, medical condition, marital status, gender, sexual orientation, age, HIV status or condition of disability?

<table>
<thead>
<tr>
<th>When was your agency's nondiscrimination policy for employees/applications established? Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

Is this policy signed by the Executive Director and the Chair of the agency’s Board of Directors?

<table>
<thead>
<tr>
<th>Date of the last revision? (If applicable): Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>

Does your agency have a current written policy that specifically prohibits discrimination of applicants for services, clients or program participants?

<table>
<thead>
<tr>
<th>Does this written policy specifically address each of the following: race, gender, sexual orientation, HIV status, color, religion, ancestry, national origin, age and disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
</tbody>
</table>
When was your agency's nondiscrimination policy for participants established? Click or tap here to enter text.

<table>
<thead>
<tr>
<th>Date of the last revision? <em>(If applicable)</em> Click or tap here to enter text.</th>
</tr>
</thead>
</table>

Do all full and part-time employees and contract staff receive copies of these policies?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

Does the agency have a current written policy that specifically prohibits discrimination of access or provision of services to clients engaged with Medication Assisted Treatment?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

Do these policies (employee/applicant and participant) meet the requirements of the Americans with Disabilities Act?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

Does your agency post, in a conspicuous place available to employees and applicants for employment, a notice setting forth the Fair Employment Practices outlined on the preceding page?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

*If no, to any of the above questions, please provide additional explanation.*

Click or tap here to enter text.
HIV/AIDS RELATED NONDISCRIMINATION

PSC Exhibit I “Contractor shall develop and implement policies and procedures that ensure: non-discrimination in the provision of services based on a diagnosis of Acquired Immune Deficiency (AIDS) or AIDS-related complex (ARC), or upon testing positive for Human Immunodeficiency Virus (HIV); the prohibition of the use of HIV antibody testing as a screening criterion for program participation; training of all staff and all participants in AIDS-related problems, issues, and special recovery needs; provision of information to all participants regarding high-risk behaviors, safer sex practices, and perinatal transmission of HIV infection; and development of procedures for addressing the special needs and problems of those individuals who test positive for antibodies to HIV. No individual shall be required to disclose his or her HIV status” [Reference PSC, Exhibit I]

“... Contractor prioritizes HIV positive persons seeking treatment ...” [Reference Reauthorization Act, Public Law 102-321]
Does all staff, interns, volunteers and contractors involved in direct service receive formal training in HIV/AIDS-related problems, issues and special recovery needs?

☐ N/A             ☐ Yes             ☐ No             ☐ Reviewed

If yes, answer the following questions:
Is the HIV/AIDS training documented?

☐ N/A             ☐ Yes             ☐ No             ☐ Reviewed

Describe how the HIV/AIDS training is documented and the date(s) of the most recent training(s). Click or tap here to enter text.

Within how many months of employment is HIV/AIDS training provided for direct service personnel? Click or tap here to enter text.

If you answered "No" to any of the above questions, please provide additional explanation. Click or tap here to enter text.

How frequently is HIV/AIDS staff training provided? Click or tap here to enter text.

Does your agency have a written policy and procedures that require all program participants receive information regarding high-risk behaviors, safer sex practices, and perinatal transmission of HIV infection?

☐ N/A             ☐ Yes             ☐ No             ☐ Reviewed

When was your agency's HIV/AIDS policy for program participants established? Click or tap here to enter text.

Is this policy signed by the Executive Director and the Chair of the agency’s Board of Directors?

☐ N/A             ☐ Yes             ☐ No             ☐ Reviewed

Date of the last revision? (If applicable) Click or tap here to enter text.
When do participants receive information on HIV/AIDS, high-risk behavior, safer sex and perinatal transmission?

If other, specify Click or tap here to enter text.

Does your agency admit individuals who identify as HIV positive on a priority basis?

☐ N/A ☐ Yes ☐ No ☐ Reviewed
### BILINGUAL/BICULTURAL SERVICES

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
</tr>
</thead>
</table>

How does your agency ensure that services are delivered in a manner that is culturally and linguistically appropriate to clients and community members? [Click or tap here to enter text.]

Does your agency employ bilingual and/or bicultural staff, consultants, interns or volunteers?

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

Total number of employees providing Agreement service [Click or tap here to enter text.]

Number of bilingual staff, consultants, and interns involved in providing Agreement services [Click or tap here to enter text.]

Please list languages, other than English, in which services are delivered? [Click or tap here to enter text.]

Has your agency made available bilingual materials that are specifically addressed to special target populations?

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

*If yes, please list and describe the type(s) of materials that have been made available:* [Click or tap here to enter text.]*
CULTURAL COMPETENCE

Counties receiving SABG funds are required to ensure equal access to quality care by diverse populations. To assist in meeting this requirement, DHCS has adopted the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health. U.S. Department of Health and Human Services as the guiding document to support continuous quality improvement for prevention and treatment services. The purpose and intent of CLAS is to advance health equity, improve quality, and help eliminate health care disparities; to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from federal financial assistance programs and comply with Title IV of the Civil Rights Act of 1964.

### Standard 1: Do the people you serve receive care responsive to beliefs, practices and preferred language.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 2: Advance and sustain organizational leadership that promotes CLAS through policy, practices and allocated resources.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 3: Recruit, retain, and promote diverse staff representing demographics of service areas.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 4: Ongoing education and training in CLAS service delivery.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 5: Offer language assistance services.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 6: Verbal/written notices of language assistance services.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 7: Competency of interpreters and bilingual staff.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 8: Provide easy-to-understand materials and signage.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 9: Establish appropriate goals and policies and infuse them throughout organization’s planning and operations.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

### Standard 10: Ongoing self-assessments of CLAS related activities.

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed
**Standard 11:** Collect demographic data to monitor and evaluate impact of CLAS  
☐ N/A  ☐ Yes  ☐ No  ☐ Review

**Standard 12:** Conduct regular needs assessments and use the results to plan and implement responsive services.  
☐ N/A  ☐ Yes  ☐ No  ☐ Review

**Standard 13:** Participative and collaborative partnerships with communities.  
☐ N/A  ☐ Yes  ☐ No  ☐ Review

**Standard 14:** Conflict and grievance resolution process.  
☐ N/A  ☐ Yes  ☐ No  ☐ Review

**Standard 15:** Public information about progress.  
☐ N/A  ☐ Yes  ☐ No  ☐ Review

Describe any new or ongoing initiatives/strategies to ensure equitable and inclusive service delivery. [Click or tap here to enter text.](#)

Describe how your agency recruits, promotes, trains, and supports a culturally and linguistically diverse workforce at all levels. [Click or tap here to enter text.](#)

*Attach your agency’s Cultural Competency Training policy and procedure. Note: Agencies will be asked to provide examples at the Site Visit.*
“The Contractor shall comply with any and all Federal, State and local laws and resolutions (including, but not limited to the County of Marin Nuclear Free Zone, Living Wage Ordinance, and Resolution #2005-97 of the Board of Supervisors prohibiting the off-shoring of professional services involving employee/retiree medical and financial data) affecting services covered by this Contract.” [Reference PSC Accessibility Requirements for Delegated Direct Services, Section 20 and ODS Contract, Exhibit A, Section 5]

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMERICANS WITH DISABILITIES ACT (ADA)</strong></td>
</tr>
</tbody>
</table>

Does your agency have an organizational plan to meet the requirements of the ADA?
- □ N/A
- □ Yes
- □ No
- □ Reviewed

Does your agency’s ADA plan address staff and participant accommodations?
- □ N/A
- □ Yes
- □ No
- □ Reviewed

Does your agency’s ADA plan carry the signatures of the Executive Director and the Chair of the agency’s Board of Directors?
- □ N/A
- □ Yes
- □ No
- □ Reviewed

Have all ADA-related access issues been addressed?
- □ N/A
- □ Yes
- □ No
- □ Reviewed

*If no, please list and describe the ADA-related access issues that remain to be addressed: Click or tap here to enter text.*

Does your agency/program accept persons with disabilities (PWD)?
- □ N/A
- □ Yes
- □ No
- □ Reviewed

*If no, please describe why, including how you are still meeting ADA requirements and to where PWD are being referred. Click or tap here to enter text.*
CLEAN AIR AND WATER

Is your agency in compliance with the requirements of § 114 of the Clean Air Act, as amended (42 U.S.C. 7401 et seq.) and § 308 of the Federal Water Pollution Control Act (33 USC 1251 et seq.) respectively relating to inspection monitoring, entry, reports, and information, as well as other requirements specified in § 114 and § 308 of the Air Act and the Water Act, respectively, and all regulations and guidelines issued thereunder before the award of this Contract [only applicable if the Contract exceeds $100,000 or a facility to be used has been the subject of a conviction under the Clean Air Act [42 U.S.C. 7413 (c) (1)] or the Federal Water Pollution Control Act (33 U.S.C. 1319[c]) and is listed by EPA, or the contract is not otherwise exempt.]

☐ N/A ☐ Yes ☐ No ☐ Reviewed

TRAFFICKING VICTIMS PREVENTION ACT OF 2000

Is your agency in compliance with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104(g)

☐ N/A ☐ Yes ☐ No ☐ Reviewed
DRUG MEDI-CAL AND SABG TREATMENT REGULATION

COMPLIANCE

SERVICE MODALITIES

TREATMENT PROVIDERS ONLY

The following is to be completed by Providers that receive SABG Block Grant or Drug/Medi-Cal Funds for treatment services. References: Relevant Sections of Title 9, DMC-ODS Standard Terms and Conditions, Minimum Quality Drug Treatment Standards; 42 CFR, Part 438, Drug/Medi-Cal Certification Standards, Alcohol and Drug Certification Standards, MHSUS-ADP-18, State/County SABG Contract and State/County DMC-ODS Intergovernmental Agreement]
List the sites and modalities of service that are currently Drug/Medi-Cal certified. Click or tap here to enter text.

