Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2024 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2024 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2024 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

Many questions require you to address multiple elements in a single text box. Number your responses to correspond with multi-element questions using the same numbers in the question. This will help you organize your responses to ensure they are complete and help us to review and score your responses.

Attachments

Questions requiring attachments to receive points state, "You Must Upload an Attachment to the 4B. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1A-1. CoC Name and Number: CA-608 - Riverside City & County CoC

1A-2. Collaborative Applicant Name: County of Riverside

1A-3. CoC Designation: CA

1A-4. HMIS Lead: County of Riverside

1B. Coordination and Engagement–Inclusive Structure and Participation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
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- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections V.B.1.a.(1), V.B.1.e., V.B.1f., and V.B.1.p.	

	In the chart below for the period from May 1, 2023 to April 30, 2024:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

	Organization/Person	Participated in CoC Meetings	Voted, Including Electing CoC Board Members	Participated in CoC's Coordinated Entry System
1.	Affordable Housing Developer(s)	Yes	Yes	Yes
2.	CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes	Yes
3.	Disability Advocates	Yes	Yes	Yes
4.	Disability Service Organizations	Yes	Yes	Yes
5.	EMS/Crisis Response Team(s)	Yes	Yes	Yes
6.	Homeless or Formerly Homeless Persons	Yes	Yes	Yes
7.	Hospital(s)	Yes	Yes	Yes
8.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Yes	Yes	Yes
9.	Law Enforcement	Yes	Yes	Yes
10.	Lesbian, Gay, Bisexual, Transgender (LGBTQ+) Advocates	Yes	Yes	Yes
11.	LGBTQ+ Service Organizations	Yes	Yes	Yes
12.	Local Government Staff/Officials	Yes	Yes	Yes
13.	Local Jail(s)	Yes	Yes	Yes
14.	Mental Health Service Organizations	Yes	Yes	Yes
15.	Mental Illness Advocates	Yes	Yes	Yes
16.	Organizations led by and serving Black, Brown, Indigenous and other People of Color	Yes	Yes	Yes

17.	Organizations led by and serving LGBTQ+ persons	Yes	Yes	Yes
18.	Organizations led by and serving people with disabilities	Yes	Yes	Yes
19.	Other homeless subpopulation advocates	Yes	Yes	Yes
20.	Public Housing Authorities	Yes	Yes	Yes
21.	School Administrators/Homeless Liaisons	Yes	Yes	Yes
22.	Street Outreach Team(s)	Yes	Yes	Yes
23.	Substance Abuse Advocates	Yes	Yes	Yes
24.	Substance Abuse Service Organizations	Yes	Yes	Yes
25.	Agencies Serving Survivors of Human Trafficking	Yes	Yes	Yes
26.	Victim Service Providers	Yes	Yes	Yes
27.	Domestic Violence Advocates	Yes	Yes	Yes
28.	Other Victim Service Organizations	No	No	No
29.	State Domestic Violence Coalition	No	No	No
30.	State Sexual Assault Coalition	Yes	Yes	Yes
31.	Youth Advocates	Yes	Yes	Yes
32.	Youth Homeless Organizations	Yes	Yes	Yes
33.	Youth Service Providers	Yes	Yes	Yes
	Other: (limit 50 characters)			
34.	Faith-Based Organizations	Yes	Yes	Yes
35.	Organizations Serving Veterans	Yes	Yes	Yes

1B-1a.	Experience Promoting Racial Equity.	
	NOFO Section III.B.3.c.	

Describe in the field below your CoC's experience in effectively addressing the needs of underserved communities, particularly Black and Brown communities, who are substantially overrepresented in the homeless population.

(limit 2,500 characters)

The undertaking to address racial disparities is the publication of the Racial Disparity Report, that provides a comprehensive analysis of racial imbalances within the homeless population. The report has been critical in shaping our Homeless Action Plan and continues to guide strategies to ensure all racial and ethnic groups are equitably served. We are active participants in the California Racial Equity Action Lab (REAL), a statewide, three-year initiative focused on eliminating racial disparities in homelessness systems across California. With this partnership, we engage in dialogue, share best practices, and create tailored strategies to meet the unique challenges faced by Black and Brown communities. To ensure underserved communities' voices are included in our decision-making, we regularly engage individuals with lived experience of homelessness. For instance, as part of the Youth Homelessness Demonstration Program (YHDP), we formed an advisory leadership group that includes individuals from underserved backgrounds. The group is regularly evaluated. Their contributions have been essential in shaping programs that meet the specific needs of Black and Brown populations. Our HMIS team collaborates with Riverside County's Diversity, Equity, and Inclusion (DEI) Officer to create policies addressing racial disparities and improving outcomes for underserved communities. Our CoC utilizes disaggregated data from the Homeless Management Information System (HMIS) annually to assess and tackle racial disparities. Following each Point-In-Time (PIT) Count, we release a racial and ethnic disparity report, tracking key metrics such as access to emergency shelters, exits to permanent housing, and participation in Permanent Supportive Housing (PSH) programs by race and ethnicity. For example, while Black individuals account for only 6% of Riverside County's population, they make up 19% of the homeless population, highlighting overrepresentation. However, our data shows that 21% of Black individuals experiencing homelessness transitioned successfully to permanent housing, reflecting progress in housing outcomes. Hispanic/Latino(a) individuals represent 35% of the homeless population but make up 45% of those accessing emergency shelters, demonstrating effective program reach. Native Hawaiian or Pacific Islander individuals are 1% of the general population and the homeless population, as well as 1% of those accessing shelters, showing equitable service for this group.

1B-2.	**Open Invitation for New Members.**	
	NOFO Section V.B.1.a.(2)	

	Describe in the field below how your CoC:
1.	**communicated a transparent invitation process annually (e.g., communicated to the public on the CoC's website) to solicit new members to join the CoC;**
2.	**ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats; and**
3.	**invited organizations serving culturally specific communities experiencing homelessness in your CoC's geographic area to address equity (e.g., Black, Latino, Indigenous, LGBTQ+, and persons with disabilities).**

(limit 2,500 characters)

1) The CoC has a year-round, open invitation process for soliciting members. Invitations are sent to over 1,400 contacts on its listserv and the community through email, public meeting announcements, letters, websites, recruitment flyers, and social media networks. The CoC's "Join the Riverside CoC" webpage provides a link to its membership application and detailed instructions. New members that meet attendance requirements are granted as voting members of the CoC. Regular membership, subcommittees, and Board of Governance meetings are publicly announced and posted to the website and are open to the community. During community events, anyone interested in becoming a CoC member can complete a sign-in sheet.
2) Individuals with disabilities can receive information via email, the CoC website, and HWS's social media pages. CoC meetings are recorded using the Microsoft Teams platform to accommodate anyone unable to attend. Meeting documents are provided in downloadable formats on the website and are accessible to view and preserve accessibility features. CoC staff are available to assist potential members with the electronic application process. Hard copy applications are also available.
3) Participation from providers such as Catholic Charities who serve undocumented and Latinx individuals, in addition to providers like Transgender Health and Wellness Center and TruEvolution serving LGBTQ, Black, persons with disabilities and other special populations, has proven to increase reaches to all individuals to help address and ensure equity.

