City and County of San Francisco
Office of Contract Administration
Purchasing Division

Third Amendment

THIS AMENDMENT (this "Amendment") is made as of March 14, 2017 in San Francisco, California, by and between **Positive Resource Center** ("Contractor"), and the **City and County of San Francisco**, a municipal corporation ("City"), acting by and through its Director of the Office of Contract Administration.

RECITALS

WHEREAS, the Department of Public Health, Community Behavioral Health Services ("Department") wishes to provide mental health and substance abuse services; and,

WHEREAS, City and Contractor desire to modify the Agreement on the terms and conditions set forth herein to amend the contract, add Appendices A and B for 2017-18 and increase compensation; and

WHEREAS, approval for this Agreement was obtained when the Civil Service Commission approved Contract number on 4152 09/10 on February 1, 2016;

NOW, THEREFORE, Contractor and the City agree as follows:

1. **Definitions.** The following definitions shall apply to this Amendment:

   a. Agreement. The term "Agreement" shall mean the Agreement dated October 1, 2013, Contract Number BPHM14000007 between Contractor and City as amended by the First Amendment, Contract Numbers BPHM14000007, DPHM15000108; the Second Amendment BPHM14000007, DPHM17000249 and this Third Amendment.

   b. Other Terms. Terms used and not defined in this Amendment shall have the meanings assigned to such terms in the Agreement.

2. **Modifications to the Agreement.** The Agreement is hereby modified as follows:

a. **Section 5 of the Agreement currently reads as follows:**

5. **Compensation.**

Compensation shall be made in monthly payments on or before the 30th day of each month for works set forth in Section 4 of this Agreement, that the Director of the Department of Public Health, in his or her sole discretion, concludes has been performed as of the 1st day of the immediately preceding month. In no event shall the amount of this Agreement exceed **Eight Million Ninety-Four Thousand, Nine Hundred Thirty-Two Dollars ($8,094,932).** The breakdown of costs associated with this Agreement appears in Appendix B, "Calculation of Charges," attached hereto and incorporated by reference as though fully set forth herein. No charges shall be

incurred under this Agreement nor shall any payments become due to Contractor until reports, services, or both, required under this Agreement are received from Contractor and approved by Department of Public Health as being in accordance with this Agreement. City may withhold payment to Contractor in any instance in which Contractor has failed or refused to satisfy any material obligation provided for under this Agreement.

In no event shall City be liable for interest or late charges for any late payments.

Section 5 is hereby amended in its entirety to read as follows:

5. Compensation.

Compensation shall be made in monthly payments on or before the 30th day of each month for works set forth in Section 4 of this Agreement, that the Director of the Department of Public Health, in his or her sole discretion, concludes has been performed as of the 1st day of the immediately preceding month. In no event shall the amount of this Agreement exceed **Ten Million Seven Hundred Forty-Four Thousand, Four Hundred Forty-Seven Dollars ($10,744,447).** The breakdown of costs associated with this Agreement appears in Appendix B, "Calculation of Charges," attached hereto and incorporated by reference as though fully set forth herein. No charges shall be incurred under this Agreement nor shall any payments become due to Contractor until reports, services, or both, required under this Agreement are received from Contractor and approved by Department of Public Health as being in accordance with this Agreement. City may withhold payment to Contractor in any instance in which Contractor has failed or refused to satisfy any material obligation provided for under this Agreement.

In no event shall City be liable for interest or late charges for any late payments.

u. **Appendix A dated 07/01/16 (i.e., July 1, 2016) is hereby replaced in its entirety with Appendix A dated 03/14/17 (i.e., March 14, 2017).**

v. **Appendices A-1, A2 and A-4 dated 03/14/17 (i.e. March 14, 2017) are hereby added for 2016-17.**

w. **Appendix B dated 07/01/16 (i.e., July 1, 2016) is hereby replaced in its entirety with Appendix B dated 03/14/17 (i.e. March 14, 2017).**

x. **Appendices B-1 and B-1a, B2 and B-4 dated 03/14/17 (i.e., March 14, 2017) are hereby added for 2016-17.**

y. **Appendix F, Invoices dated 07/01/16 (i.e., July 1, 2016) are hereby replaced in its entirety with Appendix F dated 03/14/17 (i.e. March 14, 2017).**

3. **Effective Date.** Each of the modifications set forth in Section 2 shall be effective on and after the effective date of the agreement.

4. **Legal Effect.** Except as expressly modified by this Amendment, all of the terms and conditions of the Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, Contractor and City have executed this Amendment as of the date first referenced above.

CITY

Recommended by:

BARBARA A. GARCIA MPA
Director of Health

Approved as to Form:

DENNIS J.HERRERA
City Attorney

By: _____ 3/21/17
KATHY MURPHY
Deputy City Attorney

Approved:

JACI FONG
Director of the Office of Contract Administration, and Purchaser

CONTRACTOR

POSITIVE RESOURCE CENTER

BRETT ANDREWS
EXECUTIVE DIRECTOR
785 MARKET STREET, 10th Floor
SAN FRANCISCO, CA 94103

City vendor number: 01497

Appendix A
Community Behavioral Health Services
Services to be provided by Contractor

1. **Terms**

A. Contract Administrator:

In performing the Services hereunder, Contractor shall report to **Valerie Wiggins** for the City, or his / her designee.

B. Reports:

Contractor shall submit written reports as requested by the City. The format for the content of such reports shall be determined by the City. The timely submission of all reports is a necessary and material term and condition of this Agreement. All reports, including any copies, shall be submitted on recycled paper and printed on double-sided pages to the maximum extent possible.

C. Evaluation:

Contractor shall participate as requested with the City, State and/or Federal government in evaluative studies designed to show the effectiveness of Contractor's Services. Contractor agrees to meet the requirements of and participate in the evaluation program and management information systems of the City. The City agrees that any final written reports generated through the evaluation program shall be made available to Contractor within thirty (30) working days. Contractor may submit a written response within thirty working days of receipt of any evaluation report and such response will become part of the official report.

D. Possession of Licenses/Permits:

Contractor warrants the possession of all licenses and/or permits required by the laws and regulations of the United States, the State of California, and the City to provide the Services. Failure to maintain these licenses and permits shall constitute a material breach of this Agreement.

E. Adequate Resources:

Contractor agrees that it has secured or shall secure at its own expense all persons, employees and equipment required to perform the Services required under this Agreement, and that all such Services shall be performed by Contractor, or under Contractor's supervision, by persons authorized by law to perform such Services.

F. Admission Policy:

Admission policies for the Services shall be in writing and available to the public. Except to the extent that the Services are to be rendered to a specific population as described in the programs listed in Section 2 of Appendix A, such policies must include a provision that clients are accepted for care without discrimination on the basis of race, color, creed, religion, sex, age, national origin, ancestry, sexual orientation, gender identification, disability, or AIDS/HIV status.

G. San Francisco Residents Only:

Only San Francisco residents shall be treated under the terms of this Agreement. Exceptions must have the written approval of the Contract Administrator.

H. Grievance Procedure:

Contractor agrees to establish and maintain a written Client Grievance Procedure which shall include the following elements as well as others that may be appropriate to the Services: (1) the name or title of the person or persons authorized to make a determination regarding the grievance; (2) the opportunity for the aggrieved party to discuss the grievance with those who will be making the determination; and (3) the right of a client dissatisfied with the decision to ask for a review and recommendation from the community advisory board or planning council that has purview over the aggrieved service. Contractor shall provide a copy of this procedure, and any amendments thereto, to each client and to the

Director of Public Health or his/her designated agent (hereinafter referred to as "DIRECTOR"). Those clients who do not receive direct Services will be provided a copy of this procedure upon request.

I. Infection Control, Health and Safety:

(1) Contractor must have a Bloodborne Pathogen (BBP) Exposure Control plan as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

(2) Contractor must demonstrate personnel policies/procedures for protection of staff and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

(3) Contractor must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

(4) Contractor is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

(5) Contractor shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

(6) Contractor shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

(7) Contractor assumes responsibility for procuring all medical equipment and supplies for use by their staff, including safe needle devices, and provides and documents all appropriate training.

(8) Contractor shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

J. Acknowledgment of Funding:

Contractor agrees to acknowledge the San Francisco Department of Public Health in any printed material or public announcement describing the San Francisco Department of Public Health-funded Services. Such documents or announcements shall contain a credit substantially as follows: "This program/service/activity/research project was funded through the Department of Public Health, City and County of San Francisco."

K. Client Fees and Third Party Revenue:

(1) Fees required by Federal, state or City laws or regulations to be billed to the client, client's family, Medicare or insurance company, shall be determined in accordance with the client's ability to pay and in conformance with all applicable laws. Such fees shall approximate actual cost. No additional fees may be charged to the client or the client's family for the Services. Inability to pay shall not be the basis for denial of any Services provided under this Agreement.

(2) Contractor agrees that revenues or fees received by Contractor related to Services performed and materials developed or distributed with funding under this Agreement shall be used to increase the gross program funding such that a greater number of persons may receive Services. Accordingly, these revenues and fees shall not be deducted by Contractor from its billing to the City, but will be settled during the provider's settlement process.

L. N/A

M. Patients Rights:

All applicable Patients Rights laws and procedures shall be implemented.

N. Under-Utilization Reports:

For any quarter that CONTRACTOR maintains less than ninety percent (90%) of the total agreed upon units of service for any mode of service hereunder, CONTRACTOR shall immediately notify the Contract Administrator in writing and shall specify the number of underutilized units of service.

O. Quality Improvement:

CONTRACTOR agrees to develop and implement a Quality Improvement Plan based on internal standards established by CONTRACTOR applicable to the SERVICES as follows:

(1) Staff evaluations completed on an annual basis.

(2) Personnel policies and procedures in place, reviewed and updated annually.

(3) Board Review of Quality Improvement Plan.

P. Working Trial Balance with Year-End Cost Report

If CONTRACTOR is a Non-Hospital Provider as defined in the State of California Department of Mental Health Cost Reporting Data Collection Manual, it agrees to submit a working trial balance with the year-end cost report.

Q. Harm Reduction

The program has a written internal Harm Reduction Policy that includes the guiding principles per Resolution # 10-00 810611 of the San Francisco Department of Public Health Commission.

R. Compliance with Community Behavioral Health Services Policies and Procedures

In the provision of SERVICES under CBHS contracts, CONTRACTOR shall follow all applicable policies and procedures established for contractors by CBHS, as applicable, and shall keep itself duly informed of such policies. Lack of knowledge of such policies and procedures shall not be an allowable reason for noncompliance.

S. Fire Clearance

Space owned, leased or operated by San Francisco Department of Public Health providers, including satellite sites, and used by CLIENTS or STAFF shall meet local fire codes. Providers shall undergo of fire safety inspections at least every three (3) years and documentation of fire safety, or corrections of any deficiencies, shall be made available to reviewers upon request."

2. Description of Services

Detailed description of services are listed below and are attached hereto

Appendix A-1: PRC Benefits Counseling Program

Appendix A-2: PRC Equal Access to Healthcare Program

Appendix A-4: Positive Resource Center Merger Support

1. **PROGRAM NAME / ADDRESS:** PRC Benefits Counseling Program
785 Market Street, 10th Floor
San Francisco, California 94103-2017

Contact Name / Phone: Sergio Perez, Director of Finance, (sergiop@positiveresource.org)
Phone: 415-972-0823 Fax: 415- 777-1770

2. **NATURE OF DOCUMENT:** Amendment Three

CBHS Program Name / Code: Other Non Medi-Cal Client Support Services / 38H101

3. GOAL STATEMENT

The primary goal of the Benefits Counseling Program of Positive Resource Center through this contract is to represent eligible clients who are uninsured, underinsured, or at risk of losing insurance to pursue or maintain SSI/SSDI/CAPI and corresponding Medi-Cal/Medicare, thus providing them with improved access to healthcare and the financial means to stabilize their living situation.

4. TARGET POPULATION

Through this contract the program will serve clients of pre-assigned County DPH Mental Health Centers and people living with HIV/AIDS in San Francisco. For clients of DPH mental health sites, emphasis will be on reaching those with open episodes in the mental health system. For people living with HIV/AIDS in San Francisco, priority will be given to those eligible for disability benefits that are unable to work. For both populations, targeted clients will include those that have no income, low or very low incomes as defined by federal poverty standards, people who have time-limited income, and people receiving County Assistance, CalWORKs or State Disability Insurance. Clients will be either uninsured, underinsured or at risk of losing public or private health insurance. These populations may include multiple diagnosed people, people who have been incarcerated, people with documented substance use, people who are homeless, single parents, people of color, immigrants, women, and the LGBT community.