<table>
<thead>
<tr>
<th>Do these D/MC services include any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotic Replacement Therapy: Services include intake, treatment planning, medical psychotherapy, individual and group counseling, collateral services, crisis intervention, patient education, medication services, discharge services and the provision of methadone as prescribed by a physician or licensed prescriber to alleviate the symptoms of withdrawal from opiates.</td>
</tr>
<tr>
<td>☐ N/A</td>
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</tbody>
</table>

General Outpatient: Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan. Services include admissions physical examinations, intake, evaluation, assessment, diagnosis, medication services, urine drug screens, treatment and discharge planning, crisis intervention, collateral services, patient education, family therapy, group counseling and individual counseling. Individual counseling shall be limited to: intake (including
evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Intensive Outpatient Treatment: Structured programming services provided to beneficiaries a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents, when determined by a Medical Director or LPHA to be medically necessary and in accordance with the individual treatment plan. Services include admissions physical examinations, intake, evaluation, assessment, diagnosis, medication services, urine drug screens, treatment and discharge planning, crisis intervention, collateral services, patient education, family therapy, group counseling and individual counseling. Individual counseling shall be limited to: intake (including evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Partial Hospitalization: Services shall be provided to beneficiaries a minimum of 20 hours per week when determined by a Medical Director or LPHA to be medically necessary and in accordance with an individualized treatment plan. Services shall consist of clinically intensive programming, which is primarily counseling and education about addiction-related problems. Beneficiaries may also receive referrals to, or consultation with, psychiatric, medical and laboratory services. Services include admissions physical examinations, intake, evaluation, assessment, diagnosis, medication services, urine drug screens, treatment and discharge planning, crisis intervention, collateral services, patient education, family therapy, group counseling and individual counseling. Individual counseling shall be limited to: intake (including evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Residential (3.1, 3.3 or 3.5): Services include intake, individual and group counseling services, treatment planning, patient education, family therapy, safeguarding medications, transportation, discharge services, collateral services and crisis intervention services. Note: The provision of room and board shall not be a Medi-Cal reimbursable service.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Additional Medication Assisted Treatment: Includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Case Management: Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The components of case management include: Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management; Transition to a higher or lower level of SUD care;
Development and periodic revision of a client plan that includes service activities; Communication, coordination, referral, and related activities; Monitoring service delivery to ensure beneficiary access to service and the service delivery system; Monitoring the beneficiary’s progress; and Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

**Physician Consultation:** Services include DMC physicians’ consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

**Recovery Services:** Recovery services may be accessed after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. The components of Recovery Services are: Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care; Recovery Monitoring: Recovery coaching, monitoring via telephone and internet; Substance Abuse Assistance: Peer-to-peer services and relapse prevention; Education and Job Skills: Linkages to life skills, employment services, job training, and education services; Family Support: Linkages to childcare, parent education, child development support services, family/marriage education; Support Groups: Linkages to self-help and support, spiritual and faith-based support; and Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

**Withdrawal Management (ASAM Levels 1-WM and 3.2-WM)** are habilitative and rehabilitative services when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) as medically necessary and in accordance with an individualized client plan. The components of Withdrawal Management services are intake, observation, medication services and discharge services. For clients in Withdrawal Management, case management will be provided to coordinate care with ancillary service providers and facilitate transitions between levels of care.

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed
## PROGRAM INTEGRITY

### TREATMENT PROVIDERS ONLY

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your agency have procedures designed to detect, prevent and report fraud, waste, and abuse of Federal or state health care funding? Reference: (42 C.F.R §438.608 (a)(7)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Does your agency have written policies for that provide detailed information about the False Claims Act (“Act”) and other Federal and State Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>How are staff informed about the policies related to the False Claims Act and rights to be protected as whistleblowers?</td>
<td>Click or tap here to enter text.</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your agency have in place a compliance program designed to detect and prevent fraud, waste and abuse?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Does the program include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written policies, procedures, and standards of conduct that articulate the organization’s commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under the contract.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>A system for training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees for the federal and state standards and requirements under the contract.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Effective lines of communication between the Compliance Officer and the organization’s employees.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Reviewed</td>
</tr>
</tbody>
</table>
Enforcement of standards through well-publicized disciplinary guidelines.
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence and ongoing compliance with the requirements under the contract as per 42 CFR §438.608(a), (a)(1)
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Were there any overpayments identified in FY 2019-20 or FY 2020-21?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes:

Did your agency report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud, immediately upon discovery and no later than 5 calendar days when it has identified payments in excess?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Did your agency return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified, or the date any corresponding cost report is due, if applicable? (42 CFR 438.608, MHSUDS IN 19-034, Public Law 111-148)
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Do you have procedures in place to link beneficiaries with afterhours care?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Do you have signage posted at your facilities (in a location that beneficiaries can access afterhours) stating how to access afterhours care?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
CERTIFICATION

TREATMENT PROVIDERS ONLY

Does the Program meet Drug/Medi-Cal requirements for certified NTP, ODF and IOT services included in, the Drug Medi-Cal Certification Standards for Substance Abuse Clinics Standards for Drug Treatment Programs, as well as other applicable laws and regulations, including General Management and Program Management, such as required services, staffing, physician direction, admission/re-admission criteria, treatment and discharge planning, clients rights and quality assurance?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

CERTIFICATION CHANGES

TREATMENT PROVIDERS ONLY

Did any of the following occur at a D/MC certified site? [DMC Certification Standards, Section II.G]

Change in ownership

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Change or reduction in scope of services such that the new services result in more restrictive or higher standards of program services and/or increase treatment hours of clients

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Significant changes in physical plant (i.e. substantial remodeling)

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Change in address and/or location

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If Yes, to any of the above, did the program notify DHCS and BHRS at least 60 days prior to any occurrence?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Did the program report within 35 days any additions or changes in information submitted in a DMC application package by submitting an application to DHCS?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Did your agency notify the County Alcohol and Drug Administrator within two (2) business days of surrendering your DMC certification or facility closure?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
CERTIFICATION – OTHER REQUIREMENTS

TREATMENT PROVIDERS ONLY

Has your agency received any DHCS Corrective Action Plans or Notices of Deficiency in FY 2019/20?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, answer the following questions:

Did your agency notify the County of Marin?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

What date were changes implemented?

What date was DHCS and the County of Marin notified of the completion of the Corrective Action Plan?

Attach any supporting documents NOT previously submitted to the County of Marin.

Are Administrative Policies included in the D/MC Certification Standards, Section III.G implemented, maintained, reviewed annually and revised as necessary?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Is the program in compliance with the Pharmaceutical Service Requirements included in the D/MC Certification Standards, Section VI?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

CERTIFICATION - PERINATAL SERVICES

TREATMENT PROVIDERS ONLY

Is this section applicable to the services your agency provides?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Is your agency in compliance with Perinatal Practice Guidelines FY2019-2020?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the Program meet Drug/Medi-Cal requirements for Perinatal services included in, the Drug Medi-Cal Certification Standards for Substance Abuse Clinics Standards for Drug Treatment Programs, as well as other applicable laws and regulations, including General Management and Program Management, such as required services, staffing, physician direction, admission/re-admission criteria, treatment and discharge planning, clients rights and quality assurance?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the Program ensure that only pregnant and postpartum (defined as the 60-day period beginning on the last day of the pregnancy) receive D/MC Perinatal Services?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
Does the Program ensure that pregnant/postpartum women, who are no longer eligible to receive Perinatal D/MC services, are transferred to treatment slots paid for by other perinatal funding sources or referred to non-perinatal D/MC treatment programs for which they are eligible?

- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

Does the Program’s Perinatal D/MC Program include the following elements and are these services in each client's treatment plans and progress noted in each participant's chart?

<table>
<thead>
<tr>
<th>Service Access</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother/Child Habilitative and Rehabilitative Services</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Education to reduce harmful effects of substance use on the mother and fetus/infant</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Coordination of Ancillary Services</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Participant completes treatment</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Participant voluntarily drops out; and/or</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Participant is suspended from the program</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
</tr>
</tbody>
</table>
SERVICE ELIGIBILITY

TREATMENT PROVIDERS ONLY

Describe your agency’s process to assess and verify initial client eligibility for Medi-Cal prior to rendering services and re-verify Medi-Cal on a monthly basis prior to rendering services. Attach procedure for monthly verification process. Click or tap here to enter text.

Describe how the agency addresses if an out-of-county Medi-Cal beneficiary requests services. Click or tap here to enter text.

Describe how the agency is ensuring that all staff assessing clients have completed the minimum two ASAM e-trainings. Click or tap here to enter text.

Describe your program’s process of ensuring that DMC-ODS services are only available to D/MC Beneficiaries who are Marin County Residents. Click or tap here to enter text.

ACCESS TO SERVICES

TREATMENT PROVIDERS ONLY

Does the Program ensure that persons who are D/MC eligible are not placed on waiting lists due to budgetary constraints?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
Describe your Program’s system to monitor and evaluate accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. In your response, be sure to address your procedures for engaging a client when there is a delay in accessing services. Click or tap here to enter text.

Excluding NTP services, describe how your Program ensures medically necessary services are initiated within five business days and no later than 10 business days from initial contact. Click or tap here to enter text.

For NTP service providers, describe how your Program ensures medically necessary services are initiated no later than 3 business days from initial contact. Click or tap here to enter text.

Does the Program ensure that services provided to D/MC beneficiaries are equivalent to services provided to non-D/MC clients?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does your agency post information regarding access to after-hours care?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the Program ensure that a participant is discharged from D/MC services when any of the following occur?