1B-3.	**CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness.**	
	NOFO Section V.B.1.a.(3)	

	Describe in the field below how your CoC:
1.	**solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;**
2.	**communicated information during public meetings or other forums your CoC uses to solicit public information;**
3.	**ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats; and**
4.	**took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.**

(limit 2,500 characters)

1) The CoC solicits feedback from a broad range of audiences via planning retreats, online surveys, etc. The CoC invites persons from racial/ethnic and gender inclusive groups that are overrepresented in the local homeless population, persons with lived experience of homelessness, the public, private organizations, and CBOs to examine the CoC's performance and to guide the development of our Strategic Action Plan, Assessment and Gaps Analysis, and 5-year Homeless Action Plan. The CoC launches monthly multidisciplinary meetings with leading homeless organizations, representatives within our local government body, and those from the community, included the YAC/YAB community. These meeting are held to share on topics impacting homelessness, highlighting efforts that are positively impacting the goal to end homelessness.
2) All CoC meetings are inclusive of agendas which provide an opportunity for public comments, are recorded, and support the use of visuals and other accessible electronic formats to engage and accommodate a diverse range of individuals.
3) The CoC communicates with the public on all meeting agendas the availability of Reasonable Accommodations by making a request by phone or by email at least 48 hours prior to the meetings. Public Comments may be requested via email. All meeting materials are provided in an electronic format, shared via email, posted on the CoC's website before the event with a short URL. Meeting hosts are trained on how to set up and implement the platform's accessibility features. They monitor and read aloud the comments in chat or Q&A function. All meeting materials are made available to the public on the CoC website and on Google Drive. The public can view the video recordings with close captioning and all meeting agendas, minutes, transcripts and PowerPoint slides are compatible with screen reader software like JAWs and Dragon.
4) The CoC utilizes a CoC subcommittee and BoG meetings to discuss homeless issues, solicit feedback, and uses suggestions to improve services and implement approaches. The subcommittee also participates in non-CoC coordinated community meetings to solicit expertise and knowledge on a variety of topics impacting homelessness including economic, workforce, healthcare, and educational sectors. The CoC develops public surveys, encourages participation in listening sessions, facilitates inclusive focus groups, and obtains feedback directly from providers who engage.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
	NOFO Section V.B.1.a.(4)	

	Describe in the field below how your CoC notified the public:
1.	that your CoC will consider project applications from organizations that have not previously received CoC Program funding;
2.	about how project applicants must submit their project applications–the process;
3.	about how your CoC would determine which project applications it would submit to HUD for funding; and
4.	ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats.

(limit 2,500 characters)

1) During presentations in public meetings, it's emphasized that all interested organizations are encouraged to apply whether they are existing CoC funded agencies or new to CoC Program. On RFP Bid-Notification that was emailed to 600+ CoC Members & posted on NOFO website, it states "All interested organizations are encouraged to submit a proposal including those that have not previously received CoC Program funding."
2) On RFP Bid Notification, it states, "Proposals must be prepared through the Esnaps portal and your agency's downloaded PDF copy must be emailed to CoC@rivco.org." The CoC provides a step-by-step guide within the RFP to demonstrate the Esnaps process as part of the virtual pre-bid workshop.
3) On RFP Bid Notification, it states, 'Proposals are evaluated by a neutral panel with expertise in homeless, housing, and/or government funded programs. Selected proposals were ranked together with all renewal projects & approved by CoC Board of Governance for inclusion in FY2024 CoC Program Competition application." All materials of RFP & virtual pre-bid workshop recordings are posted on CoC NOFO website to ensure accessibility by public, especially people with disabilities.
4) On RFP Bid Notification, it states, "The County may provide an alternative format of RFP within 3 business days." All materials of RFP & virtual pre-bid meeting recordings are posted on CoC NOFO website to ensure accessibility by public, especially people with disabilities. All materials including announcements, applications, workshops/webinars and PowerPoint slides regarding the consideration and acceptance for proposals are provided in an electronic format, shared via email, posted on CoC website before related events, and a short URL is also provided for all materials as well as web site addresses. Materials on social media are also announced and easily accessed through posted URLs.

1C. Coordination and Engagement

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

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- Frequently Asked Questions

1C-1.	**Coordination with Federal, State, Local, Private, and Other Organizations.**	
	NOFO Section V.B.1.b.	

	In the chart below:
1.	**select yes or no for entities listed that are included in your CoC's coordination, planning, and operations of projects that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness; or**
2.	**select Nonexistent if the organization does not exist within your CoC's geographic area.**

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with the Planning or Operations of Projects?
1.	Funding Collaboratives	Yes
2.	Head Start Program	Yes
3.	Housing and services programs funded through Local Government	Yes
4.	Housing and services programs funded through other Federal Resources (non-CoC)	Yes
5.	Housing and services programs funded through private entities, including Foundations	Yes
6.	Housing and services programs funded through State Government	Yes
7.	Housing and services programs funded through U.S. Department of Health and Human Services (HHS)	Yes
8.	Housing and services programs funded through U.S. Department of Justice (DOJ)	Yes
9.	Housing Opportunities for Persons with AIDS (HOPWA)	Yes
10.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Yes
11.	Organizations led by and serving Black, Brown, Indigenous and other People of Color	Yes
12.	Organizations led by and serving LGBTQ+ persons	Yes
13.	Organizations led by and serving people with disabilities	Yes
14.	Private Foundations	Yes
15.	Public Housing Authorities	Yes
16.	Runaway and Homeless Youth (RHY)	Yes
17.	Temporary Assistance for Needy Families (TANF)	Yes
	Other:(limit 50 characters)	
18.		

1C-2.	CoC Consultation with ESG Program Recipients.	
	NOFO Section V.B.1.b.	

In the chart below select yes or no to indicate whether your CoC:

1.	Consulted with ESG Program recipients in planning and allocating ESG Program funds?	Yes
2.	Provided Point-in-Time (PIT) count and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area?	Yes
3.	Ensured local homelessness information is communicated and addressed in the Consolidated Plan updates?	Yes
4.	Coordinated with ESG recipients in evaluating and reporting performance of ESG Program recipients and subrecipients?	Yes

1C-3.	Ensuring Families are not Separated.	
	NOFO Section V.B.1.c.	

Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member's self-reported sexual orientation and gender identity:

1.	Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated?	Yes
2.	Conducted optional training for all CoC- and ESG-funded service providers to ensure family members are not separated?	Yes
3.	Worked with CoC and ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients?	Yes
4.	Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC's geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance?	Yes
5.	Sought assistance from HUD by submitting questions or requesting technical assistance to resolve noncompliance by service providers?	Yes

1C-4.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts.	
	NOFO Section V.B.1.d.	

Select yes or no in the chart below to indicate the entities your CoC collaborates with:

1.	Youth Education Provider	Yes
2.	State Education Agency (SEA)	Yes
3.	Local Education Agency (LEA)	Yes
4.	School Districts	Yes

1C-4a.	Formal Partnerships with Youth Education Providers, SEAs, LEAs, School Districts.	
	NOFO Section V.B.1.d.	

Describe in the field below the formal partnerships your CoC has with at least one of the entities where you responded yes in question 1C-4.

(limit 2,500 characters)

The CoC established systemwide formal and collaborative partnerships with key education providers to better support youth experiencing homelessness across Riverside County. These relationships are inclusive of the Riverside County Office Education (RCOE), who serves as the Local Education Agency for Riverside County. RCOE provides educational, financial, legislative and, leadership services to support all K-12 school districts in Riverside County. RCOE staff participate in CoC meetings, and both facilitate and streamline communication with each of the McKinney-Vento Liaisons in all 23 school districts county wide. In addition, the CoC has established formal relationships with local colleges, including their Guardian Scholar and Educational Opportunity Program (EOP) divisions to better support youth who historically are underserved and focus on helping them achieve success in college and beyond. Additionally, RCOE and local colleges, such as the Riverside Community College and University of California, Riverside provide data, collected, and reported annually, which includes youth homeless status, frequency of homelessness, living situation, impacts of homelessness on students' education and needed supportive services. This relationship has resulted in the successful submission of grant applications submitted by educators and the CoC alike, in addition to strengthening reach to youth who experience homelessness. RCOE, school districts, and partnering colleges work closely with the CoC's Homelessness Youth Coordinator and utilize the CoC meetings and Coordinated Entry System's 24/7 HomeConnect Hotline to coordinated initiatives and services for at-risk and homeless youth. Lastly, The Youth Advisory Council (YAC), a sub-committee of the CoC was developed to raise awareness of the issues surrounding youth homelessness and bring together partner agencies, such as youth educational partners who specialize in youth services to address the issue.

1C-4b.	Informing Individuals and Families Who Have Recently Begun Experiencing Homelessness about Eligibility for Educational Services.	
	NOFO Section V.B.1.d.	

Describe in the field below written policies and procedures your CoC uses to inform individuals and families who have recently begun experiencing homelessness of their eligibility for educational services.