5. MODALITIES/INTERVENTIONS

Client Populations	UOS	UDC
Clients of DPH Mental Health Sites	7,317	475
People Living with HIV/AIDS (PLWHA)	3,507	400
Total	10,824	875

6. METHODOLOGY

Outreach, Recruitment, Promotion, and Advertisement
Mental Health referrals are made directly to the Benefits Counseling Program by DPH mental health programs that are pre-approved by DPH and PRC. People living with HIV/AIDS are most often referred by DPH funded public health clinics and

hospitals, community-based organizations, county agencies and emergency service providers, as well as by individuals from San Francisco communities. The Managing Legal Director and Supervising Attorneys, in addition to benefits staff who have specific language proficiency, will provide training and technical assistance to staff of identified DPH County Mental Health sites and service providers who work with people living with HIV/AIDS on the mode of referral to the program and the disability process. PRC has a history of conducting outreach and trainings to physicians, public health staff, multi-disciplinary teams and other community-based organizations and clinics, and presents at state-wide and national conferences on effective SSI advocacy.

Admission, Enrollment and Intake

Clients of DPH Mental Health Sites: DPH staff may identify and refer appropriate clients within the target population. After receiving a designated referral/release form in Spanish, English or Chinese, a PRC benefits staff member may schedule the client with an intake appointment.

People Living with HIV/AIDS: New clients seeking public disability benefits are screened by the benefits staff for program eligibility, and if eligible, are scheduled for an intake appointment after being prioritized for the following issues:

- clients who have no income or will have no income within the next month;
- clients who are currently on County Adult Assistance Program (GA) and are uninsured / underinsured.

Clients of the Benefits Counseling Program will be asked to sign relevant paperwork that may include an Appointment of Representative form, a HIPAA compliant Release of Information form, a copy of PRC's grievance procedure and other documents necessary within the scope of legal representation.

A case is considered opened once the following criteria are met:

- A client has signed an Appointment of Representative form and steps are being taken toward submission of an application for SSI/SSDI/CAPI benefits or work is being done on the case at the Reconsideration or ALJ level of appeal, or
- Representation is being provided to mitigate barriers that impede qualifying for SSI/SSDI benefits or to mitigate barriers that cause SSI/SSDI eligibility to be terminated. Those barriers include Continuing Disability Reviews.

If clients are screened as ineligible for SSI, but eligible for Social Security Disability Insurance or Cash Assistance Program for Immigrants, the Benefits Counseling Program will represent on these issues, as well as facilitate the Medi-Cal application process with clients who meet non-medical eligibility and who have not already filed.

To maximize Medi-Cal coverage for clients and gain up to 3 months coverage prior to the SSI application's protected filing date – or to secure the earliest possible Medi-Cal application dates for clients who are determined eligible for coverage under Medi-Cal Expansion or SSDI, but not SSI – Benefits Counseling Program staff will follow the Medi-Cal Expansion policies and procedures set forth by DPH after a client files an initial SSI application if the client does not already have a protective filing date for Medi-Cal.

Monthly, Benefits Counseling Program staff will submit a New Client Intake Spreadsheet to the State representative at the Medi-Cal Office housed within the SF Human Services Agency. This will occur after a claimant has had an intake appointment and has signed an Appointment of Representative Form. The State representative will inform Benefits Counseling Program staff if Medi-Cal Expansion forms are required for any client. Medi-Cal Expansion forms will be sent to the Medi-Cal Office on a monthly basis for all applicable clients that received an intake during that month.

Service Delivery Model

The principal site of service will be at 785 Market Street, 10th Floor in San Francisco. The program site is ADA compliant, centrally located and easily accessible from MUNI and BART. Office hours are maintained Monday through Friday, from 9:00 AM - 5:00 PM.

The Benefits Counseling Program will represent clients that:

- are at the initial stage of filing for SSI/SSDI/CAPI benefits,
- are filing requests for reconsideration of a previous denial of benefits,
- are filing requests for hearings in front of an Administrative Law Judge,
- have filed a request for review with the Appeals Council, and/or
- have, or are facing benefits cessation at the initial level or above three levels of appeal due to Continuing Disability Reviews.

Exit Criteria and Process

A client's case is considered active as long as Benefits Counseling Program staff is working to gain or maintain benefits for the client. Once a client case is won and all benefits are in effect, Benefits Counseling Program staff advises clients on future issues that may affect benefits. After this final review, the client's file is closed and the client's record is marked as closed in the benefits status database.

A client's case will be closed when the SSI/SSDI/CAPI application is awarded, or client becomes ineligible as follows:

- Client notifies PRC that they have moved out of SF County and the claim is closed.
- Claim is denied and all levels of administrative appeal are exhausted.
- Client has not worked enough to qualify for Social Security Disability Insurance, but their assets disqualify them for Supplemental Security Income or CAPI.
- Client returns to work earning above substantial gainful activity for more than six consecutive months during the first year of alleged disability.

Benefits Counseling Program staff will notify DPH when a case is closed, in accordance with the Closure Sheet. SSA Notice of Award documents will be submitted minimally to DPH on a bi-weekly basis.

Program Staffing

The Benefits Counseling Program has a Managing Legal Director leading the project, with a team of Supervising Attorneys and Staff Attorneys representing clients. The Managing Legal Director and Supervising Attorneys hire, train, supervise and evaluate the work of the staff, conduct file reviews, research changes in disability benefits laws and regulations, help develop community linkages for the program, present at national conferences and continuing education symposiums, and prepare written materials for both clients and providers. They also act as benefits advocates and hearings representatives when needed. Other Benefits Counseling Program staff includes a Quality Assurance Manager and Legal Assistants.

The Benefits Counseling staff has developed particular expertise working with dual, triple and quadruple diagnosed clients. Staff has extensive expertise in obtaining benefits for disabled clients who also have substance use and/or mental health issues and practices client-centered and harm reduction SSI advocacy. PRC has made it a priority for the agency to remain culturally and linguistically competent in order to ensure that monolingual clients have full access to services. In-house legal services are provided in Spanish, Cantonese, Mandarin and Tagalog.

7. OBJECTIVES AND MEASUREMENTS

All objectives, and descriptions of how objectives will be measured, are contained in the document entitled *Behavioral Health Services – Adult and Older Adult Performance Objectives FY 17-18.*

8. CONTINUOUS QUALITY IMPROVEMENT

The Benefits Counseling Program abides by the standards of care for services as described in Making the Connection: Standards of Care for Client-Centered Services. The Managing Legal Director trains all new staff at hire using the Benefits Counseling Policy and Procedures Manual which is available on the shared network for ongoing review. Any changes are discussed at Team Meetings. The Managing Legal Director and Supervising Attorneys ensure that staff follows policies and procedures during weekly Supervision Meetings to assure the provision of service delivery.

In order to document progress of client cases, files are created for new clients after an intake with an advocate is completed. File contents are organized into four sections to ensure uniformity: contact logs, administrative paperwork, correspondence, and medical records. The Managing Legal Director and/or Supervising Attorneys review client files as part of weekly supervision meetings when cases are discussed to ensure uniformity, proper organization of data, completion of required forms, progress toward achievement of the benefits plan and evidence of proper follow-up. Indicators for reviewing files include the completion of relevant administrative forms, including an initial or current registration on ARIES, a copy of the Grievance, ADA and Language Access Policies and Procedures, current and up-to-date contact logs, HIPAA compliant releases of information, DPH Notice of HIPAA Privacy Policy, a review of all eligible benefits, a plan to achieve benefits, a Representative form for Social Security, an attorney retainer agreement, relevant correspondence and medical records. During weekly Team Meetings and Case Conferences, advocates bring new intake files, give a brief case synopsis and pass the file around to the team. This further ensures that new client files are in order and appropriate action plans are created.

A Benefits Counseling Database is maintained which documents all clients enrolled and served, including relevant statistical information. When a benefits claim is initiated, information is entered into the Database in order to efficiently track the progress of the claim and create an additional level of quality assurance. The Database tracks filing dates, appeal deadlines, level of appeal, onset date of disability and relevant notes. All active claims/issues are marked as "Active" on the database. When cases are resolved, the award information is entered into the database, including the date of the award, amount obtained and retroactive amount. The Quality Assurance Manager is responsible for monitoring the Database, tracking claims, procuring and submitting documentation, reporting outcomes through spreadsheet development, ensuring that files are properly closed out and maintaining efficient and effective protocol to ensure compliance with contract objectives and legal duties.

Applicable DPH Privacy Policies are integrated into the program's adopted, approved and implemented policies and procedures. All required documentation for auditing is maintained and up-to-date, and all record-keeping complies with the timeline required by DPH and is submitted as follows:

Type of Documentation / Information	Timelines / Due Dates
I. *SSI/SSDI Medi-Cal Expansion Forms* and/or *SSI/SSDI Cover Letters* to Medi-Cal Office as requested by State representative	I. By the end of each month for all applicable clients that received an intake during that month
II. Closure Sheets to Medi-Cal Office	II. Monthly, as received and processed
III. SSA Award Letters to Medi-Cal Office	III. Monthly, as received and processed
IV. Contract Documents (App A and App B) to SFDPH Contract Development and Technical Assistance (CDTA) Unit	IV. Will comply with SFDPH deadlines
V. DPH Declaration of Compliance and Required Reports	V. As specified by the SFDPH Business Office Contract Compliance (BOCC) Unit
VI. DPH Contract Performance Tracking Report: A. Monitoring Protocol Response B. Client Demographics	VI. Will comply with SFDPH System of Care and BOCC requirements for reporting as requested

HIV Health Services Database
PRC collects and submits unduplicated client and services data through the DPH HIV Client and Services Database for the Ryan White eligible HIV/AIDS clients served through DPH funds. PRC complies with HIV Health Services (HHS) policies and procedures for collecting and maintaining timely, complete and accurate unduplicated client and service information in the Database. New client registration data is entered within 48 hours or two working days after data is collected. Service data for the preceding month, including units of service, is entered by the 15th working day of each month. The deliverables are consistent with the information that is submitted to the appropriate DPH Budget and Finance section on the "Monthly Statements of Deliverables and Invoice."

Client Satisfaction Surveys
Client Satisfaction Surveys are mechanisms used for identifying areas for quality improvement. Clients receive a Client Satisfaction Survey by mail four months after intake. In addition, surveys are displayed in each staff's office for clients to pick up, complete and anonymously drop in a box in the lobby. The survey tracks satisfaction with overall services, courtesy, accuracy and helpfulness of information, confidentiality, and cultural competency, and also gives clients an opportunity to submit written comments and suggest changes they would like to see. We particularly invite clients to give us feedback on areas where they feel we could improve. The Front Office Coordinator collects and tallies all completed surveys on a monthly basis for submission to the Managing Legal Director. Results of the surveys are analyzed by the Managing Legal Director and discussed with the Executive Director. The Managing Legal Director shares pertinent information gathered from the client satisfaction surveys as needed at weekly team meetings in order to continue to deliver state-of-the-art benefits advocacy.

Staff Training and Development
Continuous staff training through continuing legal education, in-services and attendance at community workshops ensures program staff is aware of the latest information and tools for effectively advocating on behalf of clients. The Agency's cultural and linguistic competency will continue to improve through sending staff to trainings covering cultural competency issues relevant to underserved communities, hosting in-service presentations by agencies serving specific populations, providing outreach to agencies that serve targeted clients, and attending City sponsored cultural competency trainings whenever available. Benefits Counseling Program staff conduct cross training during weekly team meetings in areas which individuals have developed particular expertise.

The Managing Legal Director or Supervisors evaluate the performance of Program staff that they supervise after the completion of an initial 90-day probationary period and annually thereafter and record the findings of these evaluations in confidential personnel folders maintained for each staff member. The Executive Director reviews all performance evaluations before they are finalized.

Results of all quality improvement activities are discussed with Benefits Counseling Program staff at team meetings and case conferences to determine any program changes that could improve client services. The Executive Director and Managing Legal Director meet on a twice monthly basis to discuss program protocols, the need for any changes based upon client and provider feedback or staff recommendations, or possible program design or methodology changes needed to meet program objectives. The Managing Legal Director submits a written report to the Board of Directors prior to Board meetings summarizing advocacy results, programmatic changes and progress towards outcome and process objectives.

9. REQUIRED LANGUAGE

A. All agencies will assure that Ryan White CARE Act funds will be used to fund only services that are not reimbursed by any other funding source.

B. The client enrollment priority is reserved for San Francisco residents who have low-income and are uninsured. Secondary enrollment is reserved for San Francisco residents who have low-income and are underinsured. Low Income status is defined as 400% of Federal Poverty Level as defined by Health and Human Services Department. A client's HIV diagnosis must be confirmed at intake. Client eligibility determination for residency, low-income, and insurance

status must be confirmed at intake and at 12-month intervals thereafter. Six-month, interim eligibility confirmation may be by a client's self-attestation, but must be documented in the client's file or in ARIES.

C. All agencies must abide by the standards of care for the services specified in this appendix as described in "Making the Connection: Standards of Care for Client-Centered Services."

D. All agencies receiving funding through HHS must collect and submit all required data through the AIDS Regional Information & Evaluation System (ARIES).

ARIES is a client management system designed for Ryan White CARE Act providers. ARIES enhances care provided to clients with HIV by helping agencies automate, plan, manage, and report on client data and services. ARIES is applicable for all Ryan White-eligible clients receiving services paid with any HHS source of funding. ARIES protects client records by ensuring only authorized agencies have access. ARIES data are safely encrypted and are kept confidential.