Fails to return to the program (No contact within 30 days)
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Transfers to another program (Including another program within your Agency)
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

For Residential Providers: What procedures do you have in place to ensure that you respond to a Pending TAR within 24 hours of receipt? Click or tap here to enter text.
How does your agency document and address the need for urgent services within 48 hours of the request? Click or tap here to enter text.

TELEHEALTH SERVICES

TREATMENT PROVIDERS ONLY

Reference: Behavioral Health Information Notice No: 20-017
Behavioral Health Information Notice No: 20-009

Has your agency reviewed the telehealth regulations and flexibilities outlined in the following INs: Behavioral Health Information Notice No: 20-017
Behavioral Health Information Notice No: 20-009?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Has your agency implemented telehealth services for contracted levels of care including for initial intake and assessment for treatment?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If No, describe your implementation plan or explain why you are not utilizing telehealth (i.e. residential level of care) Click or tap here to enter text.

If Yes, describe any implementation challenges you have had so TA can be provided Click or tap here to enter text.

Is your agency completing telehealth service documentation in the client treatment file in the manner as the agency would for an in-person visit?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If No, please explain Click or tap here to enter text.

Has your agency experienced any billing challenges with telehealth services?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If Yes, please explain Click or tap here to enter text.
Describe your program’s protocol for ensuring that all D/MC Beneficiary ASAM interviews are conducted by Licensed Practitioners in the healing Arts (LPHAs)—or by certified/registered alcohol and drug counselors and **Reviewed** and approved by an LPHA. Click or tap here to enter text.

Has all Staff performing the ASAM criteria interviews completed ASAM e-training Modules 1 (Multidimensional Assessment) and 2 (From Assessment to Service Planning)?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ **Reviewed**

If the training was not accessed through the County, have you provided evidence of successful completion to BHRS prior to claiming for assessment services?

- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ **Reviewed**

How often does your Agency re-assess beneficiaries using the ASAM criteria to ensure they are receiving the most appropriate level of care? Click or tap here to enter text.

Please describe your agency’s process for determining when a client is appropriate for a change in level of care. Click or tap here to enter text.
CARE-COORDINATION
TREATMENT PROVIDERS ONLY

How does your Agency meet Care Coordination Requirements outlined in the DMC-ODS and Contract Exhibit A? Click or tap here to enter text.

Describe the process your facility uses to link a beneficiary with Recovery Support Services immediately following completion of treatment services? In your response, describe the specific procedures, staff responsible and timeframes for linkage to services. Click or tap here to enter text.

What are your procedures for linking clients with primary health and mental health (if indicated) services? In your response, be sure to include what procedures you have in place to ensure and document that all clients have--or are linked--with a primary care provider. Click or tap here to enter text.

What are your Agency's procedures for actively linking clients with other ancillary services? Click or tap here to enter text.

How does your agency ensure that each beneficiary has an assigned care coordinator? Click or tap here to enter text.

Does your agency provided information to the beneficiary of how to contact the designated person/entity with primary responsibility for coordinating care?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Please describe: Click or tap here to enter text.
Does the Care Coordinator perform the required duties:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring successful transitions between ASAM levels of care, including linking a beneficiary to services if assessed at a level of care not offered by the provider</td>
<td>☒</td>
<td></td>
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<tr>
<td>Ensuring beneficiaries are linked to other services, including mental health, primary care and Medication Assisted Treatment</td>
<td>☒</td>
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<tr>
<td>Ensuring effective communication between treating providers and other systems of care, such as Probation or Social Services</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing navigation support for clients and family members</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitating and tracking referrals between systems of care</td>
<td>☒</td>
<td></td>
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</tr>
<tr>
<td>Make a best effort to conduct an initial screening of each beneficiary’s needs and as allowable, communicate to BHRS, DHCS or other managed care organizations serving the beneficiary (e.g. Partnership Health Plan or BHRS Mental Health Plan) the results of screenings/assessments in order to prevent duplication of those activities</td>
<td>☒</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Coordinate DMC-ODS services with the services the beneficiary receives from: 1) any other managed care organization, such as Partnership Health Plan (Health Plan) or Mental Health Plan (Specialty Mental Health Services); Fee for Service (FFS) Medi-Cal system; and 3) other community and social support providers.</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide or arrange for transportation, as needed, to medically necessary services, such as treatment visits and appointments referenced in treatment plans</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up with beneficiaries within seven (7) days of discharge from DMC-ODS services to ensure successful linkage with the next level of care</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care and that in the process of coordinating care, each beneficiary’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, and 42 CFR Part 2, to the extent that they are applicable</td>
<td>☒</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## EVIDENCE BASED PRACTICES (EBP) AND QUALITY OF CARE

### TREATMENT PROVIDERS ONLY

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>List which Evidence Based Practices (EBP) are being utilized in your</td>
<td>Trail Informed Treatment, Cognitive</td>
</tr>
<tr>
<td>program (Trauma Informed Treatment, Cognitive Behavioral Therapy,</td>
<td>Behavioral Therapy, Motivational</td>
</tr>
<tr>
<td>Motivational Interviewing, Relapse Prevention, and Psycho-Education):</td>
<td>Interviewing, Relapse Prevention, and</td>
</tr>
<tr>
<td></td>
<td>Psycho-Education):</td>
</tr>
<tr>
<td></td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Provide the date of the most recent EBP fidelity review. Please attach</td>
<td>protocol for ensuring fidelity to the EBP's listed above. Click or tap here to enter text.</td>
</tr>
<tr>
<td>protocol for ensuring fidelity to the EBP's listed above.</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>How often do EBP fidelity reviews take place?</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>What are your procedures for performing follow-up with clients 30 days</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>after discharge?</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Are your follow up procedures in writing?</td>
<td>☐ N/A ☐ Yes ☐ No ☐ Reviewed</td>
</tr>
<tr>
<td>Does the Program have a Continuous Quality Improvement plan (CQI) in</td>
<td>☐ N/A ☐ Yes ☐ No ☐ Reviewed</td>
</tr>
<tr>
<td>place? If no, why and what do you need in order to complete and</td>
<td>If no, why and what do you need in order to complete and implement a CQI plan? Click or tap here to enter text.</td>
</tr>
<tr>
<td>implement a CQI plan?</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Describe how your agency used the information from the Treatment</td>
<td>Provide at least one example. Click or</td>
</tr>
<tr>
<td>Perceptions Survey to inform continuous quality improvement efforts.</td>
<td>tap here to enter text.</td>
</tr>
<tr>
<td>Provide at least one example. Click or tap here to enter text.</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Please describe how your agency ensures services are delivered in a</td>
<td>appropriate for individuals with complex</td>
</tr>
<tr>
<td>manner that is appropriate for individuals with complex conditions,</td>
<td>conditions, including co-occurring mental</td>
</tr>
<tr>
<td>including co-occurring mental health and substance use disorders?</td>
<td>health and substance use disorders? Click</td>
</tr>
<tr>
<td></td>
<td>or tap here to enter text.</td>
</tr>
</tbody>
</table>
Is your Agency currently providing trainings on complex conditions to direct service staff?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, please list what trainings. Click or tap here to enter text.

If no, please explain your plans to do so. Click or tap here to enter text.

As the culture of substance use treatment has shifted away from a ‘program driven model’ to that of a ‘client driven model’, how has your agency shifted services, including group counseling sessions, to ensure each client’s individualized goals are addressed? Click or tap here to enter text.

In FY 2019-20, has your agency received any complaints from clients (excluding complaints resulting in a formal grievance or appeal with the County)?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, list the number of complaints received, the nature of the complaints, and the steps taken to resolve the complaint. Click or tap here to enter text.
Does your agency have a written code of conduct for employees and volunteers/interns?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If your agency utilizes volunteers and/or interns, do you have procedures for the following: recruitment, screening, selection, training and orientation, duties and assignments, scope of practice, supervision, evaluation, and protection of client confidentiality?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

**BENEFICIARY PROTECTIONS**

**TREATMENT PROVIDERS ONLY**

How does the Program ensure compliance with beneficiary protections outlined in 42 CFR, Part 438, including providing information about the grievance and appeals processes and a right to a State Fair Hearing? Click or tap here to enter text.

Describe how your agency provides access to interpreter services at no cost to the beneficiary? Click or tap here to enter text.

Has your agency notified the County when a Notice of Adverse Benefit Determination needs to be issued? Provide a copy of your procedures for ensuring compliance with the NOABD requirements outlined in Contract Exhibit A: Beneficiary Protections.
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Describe how and when you provide beneficiary informing materials to clients.
Click or tap here to enter text.
UTILIZATION REVIEW REQUIREMENTS

TREATMENT PROVIDERS ONLY

Does the program establish, implement and maintain Utilization Review procedures in accordance with? [D/MC Certification Standards, Section III.E] Please attach your URC policy and procedure.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

How frequently does your agency staff review D/MC charts?
Click or tap here to enter text.
Are files Reviewed for all Medi-Cal participants?

☐ N/A ☐ Yes ☐ No ☐ Reviewed

Does the Program maintain minutes and records of each Review Committee meeting?

☐ N/A ☐ Yes ☐ No ☐ Reviewed

If yes, please attach a copy of the minutes from the Program’s most recent Review Committee meeting.

Who does your Review Committee consist of? Click or tap here to enter text.

How does your agency ensure follow-up on issues identified during the URC?
Click or tap here to enter text.

Are data and information maintained in compliance with all applicable statutes and regulations to ensure for confidentiality?

☐ N/A ☐ Yes ☐ No ☐ Reviewed

How does your agency’s committee review files written in languages other than English? (If applicable) Click or tap here to enter text.

Is notice of any disallowance sent to responsible staff/billing person for submission to the State of California Department of Health Care Services?