(limit 2,500 characters)

The CoC policies and procedures require service providers to inform homeless individuals and families of their eligibility for education services as required by the McKinney-Vento Act. Families with children that enter a shelter are provided with McKinney-Vento policies and advised of their eligibility for educational services and local school enrollment. Additionally, they are connected to community resources that will help children stay in school and on track. CoC and ESG funded service providers are required to have a designated staff person to ensure that children are enrolled in school; connected into Head Start, Early Head Start and other preschool programs, as needed; connected to educational resources; and have policies and process consistent with the laws related to providing education services to individuals and families. CoC and ESG projects assisting families with children must address the educational needs of children when the families are placed in housing not to disrupt the children's education by selecting a housing location as close as possible to the school of origin. These requirements are included in the agency monitoring took and are tracked and verified during the on-site monitoring visits. Providers are required to address education needs of children and youth in Domestic Violence programs by advocating for them to be home schooled or enrolled locally in school with transportation provided by the district to safely get them to and from school. School district liaisons work with CoC and ESG funded programs to identify homeless children and youth through the Coordinated Entry System. They also work together to inform homeless families of eligibility for McKinney-Vento education services which includes ensuring that families are aware of educational rights, their eligibility for services, their right to receive transportation to their school and their rights as parents and students to receive educational services.

1C-4c.	**Written/Formal Agreements or Partnerships with Early Childhood Services Providers.**	
	NOFO Section V.B.1.d.	

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

		MOU/MOA	Other Formal Agreement
1.	**Birth to 3 years**	Yes	No
2.	**Child Care and Development Fund**	Yes	No
3.	**Early Childhood Providers**	Yes	No
4.	**Early Head Start**	Yes	No
5.	**Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)**	No	Yes
6.	**Head Start**	Yes	No
7.	**Healthy Start**	Yes	No
8.	**Public Pre-K**	No	Yes
9.	**Tribal Home Visiting Program**	Yes	No
	Other (limit 150 characters)		
10.	Public Housing Authority / Local Law Enforcement	Yes	Yes

1C-5.	Addressing Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking–Collaboration with Federally Funded Programs and Victim Service Providers.
	NOFO Section V.B.1.e.

In the chart below select yes or no for the organizations your CoC collaborates with:

	Organizations	
1.	State Domestic Violence Coalitions	Yes
2.	State Sexual Assault Coalitions	Yes
3.	Anti-trafficking Service Providers	Yes
	Other Organizations that Help this Population (limit 500 characters)	
4.		

1C-5a.	Collaborating with Federally Funded Programs and Victim Service Providers to Address Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC regularly collaborates with organizations that you selected yes to in Question 1C-5 to:
1.	update CoC-wide policies; and
2.	ensure all housing and services provided in the CoC's geographic area are trauma-informed and can meet the needs of survivors.

(limit 2,500 characters)

1)The CoC collaborates with victim service providers (VSPs) in each region of the County. VSPs include private and non-profit organizations such as Shelter from the Storm, The Riverside Area Rape Crisis Center, Lighthouse Social Service Centers, Alternatives to Domestic Violence, His Daughters House, and Transgender Health and Wellness Center in addition to government-sponsored programs such as the Department of Justice – Family Justice Center and Behavioral Health divisions within the County's Department of Public Social Services and the Riverside University Health System – Behavioral Health. The CoC works closely with the Coordinated Entry System (CES) who provides closely monitored case management and direct services for individuals and families experiencing domestic violence. Lastly, a member from our VSP's, Shelter from the Storm is a member of the CoC board and the CoC itself is a member of the Riverside County Human-Trafficking Task Force. This multi-sector partnership, ensures the CoC is made up of members who can help influence and shape policy to better meet the needs of survivors of domestic violence, dating violence, sexual assault, and stalking. VSPs are invited to present and speak on services they provide during regular CoC-meetings, and frequently speak to needs, challenges and gaps faced by survivors.
2)The CoC is also a part of quarterly in-person Riverside DV Partner Events with VSPs, including attorneys from the DA's office and Special Crimes Unit, law enforcement, and adult protective services to provide information on resources and training. These meetings are inclusive to all levels of leadership which assists organizations with developing trauma-informed approach principles. The CES facilitates bi-weekly housing and navigation meetings which generally include front-line staff (e.g., street outreach teams, case managers, housing navigators) and their supervisors and provide ongoing trauma-informed care training to ensure all access points within the CoC, support a DV culturally sensitive and trauma-informed approach. CoC-subrecipients who administer homeless assistance programs are also provided with technical assistance to ensure their project's policies and processes also align with SAMHSA's principles of trauma informed care and provide equitable reach to all groups, including for individuals who are LGBTQ+.

1C-5b.	**Implemented Safety Planning, Confidentiality Protocols in Your CoC's Coordinated Entry to Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.**	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC's coordinated entry addresses the needs of DV survivors by including:
1.	**safety planning protocols; and**
2.	**confidentiality protocols.**

(limit 2,500 characters)

1)A CoC sponsored program hosted a DV Collaborative training on the new Violence Against Women Act (VAWA) changes to HUD regulations on 3/5/2024. In addition, CoC programs team conducted case management trainings for CoC sponsored programs on 7/22/2024 and 8/13/2024 that went over a mock file, based upon a domestic violence case. The DV Collaborative training and both case management trainings focused on a wide range of aspects including safety planning, ensuring physical and emotional safety, privacy, confidentiality, culturally relevant services, and emergency needs of participants were included. The coordination with our Coordinated Entry System (CES) also allows for only the agency who is delivering the services to these participants to have the details regarding the client's location and services received. Our victim service providers (VSPs) are not required to utilize our Clarity Homeless Management Information System (HMIS), however, most VSP's have expressed they are able to utilize the system or a comparable database to safeguard the confidentiality of DV clients' information. 2)Our CES has protocols (i.e., written policies and procedures) in place to have all client information for any person(s) fleeing a domestic violence situation to remain private in HMIS. Any referrals are not available to view by all agencies only by the agency the participant is referred to. In addition, some client's personally identifiable information such as date of birth is not required to be provided per our HMIS charter.

1C-5c.	Coordinated Annual Training on Best Practices to Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.	
	NOFO Section V.B.1.e.	

In the chart below, indicate how your CoC facilitates training for project staff and coordinated entry staff that addresses best practices on safety planning and confidentiality protocols:

		Project Staff	Coordinated Entry Staff
1.	Training Occurs at least annually?	Yes	Yes
2.	Incorporates Trauma Informed best practices?	Yes	Yes
3.	Incorporates Survivor-Centered best practices?	Yes	Yes
4.	Identifies and assesses survivors' individual safety needs?	Yes	Yes
5.	Enhances and supports collaboration with DV organizations?	Yes	Yes
6.	Ensures survivors' rights, voices, and perspectives are incorporated?	Yes	Yes
	Other? (limit 500 characters)		
7.			

1C-5d.	Implemented VAWA-Required Written Emergency Transfer Plan Policies and Procedures for Domestic Violence, Dating Violence, Sexual Assault, and Stalking.	
	NOFO Section V.B.1.e.	

Describe in the field below:

1.	whether your CoC's written policies and procedures include an emergency transfer plan;
2.	how your CoC informs all households seeking or receiving CoC Program assistance about their rights to an emergency transfer;
3.	what your CoC requires households to do to request emergency transfers; and
4.	what your CoC does in response to households requesting emergency transfers.

(limit 2,500 characters)

1). The CoC's Written Standards policies and procedures contain the Emergency Transfer Plan

2) It is made available on the CoC's website and shared with all CoC subrecipients. During an intake/enrollment process, subrecipients are aware to provide all clients with information in accordance with the Violence Against Women Act (VAWA) (Reauthorized 2022). They are informed that families assisted through the CoC program who are victims of domestic violence, sexual assault, or stalking can request an emergency transfer from their current unit to another one. This ability is available to all participants regardless of sex, gender identity, or sexual orientation. Participants must complete a HUD approved certification form, a person can confirm they have been a victim of domestic violence, dating violence, sexual assault or stalking, and they wish to use their rights under VAWA which includes moving to another unit.