A client's information relating to mental health, substance abuse, and legal issues are only available to a limited group of an agency's personnel. Authorized, ARIES-trained personnel are given certificate-dependent and password-protected access to only the information for which that person's level of permission allows. Each HHS-funded agency participates in the planning and implementation of their respective agency into ARIES. All agencies must comply with HHS policies and procedures for collecting and maintaining timely, complete, and accurate unduplicated client and service information in ARIES. Registration data must be entered into ARIES within 48 hours or two working days after the data are collected. Service data, including units of service, for the preceding month must be entered by the 15th working day of each month. Service data deliverables must match the information submitted on the "Monthly Statements of Deliverables and Invoice" form. Not adhering to HHS standards for quality and timeliness of service data will risk having payments delayed.

E. Agencies that receive vouchers from HHS must have a written protocol that describes how vouchers are secured, distributed, tracked, and managed. In addition, this voucher protocol must be described in the Methodology section of this Program Narrative.

F. In order to meet the requirements of "Vigorous Pursuit" all agencies must use the "Covered California Client Information and Acknowledgement and Documentation Form." This form details the information to be communicated to the client including the federal requirement to have health insurance, the potential tax penalty for not having health insurance coverage, and includes the client's signature to document receipt of this information. Once completed and signed, this form must be stored in the client's chart and/or noted and uploaded into ARIES.

G. All agencies must achieve the program's objectives within the agreed-upon timeframe. All objectives, and descriptions of how objectives will be measured and reported, are in the SFDPH document entitled "Ambulatory Care – Primary Care (HIV Health Services) Performance Objectives FY17-18."

1. **PROGRAM NAME / ADDRESS:** **PRC Equal Access to Healthcare Program (EAHP)**
785 Market Street, 10th Floor
San Francisco, California 94103-2017

Contact Name / Phone: Sergio Perez, Director of Finance, sergiop@positiveresource.org
Phone: 415-972-0823 Fax: 415- 777-1770

2. **NATURE OF DOCUMENT:** **Amendment Three**

3. GOAL STATEMENT

The goal of the Equal Access to Healthcare Program is to address the incomplete information and systemic barriers clients living with HIV/AIDS experience in accessing healthcare through the Affordable Care Act.

4. TARGET POPULATION

The primary target populations will be DPH clients living with HIV/AIDS in San Francisco and the DPH Eligibility Workers who provide enrollment advice to these clients. Secondarily, the contract may also serve CARE eligible clients living in San Francisco who are not connected to DPH systems of care. Positive Resource Center (PRC) will assure that Ryan White CARE Act funds will be used to fund only services that are not reimbursed by any other funding source. The client enrollment priority is reserved for San Francisco residents who have low-income and are uninsured. Secondary enrollment is reserved for San Francisco residents who have low-income and are underinsured. Low Income status is defined as 400% of Federal Poverty Level as defined by Health and Human Services Department. PRC must confirmed a client's HIV diagnosis at intake. Client eligibility determination for residency, low-income, and insurance status must be confirmed at intake and at 12-month intervals thereafter. Six-month, interim eligibility confirmation may be by a client's self-attestation, but must be documented in the client's file or in ARIES.

5. MODALITIES / INTERVENTIONS / UNITS OF SERVICE (UOS/UDC)

Service Period	Unit of Service Description	UOS	UDC
03/01/17 -02/28/18	***EAHP Client Intake Hours*** 3.15 FTE X 40 hours per week X 45 weeks X 68% effort	3,855	525
03/01/17 -02/28/18	***Training/Outreach Hours*** .40 FTE X 40 hours per week X 45wks x 65% effort	468	N/A
Total Units of Service and Unduplicated Clients		**4,323**	**525**

6. METHODOLOGY

Outreach, Recruitment, Promotion, and Advertisement
PRC will place advertisements in local media announcing ACA Open Enrollment and PRC's EAHP services. In order to maintain close working relationships and increase referrals, the Managing Legal Director and Supervising Attorney, in addition to benefits staff who have specific language proficiency, will provide outreach, educational training and technical

assistance to DPH clinics and hospitals and community-based organizations serving people living with HIV/AIDS. PRC will also continue to build on a network of referral agencies that work with underserved communities.

Admission, Enrollment and Intake
New clients seeking EAHP services will be screened by the benefits staff for program eligibility, and if eligible, will be scheduled for either a consultation or an intake appointment. Intake clients will be asked to sign relevant paperwork that may include an Appointment of Representative form, a HIPAA compliant Release of Information form, a copy of PRC's grievance procedure, an Attorney Retainer Agreement including a written scope of service, and other documents necessary within the scope of legal representation. All clients will be entered into the Benefits Counseling database.

Service Delivery Model
The program site, 785 Market Street in San Francisco, is ADA compliant and easily accessible from MUNI and BART. Office hours are maintained from 9:00 AM - 5:00 PM.

Client Intake Services
PRC Attorneys will provide counseling, advocacy and direct legal assistance and representation on issues related to access to healthcare, such as disability based Medicare, traditional disability based Medi-Cal programs, Medi-Cal managed care plans and their medical exemption, MAGI Medi-Cal, State's Office of AIDS programs such as OA HIPP and ADAP, and HIV Continuity of Care protection. A complete case file will be maintained, and relevant information entered into the Benefits Counseling database and ARIES for all clients that have completed the intake process.

Clients seeking access to MAGI Medi-Cal, Covered California, State's Office of AIDS programs such as OA HIPP and ADAP, disability based healthcare programs such as Medicare, certain types of Medi-cal programs, e.g. Aged and Disabled Medi-Cal, the Medically Needy Medi-Cal program, SSI linked Medi-Cal, and the Working Disabled Medi-Cal program, are screened by the benefits staff for program eligibility, and if eligible, are scheduled for an intake appointment after being prioritized for the following issues:

- clients who have no income or will have no income within the next month, and do not have health insurance
- clients who are currently on County Adult Assistance Program (GA) and are uninsured / underinsured for health insurance.

Clients of the Benefits Counseling Program will be asked to sign relevant paperwork that may include an Appointment of Representative form, a HIPAA compliant Release of Information form, a copy of PRC's grievance procedure and other documents necessary within the scope of legal representation.

A case is considered opened once the following criteria are met:

- A client has signed an Appointment of Representative form and steps are being taken toward submission of an application for disability based healthcare benefits or work is being done on the case at the administrative appeal level, or
- Representation is being provided to mitigate barriers that impede qualifying for disability based healthcare benefits or to mitigate barriers that cause eligibility for said benefits to be terminated. Those barriers include Continuing Disability Reviews.

If clients are screened as ineligible for disability based healthcare programs, but eligible for non-disability based programs such as MAGI Medi-Cal, the Benefits Counseling Program will represent on these issues, as well as facilitate the Medi-Cal application process with clients who meet non-medical eligibility and who have not already filed.

To maximize Medi-Cal coverage for clients and gain up to 3 months coverage prior to the application's protected filing date – or to secure the earliest possible Medi-Cal application dates for clients who are determined eligible for coverage under Medi-Cal Expansion or SSDI, but not SSI – Benefits Counseling Program staff will follow the Medi-Cal Expansion policies and procedures set forth by DPH after a client files an initial SSI application if the client does not already have a protective filing date for Medi-Cal.

Monthly, Benefits Counseling Program staff will submit a New Client Intake Spreadsheet to the State representative at the Medi-Cal Office housed within the SF Human Services Agency. This will occur after a claimant has had an intake appointment and has signed an Appointment of Representative Form and/or an Attorney Retainer Agreement. The State representative will inform Benefits Counseling Program staff if Medi-Cal Expansion forms are required for any client. Medi-Cal Expansion forms will be sent to the Medi-Cal Office on a monthly basis for all applicable clients that received an intake during that month.

Exit Criteria and Process
A client's case will be considered active as long as Benefits Counseling Program staff is working to resolve issues relating to access to healthcare. The specific scope of service for each intake client will be outlined in the Attorney Retainer Agreement Addendum, if needed. Once services defined in the addendum have been completed, Benefits Counseling Program staff will notify the client in writing that their case will be closed. The client's file will then be closed and the client's record marked as closed in the Benefits Counseling database.

Training Services
PRC staff will provide group and one-on-one outreach, educational trainings and community information sessions to San Francisco clinics, community based organizations, and low-income San Franciscans living with HIV/AIDS.

Training content will include:

- Healthcare Reform (The Affordable Care Act)
- Private health insurance through Covered California
- Insurance Exchanges
- Pharmacy and formulary issues
- Interactions among different systems of benefits
- Resources for older people living with HIV/AIDS
- Medicaid/Cal Expansion
- Modified Adjusted Gross Income (MAGI) Medi-Cal
- Disability based Medi-Cal and Medicare programs
- Medicare – Part D
- SSI/SSDI
- Public vs. Private Insurance - eligibility
- Cash Assistance Program for Immigrants (CAPI)
- State's Office of AIDS programs such as OA HIPP, OA-PCIP) and ADAP
- Accessing Healthcare
- Return to Work Rules for Social Security
- Private Long Term Disability Policies
- Effects of the repeal of DOMA and the implementation of ACA

PRC staff will also provide an expertise line to answer questions from DPH Eligibility Workers who provide enrollment advice to clients living with HIV/AIDS. PRC staff will foster relationships with enrolling entities such as Covered California and Medi-Cal in order to advance the EAHP agenda. PRC will monitor and analyze emerging issues that SF clients living with HIV/AIDS may be having with ACA enrollment and transitions and report to DPH.

Trainings will consist of:
285 hours individual sessions
112.5 hours planning, research, curriculum development, event logistics, program evaluation
70.5 hours group sessions

Sign-in sheets will be maintained and evaluation questionnaires will be distributed to all group training participants. The results of these qualitative and quantitative written evaluations will be compiled by PRC's Senior Legal Assistant who will

report outcomes to the Supervising Attorney, Managing Legal Director and Executive Director. Time spent and issues covered on one-on-one outreach, training and consultations will be tracked in the Benefits Counseling database.

Program Staffing
The Managing Legal Director will oversee the overall project. A PRC Supervising Attorney will supervise program staff, perform legal research and monitor and analyze data. Staff Attorneys and Benefits Advocates will provide consultations, advocacy and counseling to clients and DPH Eligibility Workers. Legal Assistants will provide support to project staff. Trainings will be performed by the Managing Legal Director and Staff Attorneys supported by the Senior Legal Assistant/Training Coordinator, with subcontractor AIDS Legal Referral Panel participating in some trainings.

HIV Health Services Database
All agencies receiving funding through HHS must collect and submit all required data through the AIDS Regional Information & Evaluation System (ARIES).

ARIES is a client management system designed for Ryan White CARE Act providers. ARIES enhances care provided to clients with HIV by helping agencies automate, plan, manage, and report on client data and services. ARIES is applicable for all Ryan White-eligible clients receiving services paid with any HHS source of funding. ARIES protects client records by ensuring only authorized agencies have access. ARIES data are safely encrypted and are kept confidential.

A client's information relating to mental health, substance abuse, and legal issues are only available to a limited group of an agency's personnel. Authorized, ARIES-trained personnel are given certificate-dependent and password-protected access to only the information for which that person's level of permission allows. Each HHS-funded agency participates in the planning and implementation of their respective agency into ARIES.

PRC must comply with HHS policies and procedures for collecting and maintaining timely, complete, and accurate unduplicated client and service information in ARIES. Registration data must be entered into ARIES within 48 hours or two working days after the data are collected. Service data, including units of service, for the preceding month must be entered by the 15th working day of each month. Service data deliverables must match the information submitted on the "Monthly Statements of Deliverables and Invoice" form. Not adhering to HHS standards for quality and timeliness of service data will risk having payments delayed.

7. OBJECTIVES AND MEASUREMENTS

Process Objectives

1. **Provide counseling, advocacy and direct legal assistance and representation to five hundred and twenty five (525) clients living with HIV/AIDS.**

   Measurement and Evaluation: Attorneys and Advocates will complete intake paperwork and case files for all clients, and enter relevant statistical information into the Benefits Counseling database and ARIES. The Supervising Attorney will query the database monthly to analyze progress towards the objective and report to the Managing Legal Director.

2. **Provide twenty five (25) group outreach & training sessions for San Francisco HIV clinics, community based organizations and consumers.**

   Measurement and Evaluation: A Supervising Legal Assistant will maintain a spreadsheet tracking each training session, including date, topics covered, hours performed, and number and affiliation of attendees. After each session, participants will complete qualitative and quantitative written evaluations. The results will be compiled by the Supervising Legal Assistant and reported to the Supervising Attorney and Managing Legal Director.

3. **Provide two hundred and eighty five (285) hours of individual outreach and training on issues related to healthcare access to clients living with HIV/AIDS and DPH Eligibility Workers who provide enrollment advice to these clients.**

   Measurement and Evaluation: Attorneys and Advocates will enter time spent and issues covered into the Benefits Counseling database. The Supervising Attorney will query the database monthly to analyze progress towards the objective and report to the Managing Legal Director.