☐ N/A ☐ Yes ☐ No ☐ Reviewed
Does the program establish and maintain a patient health record on every patient admitted for care? [D/MC Certification Standards, Section III.F]  
☐ N/A ☐ Yes ☐ No ☐ Reviewed  

Does the program ensure that all health records of discharged patients are completed and filed in a secure and confidential location within 30 days after discharge, and such records shall be kept for a minimum of three years in accordance with? [D/MC Certification Standards, Section III.F] Note: Federal managed care regulations requires ten years from the end of the State/County contract or completion of audit, whichever is later.  
☐ N/A ☐ Yes ☐ No ☐ Reviewed  

Is DMC-ODS documentation training provided to staff at least annually?  
☐ N/A ☐ Yes ☐ No ☐ Reviewed  

Describe the procedures for establishing and documenting medical necessity (include processes for all elements involved). Click or tap here to enter text.  

Describe the procedures for documenting the basis for the DSM V diagnosis.  
Click or tap here to enter text.  

Describe the procedures for documenting the ‘Face-to-Face’ contact between the LPHA/MD and the counselor or client to validate/verify medical necessity.  
Click or tap here to enter text.  

Describe the procedures for ensuring all Treatment Plan requirements are met (ie. completion & signature timelines, Goals for each problem, all domains/dimensions addressed, Treatment plan updates & reviews completed within timelines, etc.).  
Click or tap here to enter text.
Describe the procedures for ensuring all Progress notes meet established regulations and directly relate to treatment goals. Click or tap here to enter text.

Describe the procedures for ensuring clients receive the minimum number of hours as required in their specific level of care. (*Please include method/procedure used to track this data*) Click or tap here to enter text.

Please describe your process for ensuring continuing services justifications are completed as applicable. Click or tap here to enter text.

Do clients receive a treatment plan review session every 30 days?

☐ N/A ☐ Yes ☐ No ☐ Reviewed

*If no, why not:* Click or tap here to enter text.
CLAIMS AND PARTICIPANT FEES

TREATMENT PROVIDERS ONLY

Describe your agency’s process to ensure that D/MC reimbursable services provided to Medi-Cal beneficiaries are being claimed to D/MC. Click or tap here to enter text.

Does the Program ensure that no fees are charged to Medi-Cal beneficiaries for access to D/MC services? (Exception is Share of Cost Medi-Cal beneficiaries)

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

What is your agency’s process for determining Insurance Status of clients?
Click or tap here to enter text.

If uninsured, how does your agency process for connecting them to insurance?
Click or tap here to enter text.

If privately insured, how does your agency collect fees or process invoices?
Click or tap here to enter text.

**Payment of Last Resort Funding Requirements**

How does your agency ensure private pay clients are not being billed to the County of Marin? Click or tap here to enter text.

How does your agency ensure Drug Medi-Cal is being billed for all Medi-Cal beneficiaries? Click or tap here to enter text.

Does the Program bill for D/MC services on an all-inclusive rate method (all reimbursable costs are combined to identify a specific rate for each unit of service provided)?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the Program ensure that the following non-reimbursable activities are not included in the D/MC rates?

Recreational activities

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
Vocational Training
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Academic Education
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Services provided in jail or prison settings
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Transportation services (except as defined for residential or case management services)
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

How does your agency ensure the D/MC claims are submitted in Marin WITS by the 10th of the month for services provided in the previous month.
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

How does your agency ensure that denied DMC claims are resubmitted by the 20th of the month following notification of the denials (e.g. notification of denials in December would be resubmitted by January 20th)?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Describe your agency’s process for checking for and correcting/addressing denied claims. Click or tap here to enter text.

Does the Program ensure that the appropriate documentation is submitted to BHRS and maintained on file for DHCS/BHRS review, as applicable, including, but not limited to: DHCS Form 100224A, MC 6700 and MC 6065A and MC 6065B)?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Describe the process your agency uses to notify and return any overpayments to the County within 60 calendar days. Click or tap here to enter text.

Provider-preventable conditions: Has your agency submitted claims for provider-preventable conditions as outlined in the State/County Intergovernmental Agreement?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
DATA COLLECTION AND REPORTING REQUIREMENTS

TREATMENT PROVIDERS ONLY

"Effective July 1, 2004, all contracted providers with Behavioral Health and Recovery Services Division (BHRS), will be subject to the terms and conditions of the contract compliance policy." Specific terms include that all contracted providers must adhere to all reporting requirements, including submission timeline, location and format prescribed by the County. As outlined in the policy, contractor compliance will be used as a factor in assessing contract renewal and funding allocations. [Reference: Division Contract Compliance Policy, June 2004]

Does your agency have documented policies and procedures for CalOMS-WITS?
☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

If no, why: Click or tap here to enter text.

Does your Agency’s onboarding procedure include training for WITS and CalOMS data collection?
☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

Who is responsible for managing data quality in WITS and CalOMS? Click or tap here to enter text.

What is your agency's schedule and process for verifying quality assurance of the WITS and CalOMS data? Click or tap here to enter text.

Does your agency need training or technical assistance related to CalOMS-WITS?
☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

If yes, please describe: Click or tap here to enter text.

Is your agency submitting DATAR information to DHCS by the 10th of the month?
☐ N/A    ☐ Yes    ☐ No    ☐ Reviewed

Describe how your agency is ensuring that ASAM data is entered into Marin WITS for all beneficiaries within seven (7) days of the assessment. Click or tap here to enter text.
**TUBERCULOSIS (TB) SERVICES**

TREATMENT PROVIDERS ONLY

To be completed by Providers who offer Residential, Non-Residential and Narcotic Replacement Therapy Services. Providers that offer only Primary and Secondary Prevention Services are not required to complete this section.

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your agency, directly or through referrals, advise clients of their rights to Tuberculosis (TB) services in writing (and file in their chart) and make TB services available to individuals who receive treatment for alcohol and/or drug abuse?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If yes, where are the services provided? Click or tap here to enter text.</td>
<td></td>
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<tr>
<td>Does your agency refer clients lacking documented evidence or a physician’s clearance of a skin test to an allied health facility for a skin test?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Does your agency refer individuals in need of treatment who are denied admission based on lack of capacity to another provider of TB services?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does your agency employ infection control procedures designed to prevent transmission of TB?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>If yes, which of the following procedures are utilized?</td>
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<tr>
<td>Screen clients</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Identify individuals who are at high risk of becoming infected with TB</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Adhering to federal and state confidentiality requirements</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Report individuals identified with active TB to the appropriate State official</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Conduct case management activities to ensure individuals receive services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Fulfill employer responsibilities under CAL-OSHA</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
### HIV/AIDS AND HEPATITIS C SERVICES

#### TREATMENT PROVIDERS ONLY

To be completed by Providers who offer Residential, Non-Residential, and Narcotic Replacement Therapy Services. Providers that offer Primary and Secondary Prevention Services are not required to complete this section.

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your agency provide participants with information and education related to the cause and origin of TB, risk factors and testing information?</td>
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<tr>
<td>Did the agency have any difficulty obtaining TB tests?</td>
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<td>Is the agency in compliance with TB requirements for staff?</td>
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<td>At intake, does the agency provide HIV screening or referral for HIV testing?</td>
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<tr>
<td>At intake, does the agency provide Hepatitis C education, screening and testing?</td>
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<tr>
<td>At intake, does the agency provide Hepatitis C education and a referral for Hepatitis C testing (if not done on-site)?</td>
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</table>

If yes, where do you refer clients? Click or tap here to enter text.
INTERIM SERVICES FOR INJECTING DRUG USING (IDU) INDIVIDUALS

TREATMENT PROVIDERS ONLY

To be completed by Providers who offer Residential, Non-Residential and Narcotic Replacement Therapy Services. Providers that offer Primary and Secondary Prevention Services are not required to complete this section.

Does the agency make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are individuals entered onto the WITS waitlist and is the County contract manager notified within 48 hours when space is not available for admission of priority individuals?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, how many individuals received interim services during this reporting period? Click or tap here to enter text.

If yes, do interim services include counseling and education about?

HIV and TB

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Risks associated with needle sharing

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Risks of HIV and TB transmission to sexual partners and infants

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Steps to reduce the risk of HIV and TB transmission

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If no, explain why not: Click or tap here to enter text.
HIV AND TB SERVICES FOR INDIVIDUALS

TREATMENT PROVIDERS ONLY

To be completed by Providers who offer Residential, Non-Residential and Narcotic Replacement Therapy Services. Providers that offer Primary and Secondary Prevention Services are not required to complete this section.

Does the agency make available HIV and TB services for IDU individuals who seek treatment?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, where are the services provided? Click or tap here to enter text.

Name of off-site facility utilized: Click or tap here to enter text.

Priority Access to Services for Pregnant Women

“Contractor agrees to ask women whether they are pregnant and to give priority to pregnant women in providing treatment and recovery services. [Reference Reauthorization Act, Public Law 102-321]

To be completed by Providers who offer Residential, Non-Residential and Narcotic Replacement Therapy Services. Providers that offer Primary and Secondary Prevention Services are not required to complete this section.

Does your agency include questions about pregnancy in admission screening for all women?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are pregnancy questions asked whether or not your agency has sufficient capacity to admit new clients?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does your agency give pregnant women priority access to treatment and recovery services?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If yes, when was the pregnancy priority policy established? Click or tap here to enter text.

If the policy has been revised, date of last revision: Click or tap here to enter text.

Does this policy carry the signatures of the Executive Director and the Chair of the agency’s Board of Directors?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
INTERIM SERVICES FOR PREGNANT WOMEN AND IDU WOMEN

TREATMENT PROVIDERS ONLY

To be completed by Treatment Providers. Providers that offer only Primary and Secondary Prevention Services are not required to complete this section.