3) We provide direct referrals to DV providers. For example, the SAFE Family Justice Centers have law enforcement officers collocated with the DV advocates allowing for immediate placement and transfer to DV providers. Our CoC continuously recruit new members strategically to enhance our services and resources. A new CoC member, Domestic Violence and Abuse Protections (DVAP), a California registered 501(c)(3) non-profit corporation that provides professional physical protection services at no cost to victims of violence, abuse, and stalking, has started to serve as a safety net for our DV population. They meet our DV clients wherever they are and facilitate serving restraining orders after normal business hours; assist with collecting personal items; and help them settle in a safe environment during emergencies.

4) A provider under the CoC may request the household to submit documentation about the incident of DV and the request to transfer, which remains confidential. The household is provided with knowledge of their rights under the VAWA act in Form HUD-5380. If the household meets criteria and is certified in accordance to Form 5380, CES is contacted to provide a direct referral to the CoC DV collaborative, with safe and discrete transfer to another housing opportunity. Although the term of the lease addendum is placed, housing benefits to the household remains.

1C-5e.	Facilitating Safe Access to Housing and Services for Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.	
	NOFO Section V.B.1.e.	

Describe in the field below how your CoC ensures households experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking have safe access to all of the housing and services available within your CoC's geographic area.

(limit 2,500 characters)

The CoC's Coordinated Entry process is updated annually by the collective homeless continuum of network and ensures that survivors of domestic violence, dating violence, sexual assault, or stalking have access to housing assistance. In the last year, the CoC has successfully expanded the number of CoC-funded resources available to survivors which includes emergency shelter, transitional housing, rapid rehousing, permanent supportive housing, transitional housing – rapid rehousing projects, and other housing assistance programs. Formal partnerships with victim service providers (VSPs) and subrecipients, ensures individuals assisted through CoC-sponsored programs can easily navigate survivors across all systems of care throughout the county seamlessly. While this partnership allows for VSPs and CoC-sponsored agencies to quickly connect as needed, the CoC has also established a formal process within it's CES structure, that supports the activation of a CES-facilitated case conferencing meeting where appropriate agencies and their representatives can come together to problem solve more difficult and sensitive cases. This approach has strengthened the way local housing and service providers work together, and reduced the time in which it takes for survivors to regain stability, and further ensures VSPs and persons with lived experience are engaged with the CoC's planning body and can influence policy and program development. The CoC has proactively set up a CES system with partnerships allowing VSPs and CoC-sponsored agencies to quickly connect and facilitate case conferencing during emergency situations. Within these case conferences, discussions on the survivors physical, emotional, and mental barriers are discussed to provide holistic care and a full scope assessment of the survivors situation to best assist into safe and secure housing. In addition, the CoC's planning body systematically reviews data to identify systemic barriers that inform policy and program development. For example, our CoC has a person with lived experience of DV on our CoC Board who serves in an advisory capacity that helps shapes our policies and homeless solutions for DV population. Our CoC also ensures that we have emergency resources available. For example, the SAFE Family and Justice Center has a 5-bedroom Ally's House set aside to provide temporary emergency housing that is safe and confidential for clients and families in immediate danger.

1C-5f.	**Identifying and Removing Barriers for Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.**	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC ensures survivors receive safe housing and services by:
1.	**identifying barriers specific to survivors; and**
2.	**working to remove those barriers.**

(limit 2,500 characters)

1)The CoC continuously identifies barriers specific to survivors such as missing documentation, lack of familial support, lack of financial, legal, and transportation resources. Other barriers also include finding shelter in unfamiliar environments, especially for those with pets while fleeing, which can increase hardship for the survivor to obtain help and puts a burden on their children's need to attend school and find affordable day care. When barriers like these accumulate, it can be taxing on the survivor and their families and encourages their return to the abuser, inducing an increase of traumatic emotional reactions, like overstimulation from fight or flight responses, and overwhelming feelings of shame and guilt.

2)The CoC continuously reviews systems to proactively identify and remove barriers specific to survivors to ensure safe access to all CoC Programs/services. All races, gender, cultures, and family structures are served. The CoC makes direct referrals to our domestic violence collaborative, made up of county wide victim service providers (VSP's), that include private and non-profit organizations and government-sponsored program to provide safe, equitable, and free access to DV specific shelter, short and long term housing, community resources, and case management to ensure proper allocation of resources. The Coc and VSP's meet on a monthly basis to case conference the specific needs of survivors who have been referred. Direct referrals decrease the time a survivor reaches out for help to the time they connect with a service provider. VSPs are not required to utilize our Clarity Homeless Management Information System (HMIS) to reduce documentation burden for parent survivors that at times feel re-traumatized. Domestic Violence and Abuse Protections (DVAP), provide professional physical protection services at no cost to survivors. The Coc, in collaboration with the VSP's, make site visits, provide technical assistance, webinars, trainings, and present new community resources that have been recommended and implemented to ensure policies and procedures are implemented appropriately. In addition, CoC ensures VAWA policies and participant rights are made known during the intake process and publicly posted at all HUD-funded subrecipient locations.

1C-6.	Addressing the Needs of Lesbian, Gay, Bisexual, Transgender and Queer+–Anti-Discrimination Policy and Equal Access Trainings.	
	NOFO Section V.B.1.f.	

1.	Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBTQ+ individuals and families receive supportive services, shelter, and housing free from discrimination?	Yes
2.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?	Yes
3.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access in Accordance With an Individual's Gender Identity in Community Planning and Development Programs (Gender Identity Final Rule)?	Yes

1C-6a.	Anti-Discrimination Policy–Updating Policies–Assisting Providers–Evaluating Compliance–Addressing Noncompliance.	
	NOFO Section V.B.1.f.	

	Describe in the field below:
1.	how your CoC regularly collaborates with LGBTQ+ and other organizations to update its CoC-wide anti-discrimination policy, as necessary to ensure all housing and services provided in the CoC are trauma-informed and able to meet the needs of LGBTQ+ individuals and families;
2.	how your CoC assisted housing and services providers in developing project-level anti-discrimination policies that are consistent with the CoC-wide anti-discrimination policy;
3.	your CoC's process for evaluating compliance with your CoC's anti-discrimination policies; and
4.	your CoC's process for addressing noncompliance with your CoC's anti-discrimination policies.

(limit 2,500 characters)

1). CoC updates CoC Written Standards that includes anti-discrimination policy at least annually. Per CoC Charter, CoC engages stakeholders for input & reviews all updates during our Brown Act compliant public CoC meetings. CoC provided trainings to all CoC members on the Equal Access Rule. All CoC subrecipients implements antidiscrimination policies. CoC leverages partnerships & expertise from subject matter experts & stakeholders who serve special populations such as Alternatives to Domestic Violence, Shelter from the Storm, The Riverside Area Rape Crisis Center, Transgender Health & Wellness Center, and TruEvolution who are strong advocates among the LGBTQ+ community and have helped strengthen the CoC's anti-discrimination policies. Policies require subrecipients to maintain records of incidents involving individuals and families served. Confirmed acts of discrimination, harassment and misconduct are dealt appropriately and when needed, may/could result in termination of contracts.

2). CES Lead Agency facilitates bi-weekly housing & navigation meetings; provides ongoing trauma-informed care trainings to support a culturally sensitive and trauma-informed approach. CoC-subrecipients are provided with technical assistance to ensure their project's policies and processes align with SAMHSA's principles of trauma informed care and provide equitable reach to all groups including LGBTQ+. CoC facilitates ongoing webinars addressing barriers and services for LGBTQ+ populations (see our CoC Learning Opportunities | Housing and Workforce Solutions: HWS (rivcohhpws.org) website.)

3) CoC monitors all agencies throughout the year and provides monthly Technical Assistance calls to monitor our agencies compliance with all program regulations along with providing assistance with ongoing program execution. During the annual program monitoring our CoC evaluates all aspects of the program execution to include compliance with contracts, fiscal, HMIS, and programs. If any non-compliance is found in either of the areas a Concern or Finding is discussed along with a Corrective Action Plan (CAP) is provided in which an agency must provide how they plan to rectify any of the items found.