4. **Submit a year-end report analyzing emerging and longstanding healthcare access issues for people living with HIV/AIDS in light of the Affordable Care Act, and annual outcomes of the Equal Access to Healthcare Program, by July 31, 2017.**

   Measurement and Evaluation: Attorneys and Advocates will track clients' healthcare issues and resolutions in the Benefits Counseling database. The Supervising Attorney will query the database at the end of the contract term to analyze the outcome of the program, and submit a year-end report to PRC's Executive Director, Board of Directors and DPH.

8. CONTINUOUS QUALITY IMPROVEMENT

The Benefits Counseling Program abides by the standards of care for services as described in Making the Connection: Standards of Care for Client-Centered Services. The Managing Legal Director trains all new staff at hire using the Benefits Counseling Policy and Procedures Manual which is available on the shared network for ongoing review. Any changes are discussed at Team Meetings. The Managing Legal Director and Supervising Attorney ensure that staff follows policies and procedures during weekly Supervision Meetings to assure the provision of service delivery.

In order to document progress of client cases, files are created for new clients after an intake with an advocate is completed. File contents are organized into four sections to ensure uniformity: contact logs, administrative paperwork, correspondence, and medical records. The Managing Legal Director and/or Supervising Attorneys review client files as part of weekly supervision meetings when cases are discussed to ensure uniformity, proper organization of data, completion of required forms, progress toward achievement of the benefits plan and evidence of proper follow-up. Indicators for reviewing files include the completion of relevant administrative forms, including an initial or current registration on ARIES, a copy of the Grievance, ADA and Language Access Policies and Procedures, current and up-to-date contact logs, HIPAA compliant releases of information, DPH Notice of HIPAA Privacy Policy, a review of all eligible benefits, a plan to achieve benefits, a Representative form for various agencies responsible for adjudicating healthcare benefits, an attorney retainer agreement, relevant correspondence and medical records, as necessary. During weekly Team Meetings and Case Conferences, advocates bring new intake files, give a brief case synopsis and pass the file around to the team. This further ensures that new client files are in order and appropriate action plans are created.

A Benefits Counseling Database is maintained which documents all clients enrolled and served, including relevant statistical information. When a benefits claim is initiated, information is entered into the Database in order to efficiently track the progress of the claim and create an additional level of quality assurance. The Database tracks filing dates, appeal deadlines, level of appeal, onset date of disability, date of entitlement for Medi-Cal, Medicare, and relevant notes. All active claims/issues are marked as "Active" on the database. When cases are resolved, the award information is entered into the database, including the date of the award and types of healthcare benefits. The Quality Assurance Manager is responsible for monitoring the Database, tracking claims, procuring and submitting documentation, reporting outcomes through spreadsheet development, ensuring that files are properly closed out and maintaining efficient and effective protocol to ensure compliance with contract objectives and legal duties.

The Managing Legal Director and Supervising Attorney will meet on a weekly basis to ensure that the project is on track and discuss project design, protocols or methodology changes needed to meet outcome objectives. The Managing Legal Director will submit a written report to the Board of Directors prior to Board meetings summarizing project results and progress towards outcome objectives.

HIPAA Compliance

Item #2a: DPH Privacy Policy is integrated in the program's governing policies and procedures regarding patient privacy and confidentiality. As Measured by: Evidence that the policy and procedures abide by the rules outlined in the DPH Privacy Policy and have been adopted, approved and implemented.

Item #2b: All staff that handles patient health information are trained (including new hires), and annually updated in the program's privacy/confidentiality policies and procedures. As Measured by: Documentation exists demonstrating that individuals were trained.

Item #2c: A Privacy Notice that meets the requirements of the Federal Privacy Rule (HIPAA) is written and provided to all patients/clients served in their threshold and other languages. If document is not available in patient/client relevant language, verbal translation is provided. As Measured by: Evidence in patient/client chart or electronic file that patient was "noticed." (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian are provided.)

Item #2d: A Summary of the above Privacy Notice is posted and visible in registration and common areas of treatment facility. As Measured by: Presence and visibility of posting in said areas. (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian are provided.)

Item #2e: Each disclosure of patient/client health information for purposes other than treatment, payment, or operations is documented. As Measured by: Documentation exists.

Item #2f: Authorization for disclosure of patient/client health information is obtained prior to release (1) to providers outside the DPH Safety Net or (2) from a substance abuse program. As Measured by: An authorization form that meets the requirements of the Federal Privacy Rule (HIPAA) is signed and in patient's/client's chart/file."

9. REQUIRED LANGUAGE

A. All agencies will assure that Ryan White CARE Act funds will be used to fund only services that are not reimbursed by any other funding source.

B. The client enrollment priority is reserved for San Francisco residents who have low-income and are uninsured. Secondary enrollment is reserved for San Francisco residents who have low-income and are underinsured. Low Income status is defined as 400% of Federal Poverty Level as defined by Health and Human Services Department. A client's HIV diagnosis must be confirmed at intake. Client eligibility determination for residency, low-income, and insurance status must be confirmed at intake and at 12-month intervals thereafter. Six-month, interim eligibility confirmation may be by a client's self-attestation, but must be documented in the client's file or in ARIES.

C. All agencies must abide by the standards of care for the services specified in this appendix as described in "Making the Connection: Standards of Care for Client-Centered Services."

D. All agencies receiving funding through HHS must collect and submit all required data through the AIDS Regional Information & Evaluation System (ARIES).

ARIES is a client management system designed for Ryan White CARE Act providers. ARIES enhances care provided to clients with HIV by helping agencies automate, plan, manage, and report on client data and services. ARIES is applicable for all Ryan White-eligible clients receiving services paid with any HHS source of funding. ARIES protects

client records by ensuring only authorized agencies have access. ARIES data are safely encrypted and are kept confidential.

A client's information relating to mental health, substance abuse, and legal issues are only available to a limited group of an agency's personnel. Authorized, ARIES-trained personnel are given certificate-dependent and password-protected access to only the information for which that person's level of permission allows. Each HHS-funded agency participates in the planning and implementation of their respective agency into ARIES. All agencies must comply with HHS policies and procedures for collecting and maintaining timely, complete, and accurate unduplicated client and service information in ARIES. Registration data must be entered into ARIES within 48 hours or two working days after the data are collected. Service data, including units of service, for the preceding month must be entered by the 15th working day of each month. Service data deliverables must match the information submitted on the "Monthly Statements of Deliverables and Invoice" form. Not adhering to HHS standards for quality and timeliness of service data will risk having payments delayed.

E. Agencies that receive vouchers from HHS must have a written protocol that describes how vouchers are secured, distributed, tracked, and managed. In addition, this voucher protocol must be described in the Methodology section of this Program Narrative.

F. In order to meet the requirements of "Vigorous Pursuit" all agencies must use the "Covered California Client Information and Acknowledgement and Documentation Form." This form details the information to be communicated to the client including the federal requirement to have health insurance, the potential tax penalty for not having health insurance coverage, and includes the client's signature to document receipt of this information. Once completed and signed, this form must be stored in the client's chart and/or noted and uploaded into ARIES.

G. All agencies must achieve the program's objectives within the agreed-upon timeframe. All objectives, and descriptions of how objectives will be measured and reported, are in the SFDPH document entitled "Ambulatory Care – Primary Care (HIV Health Services) Performance Objectives FY16-17."

1. **Identifiers:**
   Program Name: Positive Resource Center Merger Support
   Program Address: 785 Market Street, 10th Floor
   City, State, ZIP: San Francisco, CA 94103
   Telephone/FAX: 415-777-0333/415-777-1770
   Website Address: www.positiveresource.org

   Person Completing this Narrative: Pat Riley
   Telephone: 415-972-0823
   Email Address: patr@positiveresource.org

2. **Nature of Document:**
   ☐ New ☐ Renewal ☒ Amendment Three

3. **Goal Statement:**

   The goal of Merger Support funding is to facilitate Positive Resource Center (PRC) in absorbing Baker Places' clinically-based residential treatment programs and AIDS Emergency Fund's emergency financial assistance program, thus providing services that cut across a full set of needs that will better serve individuals through the combined organizations.

4. **Target Population:**

   The target population is people with disabilities and chronic conditions in San Francisco, including People Living with HIV/AIDS.

5. **Modality(s)/Intervention(s)**

   The billable UOS are defined as twelve months of start-up Merger Support Months.

Units of Service (UOS) Description	Units of Service (UOS)	Number of Clients (NOC)	Unduplicated Clients (UDC)
Merger Support Months	12	N/A	
Total UOS Delivered	12		
Total UDC Served			N/A

6. **Methodology:**

   The Chief Executive Officer will oversee the overall project. The implementation team will also consist of the Chief Operations Officer, Chief of Programs, Chief Financial Officer and Chief Information Officer, who will restructure their departments to merge the three programs with the input of a variety of consultants providing professional services in specific areas of expertise.

   Professional Services will be engaged for:

   - Health Care Rates and Fees, as overseen by the Chief Financial Officer and Chief Executive Officer: Consultant Fees for a healthcare consultant to work with PRC to ensure Medi-Cal certification for the merged agency, and increase Baker Places' Medi-Cal

billing rates while reducing associated costs, ultimately bringing program revenue and expenses in line to operate in the black.

- Management Training, as overseen by the Chief Operations Officer: Senior Management training for PRC's new suite of Executive Leadership Team, management and program staff to operate under an innovative health analysis and business strategy that will: (1) reduce siloed and fragmented health and social services, (2) streamline service eligibility criteria and processes, and (3) minimize clients lost in the referral process by offering an intra-agency case management and service delivery system to better serve the clients
- IT Systems Integration, as overseen by the Chief Information Officer and Chief of Programs: address infrastructure needs, including program databases, appropriate firewalls, IT protocols, upgrades and integration, including costs for hardware, software and network systems infrastructure to integrate and maintain IT systems for the three agencies, streamline revenue billing and reporting systems; and reassure all client information is safe and secure within the guidelines of HIPPA.
- Board Development, as overseen by the Chief Executive Officer and the Chief Operating Officer: Consultant Fees to implement a board development initiative; consistent with our 2015-17 strategic plan, which will increase board engagement in the areas of fund development, board recruitment and participation to create a board that is commensurate with the size and scope of the new organization and that ultimately reflects the diversity of our client base.
- Campaign Consultant, as overseen by the Chief Executive Officer and Chief Operating Officer: Consultant Fees to create and implement a Comprehensive Campaign to raise funds for merger expenses, capital and ongoing program costs to ensure the broad spectrum of services to clients under the merged agency are financially positioned successfully in perpetuity.
- Agency Rebranding, as overseen by the Chief Executive Officer and Chief Operations Officer: Consultant fees to rebrand the merged agency into one cohesive brand and image that will reflect the consolidation of the non-residential treatment services (employment services, legal representation, emergency financial assistance, and health care enrollment), including logos, graphic design templates and style guides to retain existing clients and market service availability of the merged agency.
- Website Redesign, as overseen by the Chief Executive Officer and the Chief Operations Officer: Consultant fees to consolidate and redesign the websites of the three agencies to provide one seamless user interface for clients and various other stakeholders to better inform the clients of the new services as a result of the merger, and help educate them about other client related changes.
- Public Relations, as overseen by the Chief Executive Officer and Chief Operating Officer: Consultant fees for Public Relations firm to represent PRC to the media during and after the merger process including press releases, client communications, community partners, service providers and social media, among other press-related communications to inform existing and new clients of the merger and array of new services.

Supports for the period of transition before, during and after each part of the two mergers will focus on the exploration of cost efficiencies and the optimization of client centered decisions related to merging of services through the following long-term objectives, which exceed this contract period:

- **Reduction of administrative/occupancy expenses: Data will be collected through the financial management software system with a goal of reducing expenses by a minimum of 20% across three organizations for the fully merged organization over a period of three years**
- **Reduction of intake eligibility burden on clients: Data will be collected from eligibility staff with the goal of reducing intake time, streamlined eligibility and recertification process for a client accessing services at all three agencies by 15% per year**
- **Reduction in client attrition: Data will be collected through the client data software system with a goal of reducing attrition by 10%, 12 months after merger completion**

Within year one after the merger PRC will:

- Establish an experienced and qualified board of directors
- Implement a revised management structure
- Design and launch a comprehensive fundraising campaign
- Design and launch a communications and community relations campaign
- Transfer public contracts to the merged organization
- Fully integrate organizations and staff

7. Objectives and Measurements:

A. Objective:

1) Nine (9) Baker Places' sites will be recertified by the State of California by the end of the contract year, in order to ensure no disruption in PRC's ability to invoice for services in FY 18-19.

Measurement and Evaluation

PRC's CEO will work with BP's ED/Clinical Advisor to track the progress of the certification process and guarantee a seamless transfer of Medi-Cal certification from Baker to PRC.

2) PRC will file Dissolution and Disposition of Assets of AEF with the state Attorney General's office to ensure no disruption of client services.

Measurement and Evaluation

PRC's CEO will track the progress of the filing and guarantee a seamless transfer of services from AEF to PRC.