Priority admission for all women in perinatal funded services must be given in the following order: 1) pregnant injection drug users; 2) pregnant substance users; 3) injection drug users; and 4) all others. When a program is unable to admit a substance-using pregnant woman because of insufficient capacity or because the program does not provide the necessary services, referral to another program must be made and documented. Pregnant women must be referred to another program or provided with interim services no later than 48 hours after seeking treatment services. [Reference State/County Contract; Perinatal Practice Guidelines; 45 CFR 96.131, 45 CFR 96.121 and 96.131]

Does the agency make interim services available for pregnant women, either on-site or by referral, within 48 hours for those individuals who are in need of treatment?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are there informational materials posted that advertise the availability of priority admission for these populations?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are pregnant women receiving interim services placed at the top of the waiting list for program admission?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are individuals entered onto the WITS waitlist and is the County contract manager notified within 48 hours when space is not available for admission of priority individuals?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Are priority individuals provided a unique patient identifier when placed on the waitlist?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the agency admit injection drug-using women no later than 14 days after making the request or are admitted to a program within 120 days after making the request, if interim services are provided?
☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
**RESIDENTIAL LICENSURE REQUIREMENT**

**RESIDENTIAL SERVICE PROVIDERS ONLY**

Licensure of residential programs requires reporting to the State DHCS major incidents involving death of any resident from any cause, any facility related injury of any resident which requires medical treatment, all cases of communicable disease, poisoning, catastrophes such as flooding, tornado, earthquakes or any other natural disaster, fires or explosions which occur in or on the premises. [Reference Title 9: California Code of Regulations (CCR), Division 4: Department of Alcohol and Drug Programs, Chapter 5, Subchapter 3, Article 1. Physical Environment, 10561 Reporting Requirements (b)]

Licensure of residential programs requires program staff to be in good health. The regulations read in part “(e) All personnel shall be in good health. (3) ... good physical health shall be verified by a health screening, including a test for tuberculosis, performed under licensed medical supervision not more than sixty (60) days prior to or seven (7) days after employment with tuberculosis testing renewable every year.” [Reference Title 9: California Code of Regulations (CCR), Division 4: Department of Alcohol and Drug Programs, Chapter 5, Subchapter 3, Article 2: Staffing Standards, 10564 Personnel Requirements (e)(3)]

To be completed by providers with Residential Services.

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<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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<tbody>
<tr>
<td>Is your agency currently in compliance regarding the reporting of major incidents such as death, injury requiring treatment, communicable disease, poisoning, catastrophes, fires or explosions?</td>
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<tr>
<td>Has your agency experienced any major incidents in FY 2019/20?</td>
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<td>If Yes, did you report the incident(s) to DHCS and BHRS per the format and timeframe required?</td>
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<tr>
<td>Is your agency currently in compliance regarding the staff health and documentation of same?</td>
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</tbody>
</table>
# DISASTER MANAGEMENT

**FOR DHCS LICENSED OR CERTIFIED BH FACILITIES**

Reference [DHCS IN 20-055: Disaster Management for DHCS Licensed or Certified BH Facilities](#)

## For Residential, Outpatient & NTP:

**Do you have an emergency preparedness plan for use in the event of emergencies and natural disasters?**

- [ ] Yes
- [ ] No
- [ ] Reviewed

If yes, please attach copy.

**Do you have a Wildfire Action Plan, including identifying alternative escape routes from the facility and community?**

- [ ] Yes
- [ ] No
- [ ] Reviewed

If yes, please attach copy.

**Do you have procedures for ensuring that smoke detectors, carbon monoxide detectors, and fire extinguishers are always in place and working?**

- [ ] Yes
- [ ] No
- [ ] Reviewed

**Do you have a portable radio or scanner to stay updated on the fire, as cell phone service may not be available?**

- [ ] Yes
- [ ] No
- [ ] Reviewed

**Is there defensible space around the facility? For example, trimming trees and other vegetation, clearing away dead branches, wood piles, and vegetation from the roof, patio furniture, and play equipment, and keep rain gutters free of debris.**

- [ ] Yes
- [ ] No
- [ ] Reviewed

## For NTP Only:

Attach your plan for ensuring the continuity of treatment in the event that an emergency or disaster disrupts the program's normal functions.

In an emergency situation, does your NTP program have the following:

- Operational telephone number available 24 hours a day for patients to contact a staff member or to be directed to an appropriate referral service (e.g., crisis line, hospital emergency room).

- [ ] Yes
- [ ] No
- [ ] Reviewed

List the telephone number:

- Procedures for notifying patients of emergency situations.

- [ ] Yes
- [ ] No
- [ ] Reviewed

- Posted addresses and telephone numbers of locations where patients can receive their medication?

- [ ] Yes
- [ ] No
- [ ] Reviewed

- Procedures to be ready and able to cooperate to ensure patients have access to replacement narcotic therapy during such circumstances that involve a disruption in services.

- [ ] Yes
- [ ] No
- [ ] Reviewed
For NTP only:

Has your agency reviewed the new regulations package 14-026 for NTPs (Reference DHCS IN 20-039 Approval of Regulation Package 14-026 for NTPs)?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Has your agency updated procedures/protocols to comply with the revised regulations?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If NO, describe your plan and timeline for updating [Click or tap here to enter text.]

Is your agency testing for oxycodone and fentanyl in samples collected from patient specimens? (Reference DHCS IN 20-050)

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed
Counselor Certification Regulations

Effective April 1, 2005, any individual providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in an ADP licensed or certified program are required to be certified. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization. Licensed professionals (LCSW, MFT, Psychologist or interns) are not required to be certified.

[Reference: Adoption of Chapter 8 (commencing with Section 13000), and Amendment of Sections 9846, 10125, and 10564, Division 4, Title 9, California Code of Regulations, Health and Safety Code 11833(b)(1), and MHSUDS Information Notice No. 16-058]

DMC-ODS Staff Definitions

Licensed Practitioner of the Healing Arts (LPHA) Non-Physician: Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

LPHA Physician: Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

Counselors: As defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations.

Peers: Peer-to-peer services are eligible for reimbursement under the DMC-ODS Pilot Program when provided as substance abuse assistance services, as a component of recovery services. The county must submit a training plan to DHCS for approval prior to providing covered peer support services. See Information Notice 17-008 for more information.
<table>
<thead>
<tr>
<th>DMC-ODS Staff Service Categories</th>
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</thead>
<tbody>
<tr>
<td><strong>PHYSICIAN ONLY</strong></td>
</tr>
<tr>
<td>Physician-to-Physician Consultation</td>
</tr>
<tr>
<td>• DMC physician consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists (Note: Counties may contract with one or more physicians or pharmacists to provide consultation services)</td>
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<tr>
<td>NTP Medication Psychotherapy:</td>
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<tr>
<td>• Face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient</td>
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<tr>
<td><strong>LPHA (PHYSICIAN AND NON-PHYSICIAN) ONLY</strong></td>
</tr>
<tr>
<td>Intake and Assessment:</td>
</tr>
<tr>
<td>• Determination of Medical Necessity</td>
</tr>
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<td></td>
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<tr>
<td>Medication Services</td>
</tr>
<tr>
<td>• Prescribe and Dispense Medication by staff authorized to provide services within their scope of practice or licensure</td>
</tr>
<tr>
<td>• Buprenorphine, naloxone and disulfiram reimbursed for onsite administration and dispensing at NTP programs</td>
</tr>
<tr>
<td>• Long-acting injectable naltrexone reimbursed for onsite administration</td>
</tr>
<tr>
<td>• Ordering, prescribing, administering, and monitoring of medication assisted treatment reimbursed</td>
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<td></td>
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<tr>
<td><strong>LPHA + COUNSELOR</strong></td>
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<tr>
<td><strong>Intake</strong></td>
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<tr>
<td>• Assessment of Treatment</td>
</tr>
<tr>
<td>• Development of Client Plan</td>
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<tr>
<td>• Prepare individualized treatment plan</td>
</tr>
<tr>
<td><strong>Counseling</strong></td>
</tr>
<tr>
<td>• Individual</td>
</tr>
<tr>
<td>• Group (min 2, max 12)</td>
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<tr>
<td><strong>Family Therapy</strong></td>
</tr>
<tr>
<td>• Incorporating family into treatment process</td>
</tr>
<tr>
<td><strong>Patient Education</strong></td>
</tr>
<tr>
<td>• Research based education</td>
</tr>
<tr>
<td><strong>Collateral Services</strong></td>
</tr>
<tr>
<td>• Sessions with therapists to support treatment goals</td>
</tr>
<tr>
<td><strong>Crisis Intervention Services</strong></td>
</tr>
<tr>
<td>• Stabilization of beneficiary emergency situation</td>
</tr>
<tr>
<td><strong>Discharge / Referral Services</strong></td>
</tr>
<tr>
<td>• Prepare beneficiary for referral</td>
</tr>
<tr>
<td>• Prepare beneficiary to return to community</td>
</tr>
<tr>
<td>• Link to community treatment</td>
</tr>
<tr>
<td><strong>Withdrawal Management Services</strong></td>
</tr>
<tr>
<td>• Monitoring course of withdrawal</td>
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</tbody>
</table>
### Case Management Services
- Transferring patient to a higher or lower level of care
- Development and periodic revision of a client plan that includes service activities
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system
- Monitoring the beneficiary’s progress
- Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services

### Recovery Services
- Recovery coaching, monitoring via telephone and internet
- Providing linkages to life skills, employment services, job training, and education services
- Providing linkages to childcare, parent education, child development support services, family/marriage education;
- Providing linkages to self-help and support, spiritual and faith-based support
- Providing linkages to housing assistance, transportation, case management, individual services coordination

### LPHA + COUNSELOR + PEER

<table>
<thead>
<tr>
<th>Substance Abuse Assistance</th>
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<tbody>
<tr>
<td>Peer-to-peer services and relapse prevention</td>
<td>x</td>
<td>x</td>
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<tr>
<td>STAFF CERTIFICATION AND SIGNATURES</td>
<td></td>
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</table>

Is your agency in compliance with all sections of the Counselor Certification Regulations?

