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 inFoster Care |  |  |
|  | 60+ |  |  |  |
|  |  |  |  |  |
|  |  | Native American |  | Other: specifyother cultural/specialpopulationgroup 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.)*

|  |
| --- |
|  |

**III. Staff List**

|  |  |  |
| --- | --- | --- |
| **Name** | **Job Title** | **Contract FTE** |
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|  |  |  |
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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:  |