3) Three diverse members will be added to the Board of Directors by the end of the contract year, in order to establish an experienced and qualified board that represents the ethnic and gender diversity of our client base and community.

Measurement and Evaluation

Board demographics will be quantified at the end of the contract year and reported to DPH to ensure progress towards diversity goals.

4) Two (2) client and staff focus groups will be held to capture the needs and interests of the affected populations.

Measurement and Evaluation

PRC's CEO, Chief of Programs and BP's Clinical Director will analyze the outcomes of the focus groups. The results will inform a strategy that will be incorporated into a new "Integrated Health Analysis" program model.

5) A year-end report analyzing progress towards each activity outlined in Methodology, above, will be submitted to DPH by July 31, 2018.

Measurement and Evaluation

The CEO and COO will keep a running four-week, project-based timeline, which will be used to produce a final report to be presented to the Board of Directors and DPH.

8. Continuous Quality Improvement:

The project implementation team will meet on a weekly basis to ensure that the project is on track and discuss project design, protocols or methodology changes needed to meet outcome objectives and the client service need. The Chief Executive Officer will submit a written report to the Board of Directors prior to Board meetings summarizing project results and progress towards outcome objectives and client satisfaction.

9. Required Language:

a. Ryan White funds will be used only for services that are not reimbursed by any other source of funding.

b. Client eligibility for Ryan White funded services is assessed upon intake and at minimum every six (6) months thereafter. The Merger Support Program will also have processes in place to document compliance, and to facilitate DPH monitoring of this requirement.

c. If standards of care have been developed for the particular types of service being provided (one year or more ago), the following statement is required, "Provider agrees to abide by the standards of care for the services specified in this appendix as described in Making the Connection: Standards of Care for Client-Centered Services."

d. All agencies receiving funding through HHS are required to collect and submit unduplicated client and services data through the DPH HIV Client and Services Database. This is applicable for all Ryan White eligible clients receiving services paid with any HHS source of funding. Each HHS funded agency participates in the planning and implementation of its respective agency into the Database. The agency complies with HHS policies and procedures for collecting and maintaining timely, complete and accurate UDC and UOS service information in the Database. New client registration data is entered within 48 hours or two working days after data is collected. Service data for the preceding month, including UOS is entered no later than the 15th working day of the following month. The deliverables are consistent with the information submitted to the appropriate DPH Budget and Finance section on the Monthly Statements of Deliverables and Invoice form. If these HHS standards for quality and timeliness of data entry are not followed payments may be delayed until the data has been entered and updated.

e. Programs that receive vouchers from HHS are required to have a written protocol that describes how vouchers are secured, distributed, tracked, and managed. In addition a

description of these processes should be summarized in the Methodology section of the Program Narrative (Appendix A).

f. In order to meet the requirements of "Vigorous Pursuit" providers should use the "Covered California Client Information and Acknowledgement and Documentation Form" provided by SFDPH Primary Care HIV Health services. This form details the information to be communicated to the client including the federal requirement to have health insurance, the potential tax penalty for not having health insurance coverage, and includes clients' signatures to document receipt of this information. Once completed and signed this form must be stored in the client charts and/or noted and uploaded into ARIES.

HIPAA Compliance

DPH Privacy Policy is integrated in the program's governing policies and procedures regarding patient privacy and confidentiality. As Measured by: Evidence that the policy and procedures abide by the rules outlined in the DPH Privacy Policy and have been adopted, approved and implemented.

All staff that handles patient health information are trained (including new hires), and annually updated in the program's privacy/confidentiality policies and procedures. As Measured by: Documentation exists demonstrating that individuals were trained.

A Privacy Notice that meets the requirements of the Federal Privacy Rule (HIPAA) is written and provided to all patients/clients served in their threshold and other languages. If document is not available in patient/client relevant language, verbal translation is provided. As Measured by: Evidence in patient/client chart or electronic file that patient was "noticed." (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian are provided.)

A Summary of the above Privacy Notice is posted and visible in registration and common areas of treatment facility. As Measured by: Presence and visibility of posting in said areas. (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian are provided.)

Each disclosure of patient/client health information for purposes other than treatment, payment, or operations is documented. As Measured by: Documentation exists.

Authorization for disclosure of patient/client health information is obtained prior to release (1) to providers outside the DPH Safety Net or (2) from a substance abuse program. As Measured by: An authorization form that meets the requirements of the Federal Privacy Rule (HIPAA) is signed and in patient's/client's chart/file."

Appendix B
Calculation of Charges

1. Method of Payment

A. Invoices furnished by CONTRACTOR under this Agreement must be in a form acceptable to the Contract Administrator and the CONTROLLER and must include the Contract Progress Payment Authorization number or Contract Purchase Number. All amounts paid by CITY to CONTRACTOR shall be subject to audit by CITY. The CITY shall make monthly payments as described below. Such payments shall not exceed those amounts stated in and shall be in accordance with the provisions of Section 5, COMPENSATION, of this Agreement.

Compensation for all SERVICES provided by CONTRACTOR shall be paid in the following manner. For the purposes of this Section, "General Fund" shall mean all those funds which are not Work Order or Grant funds. "General Fund Appendices" shall mean all those appendices which include General Fund monies.

(1) Fee For Service (Monthly Reimbursement by Certified Units at Budgeted Unit Rates)

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month, based upon the number of units of service that were delivered in the preceding month. All deliverables associated with the SERVICES defined in Appendix A times the unit rate as shown in the appendices cited in this paragraph shall be reported on the invoice(s) each month. All charges incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

(2) Cost Reimbursement (Monthly Reimbursement for Actual Expenditures within Budget):

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month for reimbursement of the actual costs for SERVICES of the preceding month. All costs associated with the SERVICES shall be reported on the invoice each month. All costs incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

B. Final Closing Invoice

(1) Fee For Service Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those SERVICES rendered during the referenced period of performance. If SERVICES are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY. CITY'S final reimbursement to the CONTRACTOR at the close of the Agreement period shall be adjusted to conform to actual units certified multiplied by the unit rates identified in Appendix B attached hereto, and shall not exceed the total amount authorized and certified for this Agreement.

(2) Cost Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those costs incurred during the referenced period of performance. If costs are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY.

C. Payment shall be made by the CITY to CONTRACTOR at the address specified in the section entitled "Notices to Parties."

2. Program Budgets and Final Invoice

A. Program Budget is listed below and is attached hereto.

Appendix B-1 MH SSI Advocacy Benefits Counseling

Appendix B-1a: HIV SSI Advocacy Counseling

Appendix B-2: Equal Access to Healthcare

Appendix B-4: Organizational Support for Merger

B. COMPENSATION

Compensation shall be made in monthly payments on or before the 30th day after the DIRECTOR, in his or her sole discretion, has approved the invoice submitted by CONTRACTOR. The breakdown of costs and sources of revenue associated with this Agreement appears in Appendix B, Cost Reporting/Data Collection (CR/DC) and Program Budget, attached hereto and incorporated by reference as though fully set forth herein. The maximum dollar obligation of the CITY under the terms of this Agreement shall not exceed **Ten Million Seven Hundred Forty Four Thousand Four Hundred Forty Seven Dollars ($10,744,447) for the period of October 1, 2013 through June 30, 2018.**

CONTRACTOR understands that, of this maximum dollar obligation, **$283,877** is included as a contingency amount and is neither to be used in Appendix B, Budget, or available to CONTRACTOR without a modification to this Agreement executed in the same manner as this Agreement or a revision to Appendix B, Budget, which has been approved by the Director of Health. CONTRACTOR further understands that no payment of any portion of this contingency amount will be made unless and until such modification or budget revision has been fully approved and executed in accordance with applicable CITY and Department of Public Health laws, regulations and policies/procedures and certification as to the availability of funds by the Controller. CONTRACTOR agrees to fully comply with these laws, regulations, and policies/procedures.

(1) For each fiscal year of the term of this Agreement, CONTRACTOR shall submit for approval of the CITY's Department of Public Health a revised Appendix A, Description of Services, and a revised Appendix B, Program Budget and Cost Reporting Data Collection form, based on the CITY's allocation of funding for SERVICES for the appropriate fiscal year. CONTRACTOR shall create these Appendices in compliance with the instructions of the Department of Public Health. These Appendices shall apply only to the fiscal year for which they were created. These Appendices shall become part of this Agreement only upon approval by the CITY.

(2) CONTRACTOR understands that, of the maximum dollar obligation stated above, the total amount to be used in Appendix B, Budget and available to CONTRACTOR for the entire term of the contract is as follows, not withstanding that for each fiscal year, the amount to be used in Appendix B, Budget and available to CONTRACTOR for that fiscal year shall conform with the Appendix A, Description of Services, and a Appendix B, Program Budget and Cost Reporting Data Collection form, as approved by the CITY's Department of Public Health based on the CITY's allocation of funding for SERVICES for that fiscal year.

13-14 Prev Encumb		$1,362,342
14-15 Prev Encumb		$1,946,310
15-16 Prev Encumb		$2,021,045
16-17 THIS Encumb		$2,765,235
17-18 To Be Encumb		$2,365,638
	total	$10,460,570
	Contingency	$283,877
	Grand Total	**$10,744,447**

(3) CONTRACTOR understands that the CITY may need to adjust sources of revenue and agrees that these needed adjustments will become part of this Agreement by written modification to CONTRACTOR. In event that such reimbursement is terminated or reduced, this Agreement shall be terminated or proportionately reduced accordingly. In no event will CONTRACTOR be entitled to compensation in excess of these amounts for these periods without there first being a modification of the Agreement or a revision to Appendix B, Budget, as provided for in this section of this Agreement.

C. CONTRACTOR agrees to comply with its Budget as shown in Appendix B in the provision of SERVICES. Changes to the budget that do not increase or reduce the maximum dollar obligation of the CITY are subject to the provisions of the Department of Public Health Policy/Procedure Regarding Contract Budget Changes. CONTRACTOR agrees to comply fully with that policy/procedure.

D. No costs or charges shall be incurred under this Agreement nor shall any payments become due to CONTRACTOR until reports, SERVICES, or both, required under this Agreement are received from CONTRACTOR and approved by the DIRECTOR as being in accordance with this Agreement. CITY may withhold payment to CONTRACTOR in any instance in which CONTRACTOR has failed or refused to satisfy any material obligation provided for under this Agreement.

E. In no event shall the CITY be liable for interest or late charges for any late payments.

F. CONTRACTOR understands and agrees that should the CITY'S maximum dollar obligation under this Agreement include State or Federal Medi-Cal revenues, CONTRACTOR shall expend such revenues in the provision of SERVICES to Medi-Cal eligible clients in accordance with CITY, State, and Federal Medi-Cal regulations. Should CONTRACTOR fail to expend budgeted Medi-Cal revenues herein, the CITY'S maximum dollar obligation to CONTRACTOR shall be proportionally reduced in the amount of such unexpended revenues. In no event shall State/Federal Medi-Cal revenues be used for clients who do not qualify for Medi-Cal reimbursement.

Appendix B - DPH 1: Department of Public Health Contract Budget Summary

DHCS Legal Entity Number (MH)	01695			Page #	4
DHCS Legal Entity Name (MH)/Contractor Name (SA)	Positive Resource Center (PRC)			Fiscal Year	2017-18
Contract CMS #	7383			Document Date	03/14/17
Contract Appendix Number	B-1	B-1a	B-2	B-4	
Provider Number	38H1	38H1	38H1	38H1	
Program Name(s)	MH SSI Advocacy Benefits Counseling	HIV SSI Advocacy Benefits Counseling	Equal Access to Healthcare Program	Organizational Support for Merger	
Program Code(s)	38H101	N/A - HIV Hlth Svcs	N/A - HIV Hlth Svcs	N/A	
Funding Term (mm/dd/yy - mm/dd/yy)	07/01/17 - 06/30/18	07/01/17 - 06/30/18	03/01/17 - 2/28/18	07/01/17 - 06/30/18	TOTAL
FUNDING USES					
Salaries	$ 555,778	$ 266,379	$ 326,611	$ 94,681	$ 1,243,449
Employee Benefits	$ 133,244	$ 63,862	$ 76,017	$ 18,903	$ 292,026
Subtotal Salaries & Employee Benefits	$ 689,022	$ 330,241	$ 402,628	$ 113,584	$ 1,535,475
Operating Expenses	$ 179,366	$ 85,969	$ 126,632	$ 198,918	$ 590,885
Subtotal Direct Expenses	$ 868,388	$ 416,210	$ 529,260	$ 312,502	$ 2,126,360
Indirect Expenses	$ 104,208	$ 49,942	$ 47,630	$ 37,498	$ 239,278
Indirect %	12.0%	12.0%	9.0%	12.0%	11.3%
TOTAL FUNDING USES	$ 972,596	$ 466,152	$ 576,890	$ 350,000	$ 2,365,638
					23.9%
BHS MENTAL HEALTH FUNDING SOURCES					
MH WORK ORDER - Human Services Agency	$ 948,874				$ 948,874
MH COUNTY Adult WO CODB	$ 23,722				$ 23,722
MH COUNTY Adult - General Fund					$ -
TOTAL BHS MENTAL HEALTH FUNDING SOURCES	$ 972,596	$ -	$ -	$ -	$ 972,596
OTHER DPH FUNDING SOURCES					
HHS COUNTY GF		$ 11,370			$ 11,370
HHS COUNTY GF		$ 454,782			$ 454,782
HHS FED CARE Part A - PD13, CFDA #93.914			$ 576,890		$ 576,890
HHS STATE SAM - HCAQ16, CFDA #93.917					$ -
Work Order ECN (BOS add-back)				$ 350,000	
TOTAL OTHER DPH FUNDING SOURCES	$ -	$ 466,152	$ 576,890	$ 350,000	$ 1,393,042
TOTAL DPH FUNDING SOURCES	$ 972,596	$ 466,152	$ 576,890	$ 350,000	$ 2,365,638
NON-DPH FUNDING SOURCES					
TOTAL NON-DPH FUNDING SOURCES	$ -	$ -	$ -	$ -	$ -
TOTAL FUNDING SOURCES (DPH AND NON-DPH)	$ 972,596	$ 466,152	$ 576,890	$ 350,000	$ 2,365,638
Prepared By	Sergio Perez			(415) 972-0823	