- □ N/A
- □ Yes
- □ No
- □ Reviewed

If yes, please describe how you are ensuring that all counselors are registered to obtain certification prior to providing services. Click or tap here to enter text.

What is your Agency's schedule for verifying that certifications are effective and up to date? Click or tap here to enter text.

What is your agency’s schedule for verifying the Excluded Provider or Debarment List?

Click or tap here to enter text.

Total number (and % of total staff) who are:

- LPHA Physician #: %:
- LPHA Non-Physician #: %:
- Certified Counselor #: %:
- Registered Counselor #: %:
- Peer #: %:
- Licensing Intern (ASW, MFTi, etc.) #: %:

How is your agency ensuring LPHA staff are meeting their CEU requirements (e.g. LPHAs are required to have at least 5 CEUs in Addiction Medicine annually)? Click or tap here to enter text.

Does your Agency accommodate time off for staff to attend trainings for CEUs?

- □ N/A
- □ Yes
- □ No
- □ Reviewed

Are confirmations of registration or certification maintained in the personnel files?

- □ N/A
- □ Yes
- □ No
- □ Reviewed
Please complete the form below.

1. Staff Certification and Training Log
This includes a list of all License, Certified, and Registered clinicians in your organization providing services under the contract with the county. This list also includes the clinicians’ license/registered/certification number, license/registered/certification date, expiration date, certifying body, estimated certification date (if applicable), and the date of the last Excluded Provider check.
# STAFF CERTIFICATION AND TRAINING LOG

For each staff member, list the date of the most recent training. Staff Training Dates (All Providers)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Position</th>
<th>Employee Start Date</th>
<th>License /Reg/Cert Number</th>
<th>License/Reg/Cert Number</th>
<th>Expiration Date</th>
<th>Licensing/Certifying Body</th>
<th>Estimated Certification Date</th>
<th>Excluded Provider Check Date</th>
<th>Cultural Comp [training date]</th>
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<tbody>
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<td>Last Name</td>
<td>Oath of Confidentiality [date signed]</td>
<td>Non-Discrimination [training date]</td>
<td>PPSDS (Prevention Only) [training date]</td>
<td>Information Privacy &amp; Security (42 CFR &amp; HIPAA) [training date]</td>
<td>ASAM (E-Training 1 and 2)</td>
<td>CPR and First Aid [training date]</td>
<td>HIV/AIDS [training date]</td>
<td>CalOMS Treatment [training date]</td>
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</table>
MEDICATION ASSISTED TREATMENT (MAT)

**ALL PROVIDERS - EXCEPT PREVENTION**

PSC Exhibit A and I “Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.” Reference [State/County Contract, STC’s, Exhibit A and I]

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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</thead>
<tbody>
<tr>
<td>Are individuals with a primary opioid or alcohol use disorder linked to a MAT assessment and/or MAT services?</td>
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<tr>
<td>Does your agency ensure that the first face-to-face Medication Assisted Treatment appointment for individuals with alcohol or opioid disorders occur within five (5) and no longer than ten (10) business days?</td>
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<tr>
<td>Please describe your agency’s process and time frames for linking eligible clients to MAT?</td>
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<tr>
<td>Does your agency have a system for collecting and tracking the number or frequency of individuals reporting receiving their MAT services as prescribed?</td>
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<tr>
<td>Do individuals who are currently using MAT services have a signed 42 CFR part 2 compliant Release of Information for communicating with their physician who are prescribing these medications?</td>
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<tr>
<td>Does your agency’s MAT procedure include the following? How individuals are screened/referred for screening?</td>
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<tr>
<td>Assessed for MAT?</td>
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<tr>
<td>Communicating with Physicians of beneficiaries who are prescribing MAT medications?</td>
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<tr>
<td>Is your agency’s MAT Policy and Procedures attached?</td>
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</tbody>
</table>

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## PERINATAL SERVICE COMPLIANCE

### RESIDENTIAL WOMEN & CHILDREN AND SABG PERINATAL SET-ASIDE

The following is to be completed by Providers that receive Residential Women & Children and SABG Perinatal Set-Aside Funds Only.

<table>
<thead>
<tr>
<th>Task</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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</thead>
<tbody>
<tr>
<td>Is your agency in compliance with all of the provisions of the Perinatal Practice Guidelines FY2020-21?</td>
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<tr>
<td>Does the Program's Admission policy identify the following demographics as the target population for perinatal services: pregnant women, women with dependent children, women attempting to regain custody of their children, postpartum women and their children, women with substance exposed infants?</td>
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<tr>
<td>Does the Program's Admission policy outline the following target populations as priority populations: Pregnant injecting drug users, pregnant substance users, injection drug users, all others?</td>
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<tr>
<td>Does the agency have an operational manual that sets forth policies and procedures for the following elements.</td>
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<tr>
<td>Linkage to Primary Medical Care</td>
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<tr>
<td>Linkage to Primary Pediatric Medical Care</td>
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<tr>
<td>Gender-Specific Services</td>
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<tr>
<td>Therapeutic Interventions for Children</td>
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<td>Case Management</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Capacity Management and Wait List</td>
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<tr>
<td>Referrals</td>
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<tr>
<td>Outreach and Engagement Services</td>
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<tr>
<td>Interim Services</td>
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</tbody>
</table>
Child Care
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Parenting Skills
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Does the agency include the following services?
Assessment
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Linkages to ancillary services
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Withdrawal Treatment
☐ N/A ☐ Yes ☐ No ☐ Reviewed

A Recovery and Treatment Plan
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Individual and Group Counseling Sessions
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Addiction Education
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Continuing Self-Help/Support Groups
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Relapse Prevention Education/Activities
☐ N/A ☐ Yes ☐ No ☐ Reviewed

A Discharge Plan including Referrals (Housing, MH, Primary Care, Tx provider)
☐ N/A ☐ Yes ☐ No ☐ Reviewed

For Contractors providing on-site child care services, are you, as applicable compliant with all general licensing requirements outlined in, Perinatal Practice Guidelines FY19-20, Section C, Part 5?
☐ N/A ☐ Yes ☐ No ☐ Reviewed

If no, does the SUD treatment program partner with local, licensed child care facilities through cooperative arrangement between parents for the care of their children? Click or tap here to enter text.
Are the following child-care component included.

<table>
<thead>
<tr>
<th>Component Description</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate referrals for child-care assessments and services</td>
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<tr>
<td>Age appropriate toys and activities</td>
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<tr>
<td>Written policies and training on procedures for appropriate child discipline by staff</td>
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<tr>
<td>Cultural awareness and sensitivity</td>
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<td>Is smoking prohibited in any indoor facility where services for children are provided?</td>
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<tr>
<td>If child-care is provided off-site, is the child-care placement licensed or licensure-exempt?</td>
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<tr>
<td>If child-care is provided off-site, does the Program seek alternative funding for these services?</td>
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<tr>
<td>If no alternative funding exists, does the Program use perinatal funds as the payer of last resort?</td>
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<tr>
<td>If child care is provided off-site, is there a cooperative arrangement in place which outlines the following: A. Parents rotating as the responsible care giver B. Any person caring for the children shall be a parent, family member or legal guardian C. No monetary compensation D. No more than 12 children can receive care in the same place at the same time</td>
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<tr>
<td>Does the agency provide transportation services?</td>
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<tr>
<td>If yes, are transportation services provided to and from the recovery and treatment site?</td>
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<tr>
<td>to and from ancillary services (e.g., primary medical care, gender specific treatment, primary pediatric care and therapeutic interventions for children) for women who do not have their own transportation? (Transitional living centers are exempt)</td>
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<tr>
<td>Are the following educational areas incorporated into the treatment and recovery program:</td>
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<tr>
<td>Effects of substance abuse (e.g., impact of alcohol, drugs and tobacco use during pregnancy and while breast feeding, and/or information on smoking cessation)</td>
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</tbody>
</table>
### Marin County Behavioral Health and Recovery Services
Provider Self-Audit FY2020-21

<table>
<thead>
<tr>
<th>Service</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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</thead>
<tbody>
<tr>
<td>Prenatal Education</td>
<td></td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Parenting skills and child development info</td>
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<td><a href="#">Reviewed</a></td>
</tr>
<tr>
<td>HIV and AIDS (transmission, access to HIV testing, sexually transmitted diseases and safer sex practices)</td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Tuberculosis, testing, education, and counseling</td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Continuing educational and/or vocational training</td>
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<td><a href="#">Reviewed</a></td>
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</tbody>
</table>

If yes, include a list of services at the end of this section

<table>
<thead>
<tr>
<th>Service</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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</thead>
<tbody>
<tr>
<td>HIV and AIDS (transmission, access to HIV testing, sexually transmitted diseases and safer sex practices)</td>
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<td><a href="#">Reviewed</a></td>
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</table>

Are the following life skills topics incorporated into the treatment and recovery program?

- Family Planning
- Home management
- Financial management
- Time management
- Stress management
- Child and adult nutritional needs

Does the agency provide referrals and assist participants in coordinating appointments with?