4) A letter to address non-compliance along with a Corrective Action Plan (CAP) is provided in which an agency must provide how they plan to rectify any of the items found. This CAP must be provided within 30 days of receipt of letter.

1C-7.	Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.	
	NOFO Section V.B.1.g.	

You must upload the PHA Homeless Preference\PHA Moving On Preference attachment(s) to the 4B. Attachments Screen.
Enter information in the chart below for the two largest PHAs highlighted in gray on the current CoC-PHA Crosswalk Report or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing or Housing Choice Voucher Program During FY 2023 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
Housing Authority of the County of Riveside	35%	Yes-Both	Yes

1C-7a.	Written Policies on Homeless Admission Preferences with PHAs.	
	NOFO Section V.B.1.g.	

	Describe in the field below:
1.	steps your CoC has taken, with the two largest PHAs within your CoC's geographic area or the two PHAs your CoC has working relationships with, to adopt a homeless admission preference–if your CoC only has one PHA within its geographic area, you may respond for the one; or
2.	state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.

(limit 2,500 characters)

The CoC partners with its local PHA, to establish homeless admission preferences for the Housing Choice Voucher Program. Up to 15% of annual admissions are targeted for an extraordinary local preference and support referrals from the CoC's CES System Lead Agency, Behavioral Health, for those who are not eligible for HUD funded long-term housing through the CoC and are able to live independently with minimal support; and registrants displaced by government action or emergency as certified by a city, county or state agency official. Admissions must meet County of Riverside Residency preference, and 1) Qualified veterans, or 2) Families whose head of household, spouse or co-head is 70 years of age and older, or 3) A client referred by Adult Protective Services, a division within the County of Riverside Department Public Social Services, who is 62 years or older and homeless or at-risk of being homeless; or 4) Families or Foster Care Youth referred to the HA by the Riverside County Public Child Welfare Agency for admission through the Family Unification Program, or 5) Participants who have utilized a special rental assistance program administered by or under contract/MOU with the HA for a minimum of a six (6) month term and no longer require supportive services; or 6) Participants transitioning or "moving on" who have been assisted through a Permanent Supportive Housing Program administered by a partnering agency and no longer required intensive supportive services; or 7) Non-elderly persons at least 18 years of age and less than 62 years of age with disabilities who are transitioning out of institutional and other segregated settings, at serious risk of institutionalization, homeless, or at risk of becoming homeless; or 8) Family Unification Program (FUP) Youth or Foster Youth to Independence Initiative (FYI) Youth whose FUP/FYI youth assistance is expiring and will have a lack of adequate housing as a result of their termination from the program. HA's admin plan includes protections for survivors of domestic violence, dating violence, sexual assault, or stalking who live in public housing or assisted housing & are at-risk of homelessness or who need to relocate to ensure their safety.

1C-7b.	**Moving On Strategy with Affordable Housing Providers.**	
	Not Scored–For Information Only	

Select yes or no in the chart below to indicate affordable housing providers in your CoC's jurisdiction that your recipients use to move program participants to other subsidized housing:

1.	**Multifamily assisted housing owners**	No
2.	**PHA**	Yes
3.	**Low Income Housing Tax Credit (LIHTC) developments**	Yes
4.	**Local low-income housing programs**	Yes
	Other (limit 150 characters)	
5.		

1C-7c.	Include Units from PHA Administered Programs in Your CoC's Coordinated Entry.	
	NOFO Section V.B.1.g.	

In the chart below, indicate if your CoC includes units from the following PHA programs in your CoC's coordinated entry process:

1.	Emergency Housing Vouchers (EHV)	Yes
2.	Family Unification Program (FUP)	Yes
3.	Housing Choice Voucher (HCV)	Yes
4.	HUD-Veterans Affairs Supportive Housing (HUD-VASH)	Yes
5.	Mainstream Vouchers	Yes
6.	Non-Elderly Disabled (NED) Vouchers	No
7.	Public Housing	Yes
8.	Other Units from PHAs:	
		No

1C-7d.	Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.	
	NOFO Section V.B.1.g.	

1.	Did your CoC coordinate with a PHA(s) to submit a competitive joint application(s) for funding or jointly implement a competitive project serving individuals or families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other programs)?	Yes
		Program Funding Source
2.	Enter the type of competitive project your CoC coordinated with a PHA(s) to submit a joint application for or jointly implement.	Family Unification Program (FUP)

1C-7e.	Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including Emergency Housing Voucher (EHV).	
	NOFO Section V.B.1.g.	

	Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan?	Yes

1D. Coordination and Engagement Cont'd

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1D-1.	Preventing People Transitioning from Public Systems from Experiencing Homelessness.	
	NOFO Section V.B.1.h.	

Select yes or no in the chart below to indicate whether your CoC actively coordinates with the public systems listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.

1.	Prisons/Jails?	Yes
2.	Health Care Facilities?	Yes
3.	Residential Care Facilities?	Yes
4.	Foster Care?	Yes

1D-2.	Housing First–Lowering Barriers to Entry.	
	NOFO Section V.B.1.i.	

1.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe Haven, and Transitional Housing projects your CoC is applying for in FY 2024 CoC Program Competition.	24
2.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe Haven, and Transitional Housing projects your CoC is applying for in FY 2024 CoC Program Competition that have adopted the Housing First approach.	24
3.	This number is a calculation of the percentage of new and renewal PSH, RRH, SSO non-Coordinated Entry, Safe Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in the FY 2024 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	100%

1D-2a.	Project Evaluation for Housing First Compliance.	
	NOFO Section V.B.1.i.	

You must upload the Housing First Evaluation attachment to the 4B. Attachments Screen.
Describe in the field below:

1.	how your CoC evaluates every project–where the applicant checks Housing First on their project application–to determine if they are using a Housing First approach;
2.	the list of factors and performance indicators your CoC uses during its evaluation;
3.	how your CoC regularly evaluates projects outside of your local CoC competition to ensure the projects are using a Housing First approach; and
4.	what your CoC has done to improve fidelity to Housing First.

(limit 2,500 characters)

1)The CoC evaluates the performance of funded projects through HF requirements that are outlined in all bidder applications and provider agreements to ensure alignment with HUD CoC Program Guidelines and the USICH's Housing First Checklist. All funded agencies provide the CoC with Policies and Procedures that include the Housing First approach.

2) The following is a list of factors and performance indicators the CoC uses during its evaluation: abstinence of substances, minimum income requirements, health or mental health history, medication adherence, age, criminal justice history, financial history, completion of treatment, participation in services, "housing readiness," history or occurrence of victimization, survivor of sexual assault or an affiliated person of such a survivor or other unnecessary conditions unless required by law or funding source. Projects do not require specific appointment times and assessments are focused on identifying household strengths, resources, and housing barriers

3) The CoC recruits a committee of members who have direct knowledge in administering homeless programs and are responsible for updating its HUD CoC Program Competition Scorecard, used as part of its review and ranking tool for both renewal and new projects each year. Project performance is weighted heavily on compliance with Housing First, measuring the rate in which agencies successfully place individuals into permanent housing, average number of tenants that remain in or obtain housing stability and average percentages in returns to homelessness. For renewal projects, the scorecard incorporates points based on Annual Site Visit Reviews and Annual Performance Reports to further ensure performance and compliance of HF.

4)The following methods are used to measure performance and compliance: a) Annual Monitoring Site Visits, b) Annual Performance Reports and c) HUD CoC Program Competition Project Scorecard. Annual Monitoring Site Visits and review of Annual Performance Reports are tools to review case files and documents such as Intakes, Annual and Exit Assessment Tools and Individual Service Plans (ISPs). CoC staff also review ISPs and interview clients to ensure service plans are client-centered and inclusive of client driven goals. P&Ps developed by each project are also reviewed to ensure avenues for clients to access the program, request any needed supports and accommodations, and address any grievances exist.

1D-3.	Street Outreach–Data–Reaching People Least Likely to Request Assistance.	
	NOFO Section V.B.1.j.	

Describe in the field below how your CoC tailored its street outreach to people experiencing homelessness who are least likely to request assistance.