Appendix B -DPH 6: Contract-Wide Indirect Detail

Contractor Name: Positive Resource Center (PRC) Page # 5

Contract CMS #:: 7383 Fiscal Year: 2017-18

Document Date 3/14/17

1. SALARIES & BENEFITS

Position Title	FTE	Amount
Executive Director	0.25	$ 42,263
Director of Finance	0.25	$ 22,313
Information Technology Manager	0.28	$ 24,888
Operations & Human Resources Manager	0.25	$ 19,161
Subtotal:	1.03	$ 108,625
Employee Fringe Benefits:	25%	$ 27,156
Total Salaries and Benefits:		$ 135,781

2. OPERATING COSTS

Expense line item:	Amount
Rental of Property	$ 16,065
Utilities(Elec, Water, Gas, Phone, Scavenger)	$ 268
Office Supplies, Postage	$ 409
Printing and Reproduction	$ 237
Insurance	$ 660
Rental of Equipment	$ 730
Total Operating Costs	$ 18,369

Total Indirect Costs (Salaries & Benefits + Operating Costs)	$ 154,150

Appendix B -DPH 6: Contract-Wide Indirect Detail

Contractor Name: Positive Resource Center (PRC) Page # 6

Contract CMS #:: 7383 Fiscal Year: 2017-18

Document Date 3/14/17

1. SALARIES & BENEFITS

Position Title	App B-2 FTE	App B-2 Amount	App B-2a FTE	App B-2a Amount	Totals Amount
Executive Director	0.04	$ 6,762	0.01	$ 1,691	$ 8,453
Director of Finance	0.10	$ 8,925	0.01	$ 893	$ 9,818
Information Technology Manager	0.12	$ 10,710	0.01	$ 1,014	$ 11,724
Operations & Human Resources Manager	0.03	$ 2,564	0.01	$ 766	$ 3,330
Subtotal:	0.29	$ 28,961	0.04	$ 4,364	$ 33,325
Employee Fringe Benefits:	25%	$ 7,240	25%	$ 1,091	$ 8,331
Total Salaries and Benefits:		$ 36,201		$ 5,455	$ 41,656

2. OPERATING COSTS

Expense line item:	Amount	Amount	Totals
Rental of Property	$ 4,582	$ 642	$ 5,224
Utilities(Elec, Water, Gas, Phone, Scavenger)	$ 76	$ 11	$ 87
Office Supplies, Postage	$ 117	$ 16	$ 133
Printing and Reproduction	$ 68	$ 10	$ 78
Insurance	$ 188	$ 27	$ 215
Rental of Equipment	$ 208	$ 29	$ 237
Total Operating Costs	$ 5,239	$ 735	$ 5,974
Total Indirect Costs (Salaries & Benefits + Operating Costs)	$ 41,440	$ 6,190	$ 47,630

Appendix B -DPH 6: Contract-Wide Indirect Detail

Contractor Name: Positive Resource Center (PRC) 7

Contract CMS #:: 7383 Fiscal Year: 2017-18

Document Date 3/14/17

1. SALARIES & BENEFITS

Position Title	FTE	App B-4 Amount	FTE	Amount	Totals Amount
Executive Assistant	0.04	$ 7,758			$ 7,758
Finance Clerk	0.05	$ 5,546			$ 5,546
Information Technology Assistant	0.05	$ 6,269			$ 6,269
Operations & Human Resources Manager	0.12	$ 10,425			$ 10,425
Subtotal:	0.25	$ 29,998			$ 29,998
Employee Fringe Benefits:	25%	$ 7,500			$ 7,500
Total Salaries and Benefits:		$ 37,498			$ 37,498

2. OPERATING COSTS

Expense line item:	Amount	Amount	Totals
Rental of Property			
Utilities(Elec, Water, Gas, Phone, Scavenger)			
Office Supplies, Postage			
Printing and Reproduction			
Insurance			
Rental of Equipment			
Total Operating Costs	$ -	$ -	$ -
Total Indirect Costs (Sals & Bens + Operating Costs)	$ 37,498	$ -	$ 37,498

Appendix B - DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA) 01695				B-1 and 1a
Provider Name Positive Resource Center				1
Provider Number 38H1				2017-18
			Document Date	03/14/17
	Program Name	MH SSI Advocacy Benefits Counseling	HIV SSI Advocacy Benefits Counseling	
	Program Code	38H101	N/A	
	Mode/SFC (MH) or Modality (SA)	60/78	N/A	
	Service Description	SS-Other Non-MediCal Client Support Exp	N/A	
	Funding Term (mm/dd/yy - mm/dd/yy)	07/01/17 - 06/30/18	07/01/17 - 06/30/18	TOTAL
FUNDING USES				
	Salaries & Employee Benefits	689,022	330,241	1,019,263
	Operating Expenses	179,366	85,969	265,335
	Capital Expenses	-	-	-
	Subtotal Direct Expenses	868,388	416,210	1,284,598
	Indirect Expenses	104,208	49,942	154,150
	TOTAL FUNDING USES	972,596	466,152	1,438,748
BHS MENTAL HEALTH FUNDING SOURCES	Accounting Code (Index Code or Detail)			
MH WO HSA HAP PRC	HMHMHAPPRCWO	948,874		948,874
MH COUNTY Adult WO CODB	HMHMCC730515	23,722		23,722
				-
				-
This row left blank for funding sources not in drop-down list				-
	TOTAL BHS MENTAL HEALTH FUNDING SOURCES	972,596	-	972,596
BHS SUBSTANCE ABUSE FUNDING SOURCES	Accounting Code (Index Code or Detail)			
				-
				-
				-
This row left blank for funding sources not in drop-down list				-
	TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-
OTHER DPH FUNDING SOURCES	Accounting Code (Index Code or Detail)			
HHS WO HSA AIDS Health Services	HCHMHSVCSWO		454,782	454,782
HHS COUNTY GF	HCHPDHIVSVGF		11,370	11,370
This row left blank for funding sources not in drop-down list				-
	TOTAL OTHER DPH FUNDING SOURCES	-	466,152	466,152
	TOTAL DPH FUNDING SOURCES	972,596	466,152	1,438,748
NON-DPH FUNDING SOURCES				
This row left blank for funding sources not in drop-down list				-
	TOTAL NON-DPH FUNDING SOURCES	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		972,596	466,152	1,438,748
BHS UNITS OF SERVICE AND UNIT COST				
	Number of Beds Purchased (If applicable)			
	SA Only - Non-Res 33 - ODF # of Group Sessions (classes)			
	SA Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program			
	Payment Method	Fee-For-Service (FFS)	Fee-For-Service (FFS)	Fee-For-Service (FFS)
	DPH Units of Service	7,317	3,507	10,824
	Unit Type	Hours	Hours	Hours
	Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	$ 132.92	$ 132.92	$ 132.92
	Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES)	$ 132.92	$ 132.92	$ 132.92
	Published Rate (Medi-Cal Providers Only)			Total UDC
	Unduplicated Clients (UDC)	475	400	875

Appendix B - DPH 3: Salaries & Benefits Detail

Appendix #: B-1 and 1a
Page #: 2
Fiscal Year: 2017-18
Document Date: 03/14/17

Program Name: MH SSI Advocacy Benefits Counseling & HIV SSI Advocacy Benefits Counseling
Program Code: 38H101

			B1		B1a		B1a			
	TOTAL		MH Work Order HSA HMHMHAPPRCWO		HIV Work Order HSA HCHIVHSVCSWO		General Fund HCHIVHSVCSGF			
			07/01/17 - 06/30/18		07/01/17 - 06/30/18		07/01/17 - 06/30/18			
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries		
Managing Legal Director	0.25	$ 26,962	0.17	$ 18,226	0.08	$ 8,736				
Supervising Attorneys	1.80	$ 140,922	1.22	$ 95,263	0.58	$ 45,659				
Attorneys	5.95	$ 348,811	4.05	$ 235,796	1.90	$ 101,645		$11,370.00		
Quality Assurance Mngr / Sr Bilingual Benefits Advocate	0.90	$ 73,783	0.61	$ 49,877	0.29	$ 23,906				
Bilingual Benefits Advocate	0.50	$ 27,563	0.34	$ 18,633	0.16	$ 8,930				
Legal Assistants	3.75	$ 191,792	2.55	$ 129,651	1.20	$ 62,141				
Front Office Coordinator	0.25	$ 12,324	0.17	$ 8,331	0.08	$ 3,993				
Totals:	13.40	$ 822,157	9.11	$ 555,778	4.29	$ 255,009	0.00	$11,370.00		
Employee Fringe Benefits:	24%	$ 197,106	24%	$ 133,244	25%	$ 63,862	0.00%			
TOTAL SALARIES & BENEFITS		$ 1,019,263		$ 689,022		$ 318,871		$11,370.00		

Appendix B - DPH 4: Operating Expenses Detail

Program Name: MH SSI Advocacy Benefits Counseling & HIV SSI Advocacy Benefits Counseling
Program Code: 38H101

Appendix #: B-1 and 1a
Page #: 3
Fiscal Year: 2017-18
Document Date: 03/14/17

		B1	B1a				
Expense Categories & Line Items	**TOTAL**	**MH Work Order HSA HMHMHAPPRCWO**	**HIV Work Order HSA HCHIVHSVCSWO**				
07/01/17 - 06/30/18							
Rent	$ 209,262	$ 141,461	$ 67,801				
Utilities(telephone, electricity, water, gas)	$ 3,488	$ 2,358	$ 1,130				
Building Repair/Maintenance	$ -	$ -	$ -				
Occupancy Total:	**$ 212,750**	**$ 143,819**	**$ 68,931**				
Office Supplies	$ 9,323	$ 6,302	$ 3,021				
Photocopying	$ 7,084	$ 4,789	$ 2,295				
Program Supplies	$ -	$ -	$ -				
Computer Hardware/Software	$ -	$ -	$ -				
Materials & Supplies Total:	**$ 16,407**	**$ 11,091**	**$ 5,316**				
Training/Staff Development	$ 8,500	$ 5,746	$ 2,754				
Insurance	$ 13,169	$ 8,902	$ 4,267				
Professional License	$ 3,500	$ 2,366	$ 1,134				
Permits	$ -	$ -	$ -				
Equipment Lease & Maintenance	$ 9,509	$ 6,428	$ 3,081				
General Operating Total:	**$ 34,678**	**$ 23,442**	**$ 11,236**				
Local Travel	$ -						
Out-of-Town Travel	$ -						
Field Expenses	$ -						
Staff Travel Total:	$ -	$ -	$ -				
Consultant/Subcontractor (Provide Consultant/Subcontracting Agency Name, Service Detail w/Dates, Hourly Rate and	$ -						
(add more Consultant/Subcontractor lines as necessary)	$ -						
Consultant/Subcontractor Total:	$ -	$ -	$ -				
Interpreter	$ 1,500	$ 1,014	$ 486				
	$ -						
	$ -						
Other Total:	**$ 1,500**	**$ 1,014**	**$ 486**				
TOTAL OPERATING EXPENSE	**$ 265,335**	**$ 179,366**	**$ 85,969**				

Appendix B - DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA) 01695
Provider Name Positive Resource Center
Provider Number 38H1