- Obstetrical Care
- Gynecological Care
- Pediatric Care
- Social Services

Does the agency provide or arrange for sufficient case management in the following areas:

- Mental Health Services
- Intimate Partner Violence
- Safe Housing

<table>
<thead>
<tr>
<th>Service</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td></td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Intimate Partner Violence</td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Safe Housing</td>
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<td><a href="#">Reviewed</a></td>
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<tr>
<td>Service</td>
<td>Reviewed</td>
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<tr>
<td>Primary Medical Care</td>
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<td>Primary Pediatric Care</td>
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<tr>
<td>Gender Specific Treatment</td>
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<tr>
<td>Therapeutic Interventions for Children</td>
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<tr>
<td>Developmental Needs</td>
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<td>Sexual Abuse</td>
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<td>Physical Abuse</td>
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<td>Neglect</td>
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<tr>
<td>Gender specific differences</td>
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<tr>
<td>Understanding trauma in women and girls</td>
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<tr>
<td>Relationships</td>
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<tr>
<td>Sexual and Physical Abuse</td>
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<tr>
<td>Parenting (Child services must be provided while the women are receiving gender-specific treatment services)</td>
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<tr>
<td>Does your agency provide or arrange for primary medical care including referral for prenatal care for pregnant and parenting women receiving SUD treatment services?</td>
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<tr>
<td>Does your agency provide Therapeutic Interventions for children including the following?</td>
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<tr>
<td>Does your agency offer gender responsive treatment that includes the following?</td>
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</table>

Please list all Perinatal and Parenting services your Program provides:
# ADOLESCENT TREATMENT SERVICE

## ADOLESCENT TREATMENT SERVICE PROVIDERS ONLY

The following is to be completed by Providers that receive funding to provide Adolescent Treatment services.

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Is your agency in compliance with all of the provisions of the Youth Treatment Guidelines?</td>
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<td>Reviewed</td>
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<tr>
<td>If no, why not: Click or tap here to enter text.</td>
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<tr>
<td>Does the program serve ages 12 through 17?</td>
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<tr>
<td>For youth served over age 17 or under age 12, does the program:</td>
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<td>Reviewed</td>
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<tr>
<td>Document clinical appropriateness individually for each client?</td>
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<tr>
<td>Have a written protocol that addresses developmentally appropriate services for that age group?</td>
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<td>Reviewed</td>
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<tr>
<td>Is program admission based on client’s individual ASAM assessment?</td>
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<td>Reviewed</td>
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<tr>
<td>Does the Program assess the following desired client level outcomes for youth in treatment?</td>
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<tr>
<td>Reduction and/or elimination of AOD use</td>
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<td>Reviewed</td>
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<tr>
<td>Improved level of functioning in major life domains</td>
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<td>Reviewed</td>
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<tr>
<td>Placement and safe treatment in the most appropriate, least restrictive settings</td>
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<td>Reviewed</td>
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<tr>
<td>Does the Program provide the following service components?</td>
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<tr>
<td>Outreach</td>
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<tr>
<td>Screening</td>
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<td>Reviewed</td>
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<tr>
<td>Initial and Continuing Assessment</td>
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<td>Reviewed</td>
</tr>
<tr>
<td>Service</td>
<td>Option N/A</td>
<td>Yes</td>
<td>No</td>
<td>Reviewed</td>
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<tr>
<td>Diagnosis</td>
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<td>Placement in treatment</td>
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<td>Treatment Planning</td>
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<td>Counseling</td>
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<td>Youth Development approach to treatment</td>
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<tr>
<td>Family interventions and support systems</td>
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<tr>
<td>Educational and vocational activities</td>
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<tr>
<td>Structured recovery-related activities</td>
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<td>Alcohol and Drug Testing</td>
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<td>Discharge Planning</td>
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<tr>
<td>Continuing Care</td>
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<tr>
<td>Case Management and complementary services</td>
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<tr>
<td>Critical Linkages to Mental Health, Primary Care, etc</td>
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<tr>
<td>Does the Program provide services appropriate for the culture and language of the youth served and is the Program ADA compliant?</td>
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<tr>
<td>Does the Program provide an appropriate level of care and supervision to youth while providing services?</td>
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<tr>
<td>Does the Program Policy and Procedure Manual outline appropriate consequences/discipline for youth that are non-violent, developmentally appropriate and non-aversive?</td>
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<tr>
<td>Does the Program provide medication management to youth served as needed?</td>
<td></td>
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</tr>
</tbody>
</table>
Are staff trained to provide appropriate emergency services to youth?
- N/A
- Yes
- No
- Reviewed

Are youth in need of detoxification services referred to the most appropriate site for provision of those services?
- N/A
- Yes
- No
- Reviewed

For residential treatment only: Is the facility licensed and in compliance with all licensing requirements (DMC Certification/ASAM designation)?
- N/A
- Yes
- No
- Reviewed

Does the program comply with state and federal laws and regulations regarding voluntary treatment, informed consent, confidentiality and criminal reporting requirements?
- N/A
- Yes
- No
- Reviewed

Upon admission to services, are youth advised of the program rules, client rights, and grievance procedures in a culturally, linguistically and literacy appropriate way for the youth and families being served?
- N/A
- Yes
- No
- Reviewed

Do core program staff including case managers, have training or skills necessary to appropriately serve youth, as defined in the Youth Treatment Guidelines? Minimum training includes skills related to AOD treatment, community resources, physical and sexual abuse, family dynamics and legal issues.
- N/A
- Yes
- No
- Reviewed
# Tobacco Policy Checklist

**ALL PROVIDERS – EXCEPT PREVENTION**

<table>
<thead>
<tr>
<th>General tobacco policies:</th>
<th>Currently in effect</th>
<th>In process of implementation</th>
<th>Considering change in this area</th>
<th>No plans to</th>
<th>Would like raining/technical assistance (Please specify.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated smoking areas separate for clients and staff</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>“No Smoking” signs posted at facility and around grounds</td>
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<tr>
<td>Written comprehensive tobacco policy established</td>
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<tr>
<td>Tobacco-free program option for clients available</td>
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</tr>
<tr>
<td>Clients and staff not allowed to smoke anywhere on agency/clinic property</td>
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</tbody>
</table>

**Staff tobacco training and smoking issues:**

| Tobacco education provided for all staff | | | | | |
| Staff required to show no evidence of tobacco use during work | | | | | |
| Staff consistently encouraged to become tobacco free | | | | | |
| Staff has received training and/or updates within past 2 years on using tobacco cessation interventions with clients | | | | | |
| Tobacco cessation support offered to staff on-site | | | | | |

**Client tobacco education and nicotine treatment:**

| Client’s nicotine dependence assessed upon admission; cessation advice and referrals given | | | | | |
| Nicotine considered a drug in treatment planning | | | | | |
| Regularly scheduled tobacco education provided | | | | | |
| Tobacco information integrated into drug & alcohol education | | | | | |
| All clients required to be abstinent from tobacco use | | | | | |
| Structured cessation support offered to clients who want to quit | | | | | |
| Tobacco cessation classes conducted for clients | | | | | |
| One-on-one tobacco cessation counseling provided | | | | | |
| Pharmacological aids offered to help clients quit tobacco | | | | | |
| Official recognition/rewards given to clients who have become tobacco free | | | | | |

Adapted from Alameda County Tobacco Policy Checklist Survey, generously provided by Alameda ATOD Network, which is funded by Alameda County Department of Health Services Tobacco Control Program
PRIMARY PREVENTION APPLICABLE REGULATION COMPLIANCE

Contractor agrees to coordinate and transition to the Strategic Prevention Framework (SPF) under this Contract and shall provide evidence of engagement in these practices as requested by the County and State. Use of the SPF is mandatory for all counties beginning FY2007-2008 and SPF required data must be submitted via Primary Prevention SUD Data Service (PPSDS) as evidence of engagement and use of the practices. The SPF five-step approach is as follows:

1. Assessment
2. Capacity
3. Planning
4. Implementation
5. Evaluation

The SPF also includes Cultural Competency and Suitability. [Reference State/County SAPT Block Grant Contract, Exhibit A, Attachment I] For more information and guidance visit the SAMHSA site: www.samhsa.gov

Does the Program comply with the following Strategic Prevention Framework?

**Assessment**: Assess population needs (nature of substance use problem, where it occurs, whom it affects, how it is manifested), the resources required to address the problem, and the readiness to act.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

Please list the top two to three current population needs identified through the assessment process. Click or tap here to enter text.

**Data**: Are you reviewing local and state data sources to determine substance use prevention priorities for your community stakeholders?

☐ N/A ☐ Yes ☐ No ☐ Reviewed
If yes, please list what data sources you use.

**Capacity**: Mobilize members, identify resources and build readiness and capacity to address needs and problems identified in the Assessment to effectively prevent/reduce substance use and misuse.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

**Planning**: Develop and submit to Prevention Coordinator a comprehensive strategic plan that is aligned with County Strategic Plan Outcomes. The plan articulates a vision for implementing and evaluating specific prevention strategies, policies and practices to address the substance use problem locally. Review plan on an annual basis to ensure relevancy and effectiveness.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

Please list the proven prevention strategies currently in place. Click or tap here to enter text.

If you are not complying, describe why and your plans for compliance.

Click or tap here to enter text.

**Implementation**: Implement the evidence-based programs, strategies and infrastructure activities identified in the Planning phase.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

**Evaluation**: Develop and submit evaluation plan. Monitor and track implementation of strategies, evaluate effectiveness, sustain effective activities and improve or replace those that are not effective.

☐ N/A ☐ Yes ☐ No ☐ Reviewed

Please list documentation on-hand for this step - include a list of any prevention strategies you have eliminated, added or adapted. Please also submit as a separate attachment, the approved contractual scope of work document with the accomplishments achieved and challenges faced included in the end column of the Scope of Work. Click or tap here to enter text.
If you are not complying with Evaluation, describe why and your plans for compliance. Click or tap here to enter text.

**Cultural Competency:** At each step of the Strategic Prevention Framework (SPF), do you ensure the needs of all community members are considered and addressed.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

**Sustainability:** Do you ensure the sustainability of prevention outcomes by building stakeholder support for your program, showing and sharing results, and obtaining steady funding.

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

Does the Program comply with the State SABG and County of Marin contracts?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

**PPSDS Data Entry:** On a monthly basis, do you submit a completed, and accurate PPSDS excel spreadsheet that complies with all SABG data quality standards and outlines the prevention activities that occurred?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If you are not complying with data entry, describe why and your plans for compliance. Click or tap here to enter text.