(limit 2,500 characters)

The CoC funded program Health in Action, a mobile health and medicine clinic, targets the most vulnerable and those least likely to ask for assistance due to mental health and/or severe medical needs. Health in Action provides time sensitive medical interventions and uses a harm reduction approach to build trust and fill the gap between the homeless individual and housing access. Second, we have approximately two FTE outreach staff for every 35 unsheltered persons, providing 7-days a week bilingual coverage across 100% of the geographic area. This level of coordination enables mobile reaches and a no wrong door approach to all unsheltered residents. In addition, a 24/7 CES hotline ensures residents seeking assistance are directly linked to designated teams in their areas. Areas with higher concentrations of unsheltered residents and impacted by remote areas including encampments, riverbeds, desert areas, canyons, are visited with repeat visits by a CoC funded program Riverside County Parks and Reaction Department, with collaboration from other CoC funded programs such as City Net, Housing Authority, and Riverside University Health Systems- Behavioral Health to provide on-site mental health assessments, emergency housing opportunities, and warm hand-offs of resources (food, hygiene, clothing, etc.) Third, the CoC & CES Lead Agencies in alignment with the CES P&P's, coordinate outreach services and work alongside CBOs, public safety teams such as law enforcement, code enforcement, and probation, in addition to emergency management services, public health, medical/health and other specialized mobile teams (e.g. vets, youth, BH, foster youth, and others). There are 30 multi-agency outreach teams, made of 60 FTE staff countywide. Fourth, CoC funded programs provide bi-weekly meetings to update a by-name list and provide case conferencing during which areas and/or those least likely to request assistance are identified and geo-mapping (GIS) is documented in the Homeless Management Information System (HMIS) to pinpoint locations where people are known to be hidden.

1D-4.	Strategies to Prevent Criminalization of Homelessness.	
	NOFO Section V.B.1.k.	

Select yes or no in the chart below to indicate your CoC's strategies to prevent the criminalization of homelessness in your CoC's geographic area:

	Your CoC's Strategies	Engaged/Educated Legislators and Policymakers	Implemented Laws/Policies/Practices that Prevent Criminalization of Homelessness
1.	Increase utilization of co-responder responses or social services-led responses over law enforcement responses to people experiencing homelessness?	Yes	Yes
2.	Minimize use of law enforcement to enforce bans on public sleeping, public camping, or carrying out basic life functions in public places?	Yes	Yes
3.	Avoid imposing criminal sanctions, including fines, fees, and incarceration for public sleeping, public camping, and carrying out basic life functions in public places?	Yes	Yes
4.	Other:(limit 500 characters)		

1D-5.	Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC) or Longitudinal Data from HMIS.	
	NOFO Section V.B.1.l.	

		HIC Longitudinal HMIS Data	2023	2024
	Enter the total number of RRH beds available to serve all populations as reported in the HIC or the number of households served per longitudinal HMIS data, e.g., APR.	HIC	710	830

1D-6.	Mainstream Benefits–CoC Annual Training of Project Staff.	
	NOFO Section V.B.1.m.	

Indicate in the chart below whether your CoC trains program staff annually on the following mainstream benefits available for program participants within your CoC's geographic area:

	Mainstream Benefits	CoC Provides Annual Training?
1.	Food Stamps	Yes
2.	SSI–Supplemental Security Income	Yes
3.	SSDI–Social Security Disability Insurance	Yes
4.	TANF–Temporary Assistance for Needy Families	Yes
5.	Substance Use Disorder Programs	Yes
6.	Employment Assistance Programs	Yes
7.	Other (limit 150 characters)	

1D-6a.	Information and Training on Mainstream Benefits and Other Assistance.	
	NOFO Section V.B.1.m	

	Describe in the field below how your CoC:
1.	works with projects to collaborate with healthcare organizations, including those that provide substance use disorder treatment and mental health treatment, to assist program participants with receiving healthcare services, including Medicaid; and
2.	promotes SSI/SSDI Outreach, Access, and Recovery (SOAR) certification of program staff.

(limit 2,500 characters)

1) CoC maintains a listserv and keeps all partners up to date on federal, state and local resources available. Informational emails and local TA webinars through its Multidisciplinary Approaches to Ending Homelessness Series regularly make information on employment services such as education and training, access to job search assistance, skills assessment, job placement, and career/vocational counseling, and mainstream resources (e.g. CalFresh, SSI, General Assistance, health care, and other benefit assistance) available. The CoC also maintains relationships with healthcare partners: Inland Empire Health Plan (IEHP) to provide SS for PSH clients; DPSS/TANF to provide food stamps, Medi-Cal enrollment, General Relief program and short-term housing assistance for CalWORKS eligible families; Whole Person Care Program (WPCP) provides supportive services and housing and benefits linkage to medical recipients who are experiencing or are at-risk of homelessness and are discharged from institutional care and coordinates health services to improve health and well-being.

2) The CoC works to inform the community of SOAR certification and training opportunities in addition to the CES lead agency informing community members of staff training opportunities. The SAMSHA website is given to provide links to online courses so that upon completion of the course, program staff can receive a certificate of completion. The CoC will also work to inform the community either through webinar trainings and/or public meetings, any updates to training also keeps online resources for training opportunities.

ID-7.	**Partnerships with Public Health Agencies–Collaborating to Respond to and Prevent the Spread of Infectious Diseases.**	
	NOFO Section V.B.1.n.	

	Describe in the field below how your CoC effectively collaborates with state and local public health agencies to develop CoC-wide policies and procedures that:
1.	**respond to infectious disease outbreaks; and**
2.	**prevent infectious disease outbreaks among people experiencing homelessness.**

(limit 2,500 characters)

1)The CoC has implemented a whole CoC-wide community approach to public health and homelessness to provide more adequate healthcare and housing resources for households at-risk of or experiencing homelessness and prevent and respond to infectious disease outbreaks. This response has included the development of policies and procedures which guide the entire continuum on how to respond and prevent infectious disease outbreaks. Bi-monthly meetings are held with CoC homeless assistance providers and the local Public Health Nurse of Disease and Infectious Disease to review policies and processes for prevention of outbreaks, medical treatment services to treat communicable diseases, and interventions such as vaccination events and coordinate field based. These meetings have provided a coordinated space where homeless assistance providers can provide feedback on gaps in education and training, case conference unique client cases that require public health intervention, in addition to reviewing federal, state, and local public health guidelines and best practices from the Center for Disease Control and Prevention, California Department of Public Health (CDPH), and the Riverside University Health System. Public Health partners also participate in CoC meetings.

2)Additionally, the CoC has incorporated regular trainings to ensure all providers are aware on the CoC's plan to respond to an infectious disease outbreak. The CoC also coordinates with CDPH, the Emergency Management Department (EMD) and the local community to receive donated supplies and ensure CoC homeless assistance providers have the necessary supplies and staffing levels to maintain a safe and disease-free environment. CoC providers are also made aware of the various funding sources that can be used to obtain additional needed supplies. CoC will continue to coordinate training and disseminate information to all CoC members and partners about best practices to prepare, prevent, and respond to infectious disease outbreak.

ID-7a.	Collaboration With Public Health Agencies on Infectious Diseases.	
	NOFO Section V.B.1.n.	

	Describe in the field below how your CoC:
1.	effectively shared information related to public health measures and homelessness; and
2.	facilitated communication between public health agencies and homeless service providers to ensure street outreach providers and shelter and housing providers are equipped to prevent or limit infectious disease outbreaks among program participants.

(limit 2,500 characters)

1)The CoC has dedicated liaison team to collaborate with the County's Public Health department to regularly share and disseminate information related to public health measures that prevent or limit infectious disease outbreaks among program participants through an updated contact information and distribution list that includes partner agencies. To do this, the CoC and Public Health host joint bi-monthly meetings with homeless assistance providers to share up to date information on current stats, best practices, and updates.