Appendix # B-2 and 2a
Page # 1
Fiscal Year 2017-18
Document Date 03/14/17

Program Name		Equal Access to Healthcare Program	Benefits Counseling Training Program		
Program Code		N/A - HHS	N/A - HHS		
Mode/SFC (MH) or Modality (SA)					
Service Description					
Funding Term (mm/dd/yy - mm/dd/yy)		03/01/17 - 2/28/18	03/01/17 - 2/28/18		TOTAL
FUNDING USES					
Salaries & Employee Benefits		356,707	45,921		402,628
Operating Expenses		103,743	22,889		126,632
Capital Expenses		-	-		-
Subtotal Direct Expenses		460,450	68,810	-	529,260
Indirect Expenses		41,440	6,190		47,630
TOTAL FUNDING USES		501,890	75,000	-	576,890
BHS MENTAL HEALTH FUNDING SOURCES	Accounting Code (Index Code or Detail)				
					-
					-
					-
					-
This row left blank for funding sources not in drop-down list					-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		-	-	-	-
BHS SUBSTANCE ABUSE FUNDING SOURCES	Accounting Code (Index Code or Detail)				
					-
					-
					-
This row left blank for funding sources not in drop-down list					-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-
OTHER DPH FUNDING SOURCES	Accounting Code (Index Code or Detail)				
HHS FED CARE Part A - PD13, CFDA #93.914	HC HIV HSVCS GR	501,890	75,000	-	576,890
					-
This row left blank for funding sources not in drop-down list					-
TOTAL OTHER DPH FUNDING SOURCES		501,890	75,000	-	576,890
TOTAL DPH FUNDING SOURCES		501,890	75,000	-	576,890
NON-DPH FUNDING SOURCES					
					-
This row left blank for funding sources not in drop-down list					-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		501,890	75,000	-	576,890
BHS UNITS OF SERVICE AND UNIT COST					
Number of Beds Purchased (if applicable)					
SA Only - Non-Res 33 - ODF # of Group Sessions (classes)					
SA Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program					
Payment Method		Cost Reimbursement (CR)	Cost Reimbursement (CR)		Cost Reimbursement (CR)
DPH Units of Service		3,855	468		4,323
Unit Type		Hours	Hours	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		$ 130	$ 160	$ -	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES)		$ 130	$ 160	$ -	
Published Rate (Medi-Cal Providers Only)					Total UDC
Unduplicated Clients (UDC)		525	N/A		525

Appendix B - DPH 3: Salaries & Benefits Detail

Program Name: Equal Access to Healthcare Program
Program Code: N/A - HIV Hlth Svcs

Appendix #: B-2 and 2a
Page # 2
Fiscal Year: 2017-18
Document Date 03/14/17

			B2		B2a									
	TOTAL		Equal Access to Healthcare Program		Benefits Counseling Training Program									
03/01/17 - 02/28/18														
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries								
Managing Legal Director	0.47	$ 50,958	0.28	$ 30,467	0.19	$ 20,491								
Supervising Attorneys	1.78	$ 140,299	1.64	$ 129,254	0.14	$ 11,045								
Staff Attorneys	0.67	$ 38,924	0.67	$ 38,924										
Bilingual Benefits Advocates	0.52	$ 29,739	0.52	$ 29,739										
Legal Assistants	1.00	$ 50,819	0.90	$ 44,724	0.10	$ 6,095								
Front Office Coordinator	0.32	$ 15,872	0.32	$ 15,872										
Totals:	4.76	$ 326,611	4.33	$ 288,980	0.43	$ 37,631								
Employee Fringe Benefits:	23%	$ 76,017	23%	$ 67,727	22%	$ 8,290								
TOTAL SALARIES & BENEFITS		$ 402,628		$ 356,707		$ 45,921								

Appendix B - DPH 4: Operating Expenses Detail

Program Name: Equal Access to Healthcare Program
Program Code: N/A - HIV Hlth Svcs

Appendix #: B-2 and 2a
Page # 3
Fiscal Year: 2017-18
Document Date 03/14/17

Expense Categories & Line Items	TOTAL	B2 Equal Access to Healthcare Program	B2a Benefits Counseling Training Program
03/01/17 - 02/28/18			
Rent	$ 74,327	$ 67,691	$ 6,636
Utilities(telephone, electricity, water, gas)	$ 1,239	$ 1,128	$ 111
Building Repair/Maintenance	$ -	$ -	$ -
Occupancy Total:	**$ 75,566**	**$ 68,819**	**$ 6,747**
Office Supplies	$ 12,191	$ 1,722	$ 10,469
Photocopying	$ 1,096	$ 998	$ 98
Program Supplies	$ -	$ -	$ -
Computer Hardware/Software	$ -	$ -	$ -
Materials & Supplies Total:	**$ 13,287**	**$ 2,720**	**$ 10,567**
Training/Staff Development	$ 1,500	$ 1,500	$ -
Insurance	$ 11,331	$ 11,058	$ 273
Professional License	$ -	$ -	$ -
Permits	$ -	$ -	$ -
Equipment Lease & Maintenance	$ 3,378	$ 3,076	$ 302
General Operating Total:	**$ 16,209**	**$ 15,634**	**$ 575**
Local Travel	$ -		
Out-of-Town Travel	$ -		
Field Expenses	$ -		
Staff Travel Total:	**$ -**	**$ -**	**$ -**
AIDS Legal Referral Panel - Contracted training partner to perform research, design curriculum and present trainings in designated areas of expertise.	$ -		
20 hours research @ $75/hour	$ 1,500		$ 1,500.00
7 (2-4 hours in duration) presentations @ $500 each	$ 3,500		$ 3,500.00
Consultant/Subcontractor Total:	**$ 5,000**	**$ -**	**$ 5,000.00**
Marketing	$ 16,570	$ 16,570	$ -
	$ -		
	$ -		
Other Total:	**$ 16,570**	**$ 16,570**	**$ -**
TOTAL OPERATING EXPENSE	**$ 126,632**	**$ 103,743**	**$ 22,889**

Appendix B - DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA) 01695				Appendix #	B-4
Provider Name Positive Resource Center				Page #	1
Provider Number 38H1				Fiscal Year	2017-18
				Document Date	03/14/17
Program Name		Organizational Support for Merger			
Not Applicable - Program Code		N/A			
NOT Applicable - Mode/SFC (MH) or Modality (SA)		N/A			
NOT Applicable - Service Description		N/A			
Funding Term (mm/dd/yy - mm/dd/yy)		07/01/17 - 06/30/18			TOTAL
FUNDING USES:					
Salaries & Employee Benefits		113,584			113,584
Operating Expenses		198,918			198,918
Capital Expenses		-	-		-
Subtotal Direct Expenses		**312,502**	-		312,502
Indirect Expenses		37,498			37,498
TOTAL FUNDING USES		**350,000**	-		**350,000**
BHS MENTAL HEALTH FUNDING SOURCES -	Accounting Code - Index Code				
MH COUNTY Adult - General Fund	HMHMCC730515				-
					-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		-	-		-
OTHER DPH FUNDING SOURCES	Accounting Code - Index Code				
Work Order ECN (BOS add-back)	HCHIVHSPMSWO	350,000			350,000
TOTAL OTHER DPH FUNDING SOURCES		**350,000**	-		**350,000**
TOTAL DPH FUNDING SOURCES		**350,000**	-		**350,000**
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		**350,000**	-		**350,000**
BHS UNITS OF SERVICE AND UNIT COST					
Payment Method		Fee-For-Service (FFS)			
DPH Units of Service		12			
Unit Type		Merger Support Months			
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		$29,167			
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES)		$29,167			
Published Rate (Medi-Cal Providers Only)		N/A			Total UDC
Unduplicated Clients (UDC)		N/A			N/A

Appendix B - DPH 3: Salaries & Benefits Detail

Program Name: Organizational Support for Merger
Program Code: N/A

Appendix #: B-4
Page # 2
Fiscal Year: 2017-18
Document Date 03/14/17

B4

	TOTAL		Organizational Support for Merger (HCHIVHSPMSWO)						
			07/0/17-06/30/18						
Position Title	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**			
Chief Executive Officer	0.12	$ 30,791	0.12	$ 30,791					
Chief Operating Officer	0.12	$ 17,113	0.12	$ 17,113					
Chief Financial Officer	0.12	$ 16,720	0.12	$ 16,720					
Chief Programs Officer	0.12	$ 15,264	0.12	$ 15,264					
Chief Information Officer	0.12	$ 14,793	0.12	$ 14,793					
Totals:	0.60	$ 94,681	0.60	$ 94,681					
Employee Fringe Benefits:	20%	$ 18,903	20%	$ 18,903					
TOTAL SALARIES & BENEFITS		**$ 113,584**		**$ 113,584**					

Appendix B - DPH 4: Operating Expenses Detail

Program Name: Organizational Support for Merger
Program Code: N/A

Appendix #: B-4
Page # 3
Fiscal Year: 2017-18
Document Date 03/14/17

B4

Expense Categories & Line Items	TOTAL	Organizational Support for Merger (HCHIVHSPMSWO)			
		07/01/17-06/30/18			
Computer Hardware/Software	$ 23,131	$ 23,131			
Materials & Supplies Total:	**$ 23,131**	**$ 23,131**	**$ -**		
Training/Staff Development	$ 16,613	$ 16,613			
General Operating Total:	**$ 16,613**	**$ 16,613**	**$ -**		
WHM Creative Consultant to assist with rebranding 3 agencies to create one cohesive brand/image $250/hr x 10hrs x 20 wks	$ 30,435	$ 30,435			
WHM Creative Consultant to consolidate and redesign the websites of 3 agencies $156.25/hr x 10hrs x 16 wks.	$ 15,218	$ 15,218			
Landis Communications, Inc. Consultant for Public Relations firm to represent PRC to the media during and after merger process $8,000/mo x 8 mos	$ 38,955	$ 38,955			
HSF Consultants for healthcare consultant to work on increasing Baker Place's Medi-Cal billing rates $100/hr x 20hrs x 25 wks	$ 30,435	$ 30,435			
Brakeley Briscoe, Inc.Consultant to create and implement Comp Campaign $5,000/mo x 10 mos	$ 30,435	$ 30,435			
Neela Gentile (Consultant feesto implement a board development initiative) $150/hr x 10hrs x 15 wks	$ 13,696	$ 13,696			
Consultant/Subcontractor Total:	**$ 159,174**	**$ 159,174**			
TOTAL OPERATING EXPENSE	**$ 198,918**	**$ 198,918**			

Appendix F
Invoice

DEPARTMENT OF PUBLIC HEALTH CONTRACTOR
FEE FOR SERVICE STATEMENT OF DELIVERABLES AND INVOICE

Control Number

BHS

Contractor: Positive Resource Center

Address: 785 Market St, 10th Floor, San Francisco, CA 94103

Tel No.: (415) 777-0333

Contract Term: 07/01/2017 - 06/30/2018

PHP Division: Behavioral Health Services

INVOICE NUMBER: M06 JL 17

Ct.Blanket No.: BPHM TBD

User Cd

Ct. PO No.: POHM TBD

Fund Source: HHS WO HSA AIDS Health Services
HHS County

Invoice Period : July 2017

Final Invoice: (Check if Yes)

ACE Control Number:

Unduplicated Clients for Exhibit:	Total Contracted Exhibit UDC	Delivered THIS PERIOD Exhibit UDC	Delivered to Date Exhibit UDC	% of TOTAL Exhibit UDC	Remaining Deliverables Exhibit UDC

*Unduplicated Counts for AIDS Use Only.

DELIVERABLES Program Name/Reptg. Unit Modality/Mode # - Svc Func (MH Only)	Total Contracted UOS	Total Contracted CLIENTS	Delivered THIS PERIOD UOS	Delivered THIS PERIOD CLIENTS	Unit Rate	AMOUNT DUE	Delivered to Date UOS	Delivered to Date CLIENTS	% of TOTAL UOS	% of TOTAL CLIENT	Remaining Deliverables UOS	Remaining Deliverables CLIENTS	
B-1 and 1a SSI Advocacy Benefits Counseling													
HIV Benefits Counseling	3,507				$ 132.92	$ -	0.000		0.00%		3,507.000		$ 466,150.44
TOTAL	3,507		0.000				0.000		0.00%		3,507.000		
	Budget Amount		$ 466,152.00				Expenses To Date		% of Budget		Remaining Budget		
							$ -		0.00%		$ 466,152.00		

SUBTOTAL AMOUNT DUE	$ -
Less: Initial Payment Recovery	
(For DPH Use) Other Adjustments	
NET REIMBURSEMENT	$ -

NOTES:
AIDS-County HHS GF- HCHIVHSVCS WO - $454,782.00
HHS County GF - HCHPDHIVSVGF - $11,370.00

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Title: _____

Send to:

Behavioral Health Services-Budget/ Invoice Analyst
1380 Howard St., 4th Floor
San Francisco, CA 94103

DPH Authorization for Payment

_____ _____
Authorized Signatory Date

DEPARTMENT OF PUBLIC HEALTH CONTRACTOR
FEE FOR SERVICE STATEMENT OF DELIVERABLES AND INVOICE

Appendix F
PAGE A

Control Number

BHS

Contractor: Positive Resource Center

Address: 785 Market St, 10th Floor, San Francisco, CA 94103

Tel No.: (415) 777-0333

Contract Term: 07/01/2017 - 06/30/2018

PHP Division: Behavioral Health Services

INVOICE NUMBER: M05 JL 17

Ct.Blanket No.: BPHM TBD

User Cd

Ct. PO No.: POHM TBD

Fund Source: MH WO HSA HAP PRC

Invoice Period : July 2017

Final Invoice: (Check if Yes)

ACE Control Number:

Unduplicated Clients for Exhibit:	Total Contracted Exhibit UDC	Delivered THIS PERIOD Exhibit UDC	Delivered to Date Exhibit UDC	% of TOTAL Exhibit UDC	Remaining Deliverables Exhibit UDC

*Unduplicated Counts for AIDS Use Only.

