Exhibit A

Non-MediCal Contracts

Scope of Work, Staff List, and Budget

For Non-MediCal Contracts

**I. Program/Project Overview:**

|  |  |
| --- | --- |
| **Agency/Organization Name:**  **Program/Project Name (if applicable):** | **Contact Person Information**  **Name:**  **Address:**  **Phone:**  **Fax:**  **Email:** |
| **Check MHSA Program Component:**  **System of Care (CSS, WET, INN)**  **PEI**  **Initiative/Population:** | |

**II. Service Description**

A. Program Description

B. Service Type(s) and Reporting Requirements

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Service(s)** | **Units of**  **Service Provided** | **Numbers**  **Served** | **Intervention**  **Outcome(s)** | **Data**  **Source(s)** | **Data Collection Required**  (see table below) |
|  |  |  |  |  |  |
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Data Collection Sets and information Required Per Service Type

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A.**  **Total NumberServed** | **B.**  **Total  Units Provided** | **C.**  **Total Served By**  **Age** | **D.**  **Total Served by Gender** | **E.**  **Total**  **Served**  **Race/**  **Ethnicity** | **F.**  **Total**  **Served**  **by**  **Primary Language** | **G.**  **Total Served**  **by cultural**  **group or special population**  **(s)** | **H.**  **Total**  **Number**  **of**  **MediCal Beneficiaries** | **I.**  **Total**  **Estimated Numbers Encountered/ Reached** | **J.**  **Submit**  **Outcome**  **Data** | **K.**  **Submit Narrative** |
|  |  | 0-5 | Male | White | English | LGBTQQI |  |  |  |  |
|  | 6-15 | Female | African American | Spanish | Veterans |  |  |  |
|  | 16-25 | Transgender | Asian | Other\* | Homeless |  |  |
|  | 26-59 | other | Pacific  Islander |  | Individuals in  Foster Care |  |  |
|  | 60+ |  |  |  |
|  |  |  |  |  |
|  |  | Native American |  | Other: specify  other cultural/  special  population  group served |  |  |
|  |  |  | Hispanic |  |  |  |
|  |  | Multi Race/Ethnic |  |  |  |
|  |  | Other\* |  |  |  |
|  |  |  |  |  |  |  |  |  |

C. Cultural Responsiveness: *(Describe each specific practice, procedure, and/or strategy used to engaged and provide services to diverse cultural populations* including *staff language capacity and cultural diversity. Describe procedure to provide services to non-English speaking populations.)*

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|  |

**III. Staff List**

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| --- | --- | --- |
| **Name** | **Job Title** | **Contract FTE** |
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Any staff changes throughout the contact year must be submitted to your assigned Contract Analyst.

**IV. Report Due Dates and Instructions: (For specific Medi-Cal Contracts only for FY 12-13)**

Quarter 1: July 1 – September 30, 2012 Report Due: October 31, 2012

Quarter 2: October 1 – December 31, 2012 Report Due: January 31, 2013

Quarter 3 January 1 - March 31, 2013 Report Due: April 30, 2013

Quarter 4 April 1 – June 30, 2013 Report Due: July 31, 2013

Contractors will submit an electronic copy of the **Sonoma County Behavioral Health Outcomes Quarterly Report** on the due dates listed above addressed to the attention of the Contract Liaison listed in Section IV. of this exhibit.

|  |  |
| --- | --- |
| Mailed or personally delivered reports shall be sent to the following address:  **County of Sonoma Department of Health Services**  **Behavioral Health Division**  **3322 Chanate Road**  **Santa Rosa CA 95404-1708**  **Attn:** **Contract Contact Liaison** | Faxed reports shall be sent to:  **(707) 565-4892**  **Attn: Contract Contact Liaison** |

**V. Sonoma County Contract Contact Persons:**

|  |  |
| --- | --- |
| **List Contract Liaison:**  Name:  Phone:  Email:  Fax: | **List Contract Analyst:**  Name:  Phone:  Email:  Fax: |