2)Public Health also worked with the CoC and it's homeless assistance providers to develop an intake screening tool to help screen participants for medical needs and potential exposures. As individuals are identified to need isolation or quarantine, homeless assistance providers case conference with Public Health to determine whether it is appropriate for the person to isolate or quarantine in place or if additional accommodation are needed in Public Health operated hotel/motel rooms until clearance. Additionally, street outreach, shelter and housing providers are also provided with public health guidance surrounding PPE and levels of face-to-face engagement with program participants in order to further prevent or limit infectious disease outbreaks among participants, while employing a trauma-informed approach. When needed and as part of the CoC's mitigation strategy, Public Health and shelter operators may limit the number of new intakes or put all new intakes on hold until proper clearance has received as needed to prevent or reduce the number of new outbreaks. When these cases arises, the CoC works with the shelter and other CoC housing providers to direct any new referrals to other shelter beds in the region, also while employing a trauma-informed approach. The CoC also supports providers with meeting any supply or staffing demands it needs to ensure capacity at each site is not impacted as a result of outbreaks at each site.

1D-8.	Coordinated Entry Standard Processes.	
	NOFO Section V.B.1.o.	

	Describe in the field below how your CoC's coordinated entry system:
1.	can serve everybody regardless of where they are located within your CoC's geographic area;
2.	uses a standardized assessment process to achieve fair, equitable, and equal access to housing and services within your CoC;
3.	collects personal information in a trauma-informed way; and
4.	is updated at least annually using feedback received from participating projects and households that participated in coordinated entry.

(limit 2,500 characters)

1) Riverside County's Coordinated Entry System (CES) has adopted a "no wrong door" assessment hotline hybrid model of access to the CES. Access points cover 100 percent of the CoC's geographic area and are easily accessible by people seeking assistance

2) The CoC utilizes a standard assessment process within its Homeless Management Information System (HMIS) that has been customized to reflect local population needs and the CoC's values and standardized approach. Written Coordinated Entry System (CES) Policies and Procedures detail this standardized assessment process and is made available to all CoC homeless assistance providers to ensure uniform decision-making across the entire county. The CES P&Ps are reviewed and regularly updated by the CoC's CES Advisory Council, CoC ad hoc committees, and then adopted by the full CoC membership body. The varying levels of engagement within the CoC commits participation from all stakeholders, including current or former participants with lived experience, and homeless assistance providers. Representatives from all access point agencies participate in case conferencing, case file review, and share what they are learning to adapt CES. Providers specializing in serving specific subpopulations such as veterans, seniors, youth, and families or have clients that do not meet criteria still assist them in obtaining access to screening and referral through a more suitable provider. The CES P&Ps allow for CoC stakeholders to make recommendations to prioritization policies and to request special meetings when emergencies such as fires, flood, or other incidents that may require mass relocations.

3) Culturally and linguistic competent practices are used and staff are trained in trauma-informed care, safety planning, and provide a private place for assessments. Staff ensure introductions, assessments and understanding of services being offered are approved from homeless individuals upon approach. Homeless individuals are offered space to refuse sensitive/invasive questions during assessments and are allowed to request confidentiality regarding information shared with staff.

4)The CoC's standing Committee: CES Advisory Council allows for agencies to share feedback on CES and make suggestions for improvement throughout the year. Feedback from persons with lived experience of homelessness is collected through the CoC's Persons with Lived Experience Panel and is used as a means to improve the CES process.

1D-8a.	Coordinated Entry–Program Participant-Centered Approach.	
	NOFO Section V.B.1.o.	

	Describe in the field below how your CoC's coordinated entry system:
1.	reaches people who are least likely to apply for homeless assistance in the absence of special outreach;
2.	prioritizes people most in need of assistance;
3.	ensures people most in need of assistance receive permanent housing in a timely manner, consistent with their needs and preferences; and
4.	takes steps to reduce burdens on people seeking assistance.

(limit 2,500 characters)

CES Lead operates an assessment hotline, works with county-wide housing navigation and street outreach teams and providers who serve as access points to reach people least likely to apply for assistance. Weekly meetings are facilitated to coordinate intensive and daily outreach with teams that serve a specific region and/or are countywide. Prioritization is based on an individual's level of vulnerability and needs as documented in an assessment. The CoC has adopted the VI-SPDAT as the community assessment tool for single adults, families, and youth. The tool has been integrated into the Homeless Management Information System (HMIS). Within HMIS, one is able to generate a participant priority By Name List which includes a wide range of households who are eligible for permanent supportive housing and rapid rehousing as well as screened and assessed for diversion, emergency shelter and transitional housing services. Prioritization using the VI-SPDAT is ranked based on vulnerability and length of time homeless. The capability within HMIS to manage the By Name List streamlines the coordinated entry system process for access to homelessness dedicated resources. This ensures all households can be referred to dedicated housing and/or services for which they are eligible across the entire geographic area within Riverside County. Additionally, to reduce burdens on people using coordinated entry, the CoC has provided training to providers so they are prepared to skip-logic for unnecessary, repetitive or irrelevant assessment questions. Diversion training has also been scaled to ensure individuals can navigate immediate and short-term resources needed to more quickly resolve their homelessness. In the past year, the CoC has significantly scaled the number of multiagency street outreach teams available to respond to referrals received through the CoC's coordinated entry system. Teams have designated response areas through the county's five supervisorial districts to ensure they are knowledgeable about the resources available in the immediate region and significantly decrease the number of clients assigned to street outreach teams. As referrals are received through the CoC's Coordinated Entry System (CES) hotline or any of the CoC's access points, screenings help determine which teams are most appropriate to respond to ensure a quick service strategy and housing plan can be implemented to meet the persons needs as rapidly as possible.

1D-8b.	Coordinated Entry–Informing Program Participants about Their Rights and Remedies–Reporting Violations.	
	NOFO Section V.B.1.o.	

	Describe in the field below how your CoC through its coordinated entry:
1.	affirmatively markets housing and services provided within the CoC's geographic area and ensures it reaches all persons experiencing homelessness;
2.	informs program participants of their rights and remedies available under federal, state, and local fair housing and civil rights laws; and
3.	reports any conditions or actions that impede fair housing choice for current or prospective program participants to the jurisdiction(s) responsible for certifying consistency with the Consolidated Plan.

(limit 2,500 characters)

1.Our CoC has developed formal partnerships such as MOUs and subrecipient agreements with organizations serving underserved and marginalized communities across the entire county. Our BoG looks at distribution of funding by region to ensure all areas are being served. Coordinated Entry Access Points in underserved and marginalized communities consist of materials in multiple languages and various mediums which provides information to the targeted population (i.e., social media for TAY, etc) accessible on CoC or AE website.

2.All programs are contractually obligated to have an equal access policy. This requirement is monitored on an annual basis as part of the overall program monitoring and compliance check.

3.All consolidated plans are through the County of Riverside. All reporting is internal and immediate.

1D-9.	Advancing Racial Equity in Homelessness–Conducting Assessment.	
	NOFO Section V.B.1.p.	

1.	Has your CoC conducted a racial disparities assessment in the last 3 years?	Yes
2.	Enter the date your CoC conducted its latest assessment for racial disparities.	04/01/2023

1D-9a.	Using Data to Determine if Racial Disparities Exist in Your CoC's Provision or Outcomes of CoC Program-Funded Homeless Assistance.	
	NOFO Section V.B.1.p.	

	Describe in the field below:
1.	the data your CoC used to analyze whether any racial disparities are present in your CoC's provision or outcomes of CoC Program-funded homeless assistance; and
2.	how your CoC analyzed the data to determine whether any racial disparities are present in your CoC's provision or outcomes of CoC Program-funded homeless assistance.

(limit 2,500 characters)

1)Riverside County CoC regularly analyzes client-level data from its Homeless Management Information System (HMIS) to assess system- and project-level performance with a focus on equity. This includes reviewing service provision across all programs such as emergency shelters, rapid rehousing, and permanent supportive housing to ensure equitable access. To support these efforts, tools such as the HUD Racial Equity Analysis Tool and California's Homeless Data Integration System (HDIS) are used to examine demographic trends between the general population and those experiencing homelessness, helping to identify disparities in access and outcomes.