DELIVERABLES Program Name/Reptg. Unit Modality/Mode # - Svc Func (MH Only)	Total Contracted UOS	Total Contracted CLIENTS	Delivered THIS PERIOD UOS	Delivered THIS PERIOD CLIENTS	Unit Rate	AMOUNT DUE	Delivered to Date UOS	Delivered to Date CLIENTS	% of TOTAL UOS	% of TOTAL CLIENTS	Remaining Deliverables UOS	Remaining Deliverables CLIENTS	
B-1 and 1a MH SSI Advocacy Benefits Counseling PC# - 38H101 - HMHMHAPPRCWO													
60/ 78 Other Non Medi-Cal Client Support Svcs	7,317				$ 132.92	$ -	0.000		0.00%		7,317.000		$ 972,575.64
TOTAL	7,317		0.000				0.000		0.00%		7,317.000		

Budget Amount	$ 972,596.00	Expenses To Date	% of Budget	Remaining Budget
		$ -	0.00%	$ 972,596.00

SUBTOTAL AMOUNT DUE	$ -
Less: Initial Payment Recovery	
(For DPH Use) Other Adjustments	
NET REIMBURSEMENT	$ -

NOTES:

HSA Work Order - HMHMHAPPRCWO - $948,874.00

GF - WO CODE - HMHMCC730515 - $23,722.00

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Title: _____

Send to:

Behavioral Health Services-Budget/ Invoice Analyst
1380 Howard St., 4th Floor
San Francisco, CA 94103

DPH Authorization for Payment

_____ Authorized Signatory

_____ Date

DEPARTMENT OF PUBLIC HEALTH CONTRACTOR
COST REIMBURSEMENT INVOICE

Appendix F
PAGE A

Control Number

INVOICE NUMBER: M11 MR 17

Contractor: Positive Resource Center

Ct. Blanket No.: BPHM TBD

Address: 785 Market St, 10th Floor, San Francisco, CA 94103

User Cd

Ct. PO No.: POHM TBD

Tel No.: (415) 777-0333

Fund Source: HHS RWPA - PD13 HC HIV HSVSCGR

Invoice Period: March 2017

Funding Term: 03/01/2017 - 02/28/2018

Final Invoice: (Check If Yes)

PHP Division: Behavioral Health Services

ACE Control Number:

Program/Exhibit	TOTAL CONTRACTED UOS	TOTAL CONTRACTED UDC	DELIVERED THIS PERIOD UOS	DELIVERED THIS PERIOD UDC	DELIVERED TO DATE UOS	DELIVERED TO DATE UDC	% OF TOTAL UOS	% OF TOTAL UDC	REMAINING DELIVERABLES UOS	REMAINING DELIVERABLES UDC	% OF TOTAL UOS	% OF TOTAL UDC
B-2 and 2a Equal Access to Healthcare Program & Benefits Counseling Training Program - HCHIVHSVCSGR												
	3,855	525			0.00	0.00	0%	0%	3,855	525	100%	100%
	468				0.00	0.00	0%	#DIV/0!	468	-	100%	#DIV/0!

Unduplicated Counts for AIDS Use Only.

Description	BUDGET	EXPENSES THIS PERIOD	EXPENSES TO DATE	% OF BUDGET	REMAINING BALANCE
Total Salaries	$ 326,611.00	$ -	$ -	0.00%	$ 326,611.00
Fringe Benefits	$ 76,017.00	$ -	$ -	0.00%	$ 76,017.00
Total Personnel Expenses	$ 402,628.00	$ -	$ -	0.00%	$ 402,628.00
Operating Expenses					
Occupancy	$ 75,566.00	$ -	$ -	0.00%	$ 75,566.00
Materials and Supplies	$ 13,287.00	$ -	$ -	0.00%	$ 13,287.00
General Operating	$ 16,209.00	$ -	$ -	0.00%	$ 16,209.00
Staff Travel	$ -	$ -	$ -	0.00%	$ -
Consultant/ Subcontractor	$ 5,000.00	$ -	$ -	0.00%	$ 5,000.00
Other: Marketing	$ 16,570.00	$ -	$ -	0.00%	$ 16,570.00
	$ -	$ -	$ -	0.00%	$ -
	$ -	$ -	$ -	0.00%	$ -
Total Operating Expenses	$ 126,632.00	$ -	$ -	0.00%	$ 126,632.00
Capital Expenditures	$ -	$ -	$ -	0.00%	$ -
TOTAL DIRECT EXPENSES	$ 529,260.00	$ -	$ -	0.00%	$ 529,260.00
Indirect Expenses	$ 47,630.00	$ -	$ -	0.00%	$ 47,630.00
TOTAL EXPENSES	$ 576,890.00	$ -	$ -	0.00%	$ 576,890.00
Less: Initial Payment Recovery			NOTES:		
Other Adjustments (DPH use only)					
REIMBURSEMENT		$ -			

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Printed Name: _____

Title: _____ Phone: _____

Send to:

Behavioral Health Services-Budget/ Invoice Analyst
1380 Howard St., 4th Floor
San Francisco, CA 94103

DPH Authorization for Payment

Authorized Signatory Date

DEPARTMENT OF PUBLIC HEALTH CONTRACTOR
FEE FOR SERVICE STATEMENT OF DELIVERABLES AND INVOICE

Control Number

BHS

Contractor: Positive Resource Center

Address: 785 Market St, 10th Floor, San Francisco, CA 94103

Tel No.: (415) 777-0333

Contract Term: 07/01/2017 - 06/30/2018

PHP Division: Behavioral Health Services

INVOICE NUMBER: M07 JL 17

Ct.Blanket No.: BPHM TBD

User Cd

Ct. PO No.: POHM TBD

Fund Source: Work Order ECN (BOS add-back)

Invoice Period : July 2017

Final Invoice: (Check if Yes)

ACE Control Number:

Unduplicated Clients for Exhibit:	Total Contracted Exhibit UDC	Delivered THIS PERIOD Exhibit UDC	Delivered to Date Exhibit UDC	% of TOTAL Exhibit UDC	Remaining Deliverables Exhibit UDC

*Unduplicated Counts for AIDS Use Only.

DELIVERABLES Program Name/Reptg. Unit Modality/Mode # - Svc Func (MH Only)	Total Contracted UOS	Total Contracted CLIENTS	Delivered THIS PERIOD UOS	Delivered THIS PERIOD CLIENTS	Unit Rate	AMOUNT DUE	Delivered to Date UOS	Delivered to Date CLIENTS	% of TOTAL UOS	% of TOTAL LIENT	Remaining Deliverables UOS	Remaining Deliverables CLIENTS
B-4 - Organizational Support for Merger												
	12				$ 29,167.00	$ -	0.000		0.00%		12.000	
TOTAL	12		0.000				0.000		0.00%		12.000	

Budget Amount	$ 350,000.00	Expenses To Date	% of Budget	Remaining Budget
		$ -	0.00%	$ 350,000.00

SUBTOTAL AMOUNT DUE	$ -
Less: Initial Payment Recovery	
(For DPH Use) Other Adjustments	
NET REIMBURSEMENT	$ -

NOTES:

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Title: _____

Send to:

Behavioral Health Services-Budget/ Invoice Analyst
1380 Howard St., 4th Floor
San Francisco, CA 94103

DPH Authorization for Payment

_____ Authorized Signatory

_____ Date

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/3/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Viktoria Cordes	
RCU Insurance Services 3033 Cleveland Ave Ste 100 Santa Rosa CA 95403	PHONE (A/C, No, Ext): (707) 576-5082	FAX (A/C, No): (707) 522-6851
	E-MAIL ADDRESS: vcordes@redwoodcu.org	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: Nonprofit Insurance Alliance	
INSURED Positive Resource Center 785 Market Street, 10th Floor San Francisco CA 94103	INSURER B: Republic Indemnity Co of America	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL172900472 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:	X		201716972NPO	2/3/2017	2/3/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG SSPL	$ 1,000,000 $ 500,000 $ 20,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [X] HIRED AUTOS [ ] SCHEDULED AUTOS [X] NON-OWNED AUTOS			201716972NPO	2/3/2017	2/3/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $ $
A	[X] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 10,000			201716972UMBNPO	2/3/2017	2/3/2018	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000 $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [Y] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		25105101	8/1/2016	8/1/2017	[ ] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
A	Business Property			CWB001274700	2/3/2017	2/3/2018		475,000
	Directors & Officers			201716972DO	2/3/2017	2/3/2018		1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

The City and County of San Francisco, its officers, agents and employees are named as Additional Insured.

CERTIFICATE HOLDER

City and County of San Francisco
Community Behavioral Health Services
Luciana Garcia, Contract Analyst
1380 Howard Street
Room 442
San Francisco, CA 94103

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Viktoria Cordes/VC

NONPROFITS INSURANCE ALLIANCE OF CALIFORNIA

A Head for Insurance. A Heart for Nonprofits.

POLICY NUMBER: 2017-16972

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED PRIMARY AND NON-CONTRIBUTORY ENDORSEMENT FOR PUBLIC ENTITIES

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

A. **SECTION II – WHO IS AN INSURED** is amended to include any public entity as an additional insured for whom you are performing operations when you and such person or organization have agreed in a written contract or written agreement that such public entity be added as an additional insured(s) on your policy, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:
   1. Your negligent acts or omissions; or
   2. The negligent acts or omissions of those acting on your behalf; in the performance of your ongoing operations.

   No such public entity is an additional insured for liability arising out of the "products-completed operations hazard" or for liability arising out of the sole negligence of that public entity.

B. With respect to the insurance afforded to these additional insured(s), the following additional exclusions apply.

   This insurance does not apply to "bodily injury" or "property damage" occurring after:
   1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or
   2. That portion of "your work" out of which injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. The following is added to **SECTION III – LIMITS OF INSURANCE:**

   The limits of insurance applicable to the additional insured(s) are those specified in the written contract between you and the additional insured(s), or the limits available under this policy, whichever are less. These limits are part of and not in addition to the limits of insurance under this policy.

D. With respect to the insurance provided to the additional insured(s), **Condition 4. Other Insurance** of **SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS** is replaced by the following:

   4. Other Insurance
   a. Primary Insurance
   This insurance is primary if you have agreed in a written contract or written agreement:

(1) That this insurance be primary. If other insurance is also primary, we will share with all that other insurance as described in c. below; or
(2) The coverage afforded by this insurance is primary and non-contributory with the additional insured(s)' own insurance.

Paragraphs (1) and (2) do not apply to other insurance to which the additional insured(s) has been added as an additional insured or to other insurance described in paragraph b. below.

b. Excess Insurance

This insurance is excess over:

1. Any of the other insurance, whether primary, excess, contingent or on any other basis:
   (a) That is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage for "your work";
   (b) That is fire, lightning, or explosion insurance for premises rented to you or temporarily occupied by you with permission of the owner;
   (c) That is insurance purchased by you to cover your liability as a tenant for "property damage" to premises temporarily occupied by you with permission of the owner; or
   (d) If the loss arises out of the maintenance or use of aircraft, "autos" or watercraft to the extent not subject to Exclusion **g. of SECTION I – COVERAGE A – BODILY INJURY AND PROPERTY DAMAGE.**
   (e) That is any other insurance available to an additional insured(s) under this Endorsement covering liability for damages arising out of the premises or operations, or products-completed operations, for which the additional insured(s) has been added as an additional insured by that other insurance.

(1) When this insurance is excess, we will have no duty under Coverages A or B to defend the additional insured(s) against any "suit" if any other insurer has a duty to defend the additional insured(s) against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to the additional insured(s)' rights against all those other insurers.

(2) When this insurance is excess over other insurance, we will pay only our share of the amount of the loss, if any, that exceeds the sum of:
   (a) The total amount that all such other insurance would pay for the loss in the absence of this insurance; and
   (b) The total of all deductible and self-insured amounts under all that other insurance.

(3) We will share the remaining loss, if any, with any other insurance that is not described in this **Excess Insurance** provision and was not bought specifically to apply in excess of the Limits of Insurance shown in the Declarations of this Coverage Part.

c. Methods of Sharing

If all of the other insurance available to the additional insured(s) permits contribution by equal shares, we will follow this method also. Under this approach each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.

If any other the other insurance available to the additional insured(s) does not permit contribution by equal shares, we will contribute by limits. Under this method, each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of insurance of all insurers.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SOCIAL SERVICE AGENCIES – VOLUNTEERS AS INSUREDS

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM
MOTOR CARRIER COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

The following is added to the **Who Is An Insured** provision under **Covered Autos Liability Coverage:**

Anyone volunteering services to you is an "insured" while using a covered "auto" you don't own, hire or borrow to transport your clients or other persons in activities necessary to your business. Anyone else who furnishes that "auto" is also an "insured".