**Attendance at Marin Prevention Network (MPN) Meetings including annual planning meetings:** Each funded MPN member (i.e., community coalitions, agency partners) is required to send at least one representative to the joint MPN coalition meetings including the planning meetings. Are you complying with the above requirement?

☐ N/A  ☐ Yes  ☐ No  ☐ Reviewed

If you are not complying with MPN participation, describe why and your plans for compliance. Click or tap here to enter text.
**Recent Accomplishments/Achievements:** Please provide a brief overview of recent accomplishments and achievements as it relates to your contracted scope of work. Click or tap here to enter text.

**Friday Night Live/Club Live:**
*The following questions are only for FNL/CL providers.*

Does the Contractor receive funding for Friday Night Live and/or Club Live?
- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

If yes, please provide examples of how this agency/program offers each of the Youth Development Standards and Core Components. Click or tap here to enter text.

Offers opportunities for community engagement, leadership and advocacy.
- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed

List examples of how this agency/program offers opportunities for community engagement, leadership and advocacy. Click or tap here to enter text.

If you are not complying with this youth development strategy and/or core FNL/CL component, describe why and your plans for compliance. Click or tap here to enter text.

Offers meaningful relationships with peers and adults.
- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ Reviewed
Please list examples of how this agency/program offers meaningful relationships with peers and adults. Click or tap here to enter text.

If you are not complying with this youth development strategy and/or core FNL/CL component, describe why and your plans for compliance. Click or tap here to enter text.

Offers youth-driven activities.
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Please list examples of how this agency/program offers youth-driven activities.

If you are not complying with this youth development strategy and/or core FNL/CL component, describe why and your plans for compliance. Click or tap here to enter text.

Offers development of life-skills and resilience.
☐ N/A ☐ Yes ☐ No ☐ Reviewed

Please list examples of how this agency/program offers development of life-skills and resilience. Click or tap here to enter text.

If you are not complying with this youth development strategy and/or core FNL/CL component, describe why and your plans for compliance. Click or tap here to enter text.

Is the FNL/CL Agency a Member in Good Standing?
☐ N/A ☐ Yes ☐ No ☐ Reviewed
If no, describe the process used to fulfill the agency's responsibility to meet the FNL MIGS requirements. Click or tap here to enter text.
"Effective July 1, 2004, all contracted providers with Behavioral Health and Recovery Services Division (BHRS), will be subject to the terms and conditions of the contract compliance policy." Specific terms include that all contracted providers must adhere to all reporting requirements, including submission timeline, location and format prescribed by the County. As outlined in the policy, contractor compliance will be used as a factor in assessing contract renewal and funding allocations. [Reference: Division Contract Compliance Policy, June 2004]

**DATA COLLECTION AND REPORTING REQUIREMENTS**

**PREVENTION PROVIDERS ONLY**

Does your agency have documented policies and procedures for PPSDS?
- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

If no, why? Click or tap here to enter text.

Does your Agency's onboarding procedure include training for PPSDS data collection?
- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

Who is responsible for managing data quality in PPSDS? Click or tap here to enter text.

What is your agency's schedule and process for verifying quality assurance of the PPSDS? Click or tap here to enter text.

Does your agency need training or technical assistance related to PPSDS?
- [ ] N/A
- [ ] Yes
- [ ] No
- [ ] Reviewed

*If yes, please describe:* Click or tap here to enter text.
## SOBER LIVING ENVIORNMENTS (SLE) PROVIDERS ONLY

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your agency in compliance with the Terms and Conditions set forth in Marin County Health and Human Services Guidelines for Sober Living Environments?</td>
<td></td>
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</tr>
<tr>
<td>Does your agency have a current Policies and Procedures Manual that sets forth the rules, regulations, expectations, governance, and grievance procedures of the house?</td>
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<tr>
<td>Does your agency have a Prescribed Medication policy, including Medication Assisted Treatment, regarding the use and storage of residents' prescribed medications?</td>
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</tr>
<tr>
<td>Does your agency have the following policies and procedures, please attach a copy?</td>
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</tr>
</tbody>
</table>

- Admission and Discharge
- Confidentiality
- Sexual Harassment and Verbal Abuse
- Weapons, Alcohol, Illegal Drugs and Illegal Activity
- Prescribed Medication Policy
- Drug and Alcohol Testing Protocol
- Management and Staff Responsibilities
- Documentation/Record Keeping/
- Financial Agreements
- Incident Report Policy
- Accessibility of Service Requirements
- Cultural Competency
- Non-Discrimination

- Attached
- Not Attached
All residents in RR must be either in OS/IOS or Recovery Services. Any resident who no longer meets medical necessity for Outpatient (OS) or Intensive Outpatient (IOS) services should be referred to Recovery Services.

What is your agency’s procedure to ensure each Recovery Resident is engaged in either Outpatient (IOS or OS) Treatment or Recovery Services?
Enclosed find the required Rendering Provider Attestation as outlined in DHCS IN-18-019. If your agency already utilizes a Rendering Provider Attestation template that meets these requirements, please contact your contract manager with a copy of the Attestation.

This Attestation requires service providers of all levels to attest that they do not have a certain felony conviction which excludes them from providing Medi-Cal or Medicare services. Given the large number, please refer directly to sections 1128 and 1128A of the Social Security Act. Below are links to the Referenced Sections and rendering Provider concerns can be reviewed on a case by case basis with your Contract Manager.

Sections 1128 and 1128A of the Social Security Act:
BHRS NETWORK PROVIDERS ATTESTATION

Rendering Provider Full Name:                                           Agency Name:

I have reviewed the Marin County Behavioral Health and Recovery Services (BHRS) Credentialing Policy. As a service provider for Marin County BHRS, I understand that BHRS Policy requires me to be able to provide services for which Medicare and Medi-Cal will pay directly or indirectly, including services which are clinical or administrative/managerial in nature, including support services and I attest to the following:

I am able to provide services under federally funded health care programs. Specifically:

a. ☐ I have* ☐ I have not (please check one) been convicted of a felony offense related to health care, or
b. ☐ I have* ☐ I have not (please check one) been debarred, excluded or otherwise made ineligible to provide services under federally funded health care programs, by a State or a federal agency.

c. ☐ I have* ☐ I do not have (please check one) a history of loss or limitation of privileges or disciplinary activity;

d. ☐ I do** ☐ I do not (please check one) have limitations that affect my ability to perform any of my position’s essentials job functions with or without reasonable accommodation.

e. ☐ I am ☐ I am not (please check one) using illegal drugs.

* If you have been convicted of a felony offence related to health care, have been debarred, excluded or are otherwise ineligible, or have a history of loss or limitation of privileges or disciplinary action please provide a detailed explanation on the back of this form.

** If you require reasonable accommodations to perform your job functions please provide a detailed explanation on the back of this form.

I understand that it is my responsibility to notify my immediate Supervisor or higher-level manager of any change in my ability to provide services under federally funded health care programs, including suspension or exclusion. Further, I understand that Marin County BHRS will verify my ability to participate in federally funded health care programs on not less than a tri-annual basis.

BY SIGNING I CERTIFY THAT I HAVE COMPLETED THIS ATTESTATION ACCURATELY AND COMPLETELY AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, SERVICES RENDERED BY ME AS A PROVIDER OF MARIN COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES’ NETWORK OF CARE MAY BE BILLED TO MEDI-CAL AND MEDICARE AS APPROPRIATE.

Date            Employee Name                        Provider Signature

Date            Supervisor Name                      Supervisor Signature

02/2020
## POLICIES AND PROCEDURES

### ALL PROVIDERS

All providers must have the following written policies and procedures, per the Department of Health Care Services. Please use the below checklist to confirm you have attached a copy of each policy to the Self-Audit to be submitted for review.

#### All Providers

- **Accessibility of Services Requirements**
  - Policy Attached
  - N/A
  - Reviewed

- **Charitable Choice Requirements (MHSUS-ADP-03)**
  - Policy Attached
  - N/A
  - Reviewed

- **Compliance with OMB Circular A-133**
  - Policy Attached
  - N/A
  - Reviewed

- **Continuing Education for Employees**
  - Policy Attached
  - N/A
  - Reviewed

- **Cultural Competency**
  - Policy Attached
  - N/A
  - Reviewed

- **Nondiscrimination**
  - Policy Attached
  - N/A
  - Reviewed

- **Utilization Review Procedure**
  - Policy Attached
  - N/A
  - Reviewed

- **HIV/Early Intervention Services**
  - Policy Attached
  - N/A
  - Reviewed

#### All Treatment Providers

- **Electronic Health Records Usage Policy**
  - Policy Attached
  - N/A
  - Reviewed

- **Interim Services**
  - Policy Attached
  - N/A
  - Reviewed

- **Provision of TB Services**
  - Policy Attached
  - N/A
  - Reviewed

- **Priority Populations**
  - Policy Attached
  - N/A
  - Reviewed

- **CalOMS Treatment/WITS**
  - Policy Attached
  - N/A
  - Reviewed

- **Credentialing Attestations (not a policy but still need to be attached)**
  - Policy Attached
  - N/A
  - Reviewed

- **License/Certification Tracking – Verification of NPPES, etc.**
  - Policy Attached
  - N/A
  - Reviewed

- **Excluded Provider Checks (Monthly)**
  - Policy Attached
  - N/A
  - Reviewed

- **Background Check/Live Scan**
  - Policy Attached
  - N/A
  - Reviewed

- **Privacy and Security (Training, Oath of Confidentiality, etc.)**
  - Policy Attached
  - N/A
  - Reviewed

- **No Unlawful Use Messaging Regarding Drugs**
  - Policy Attached
  - N/A
  - Reviewed