2)Data from the Point-in-Time (PIT) Count, HMIS, and the U.S. Census Bureau are analyzed to compare the racial and ethnic composition of the homeless population with that of the general population. The analysis focuses on assessing access by determining who is utilizing services across all programs, evaluating outcomes by analyzing how various racial and ethnic groups experience outcomes such as exits to permanent housing, and ensuring equity by verifying that services across all programs, such as rapid rehousing and emergency shelters, are accessed fairly by all groups. By breaking down this data, the CoC identifies whether racial and ethnic groups are disproportionately represented in the homeless population and whether their service access or outcomes differ. In separate localized report completed in 2023, the CoC has found that Black/African American, American Indian/Alaska Native, and Native Hawaiian or Pacific Islander individuals are overrepresented in the homeless population. Multi-racial individuals are more likely to exit homelessness at lower rates; though they make up 8% of the homeless population, they only represent 3% of those accessing emergency shelters and 4% in permanent supportive housing. Hispanic/Latino(a) individuals, who make up 50% of the general population, represent 35% of the homeless population, showing underrepresentation. The CoC is actively addressing disparities by promoting equitable access and improving outcomes for all racial and ethnic groups. Initiatives include targeted outreach, enhancing cultural competency among providers, and ensuring individuals with lived experience contribute to policymaking. Progress is tracked through ongoing HMIS data analysis, reviews with the HUD Racial Equity Analysis Tool, and continuous stakeholder engagement to reduce disparities over time.

1D-9b.	**Implemented Strategies to Prevent or Eliminate Racial Disparities.**	
	NOFO Section V.B.1.p	

Select yes or no in the chart below to indicate the strategies your CoC is using to prevent or eliminate racial disparities.

1.	**Are your CoC's board and decisionmaking bodies representative of the population served in the CoC?**	Yes
2.	**Did your CoC identify steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC?**	Yes
3.	**Is your CoC expanding outreach in your CoC's geographic areas with higher concentrations of underrepresented groups?**	Yes
4.	**Does your CoC have communication, such as flyers, websites, or other materials, inclusive of underrepresented groups?**	Yes
5.	**Is your CoC training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness?**	Yes

6.	Is your CoC establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector?	Yes
7.	Does your CoC have staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness?	Yes
8.	Is your CoC educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity?	Yes
9.	Did your CoC review its coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness?	Yes
10.	Is your CoC collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system?	Yes
11.	Is your CoC conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness?	Yes
	Other:(limit 500 characters)	
12.		

1D-9c.	Plan for Ongoing Evaluation of System-level Processes, Policies, and Procedures for Racial Equity.	
	NOFO Section V.B.1.p.	

Describe in the field below your CoC's plan for ongoing evaluation of system-level processes, policies, and procedures for racial equity.

(limit 2,500 characters)

The CoC's plan for ongoing evaluation of system-level processes, policies, and procedures to prevent and eliminate racial disparities focuses on promoting equity through continuous assessment and targeted action. Key components of the plan include: (1) The CoC prioritizes diversifying its membership, leadership, and committees to ensure inclusive representation from underserved communities, including individuals with lived experience of homelessness and domestic violence survivors. (2) Efforts will continue to ensure diversity within all levels of CoC participation, including CES operations, HMIS oversight, and general meetings, to ensure diverse voices contribute to decision-making and policy evaluation. (3) The CoC will work with public and private agencies to diversify their leadership, staff, and boards of directors, ensuring that those responsible for delivering CoC Program-funded services reflect the diversity of the communities they serve. (4) Agencies will be encouraged to diversify the membership of their committees to include representation from historically underserved populations, promoting broader perspectives in decision-making. (5) The CoC will use disaggregated data from HMIS to continuously monitor racial disparities in key outcomes such as service access, housing placements, and returns to homelessness. (6) Annual racial disparity reports will analyze data from the PIT Count and other sources, identifying gaps in service provision and guiding necessary adjustments to policies and procedures (7) The CoC will conduct quarterly reviews to assess the effectiveness of racial equity strategies and make data-informed adjustments where needed. (8) Based on data findings, the CoC will create targeted racial equity action plans to address specific disparities and ensure all racial and ethnic groups have equitable access to services. (9) The CoC will continue collaborating with the Riverside County Diversity, Equity, and Inclusion (DEI) Officer to develop policies that directly address inequities in the homelessness system. (10) The CoC will publish annual racial equity reports, outlining progress in reducing disparities and highlighting ongoing efforts to ensure accountability and transparency to the community and stakeholders.

1D-9d.	Plan for Using Data to Track Progress on Preventing or Eliminating Racial Disparities.	
	NOFO Section V.B.1.p.	

	Describe in the field below:
1.	the measures your CoC plans to use to continuously track progress on preventing or eliminating racial disparities in the provision or outcomes of homeless assistance; and
2.	the tools your CoC plans to use to continuously track progress on preventing or eliminating racial disparities in the provision or outcomes of homeless assistance.

(limit 2,500 characters)

1). The CoC partners with its local PHA to establish homeless admission preferences for HCVP. Up to 15% of annual admissions are targeted for an extraordinary local preference and support referrals from the CES Lead Agency, and for those who are not eligible for HUD funded housing through the CoC and are able to live independently with minimal support. Admissions must meet County of Riverside County Residency Preference, and 1) Qualified veterans, or 2) Families whose head of household, spouse or co-head is 70 years of age and older; or 3) A client referred by Adult Protective Services (APS), who is 62 years or older and homeless or at-risk of being homeless ; or 4) Families or Foster Care Youth referred to the HA by the Riverside County Public Child Welfare Agency (PCWA) for admission through the Family Unification Program b. Family Unification Program (FUP) Youth or Foster Youth to Independence Initiative (FYI) Youth 5)Participants who have utilized a special rental assistance program administered by (or under contract/Memorandum of Understanding (MOU) with) the Housing Authority of the County of Riverside for a minimum of a six (6) month term and no longer require supportive services; or 6) Participants transitioning or “moving on” who have been assisted through a Permanent Supportive Housing Program administered by a partnering agency and no longer require intensive supportive services; or 7) Non-elderly persons aged 18-62 with disabilities who are transitioning out of institutional and other segregated settings, at serious risk of institutionalization, homeless, or at risk of becoming homeless; or 8) Family Unification Program (FUP) Youth or Foster Youth to Independence Initiative (FYI) Youth whose FUP/FYI youth assistance is expiring and will have a lack of adequate housing as a result of their termination from the program.
2) CoC uses data from HMIS, PITC, CES, SPMs, LSA, Stella P, & Racial Disparity Report to track progress on preventing or eliminating disparities in the provision or outcomes of homeless assistance. These are reviewed and discussed in public CoC Meetings. CoC uses a dashboard as an ongoing monthly tracking mechanism on demographic movements and local participation among service providers, stakeholders and the public. CoC recruited a Data Analyst to examine DEI, racial disparities, and inequities in the HMIS data and point in time count data to propose system modifications and policy adjustments to to tackle these disparities.

1D-10.	Involving Individuals with Lived Experience of Homelessness in Service Delivery and Decisionmaking–CoC’s Outreach Efforts.	
	NOFO Section V.B.1.q.	

Describe in the field below your CoC's outreach efforts (e.g., social media announcements, targeted outreach) to engage those with lived experience of homelessness in leadership roles and decisionmaking processes.

(limit 2,500 characters)

The CoC has diversified the ways in which it engages persons with lived experience of homelessness and has two dedicated residential boards that are 100 percent comprised of persons with lived experience. This includes: 1) The Youth Action Board (YAB) made up of transitional age youth who are between the ages of 18-24 and help oversee the CoC's homeless continuum of services for youth and, 2) The Residential Panel (RP) made up of three members, who review and support the CoC's Homeless Action Plan. Additionally, the CoC's Board of Governance (BoG) has two designated and permanent seats for persons with lived experience which include one youth seat and one general seat. Participants are voted in by the CoC and are able to provide direct feedback on CoC related policy and funding recommendations. As needs arise to recruit additional persons with lived experience on the BoG or the CoC's Residential Panel for its Homeless Action Plan, the CoC market's potential vacancies at all COC-related meetings, through emails sent to nearly 500 members on its list-serv, website page, and social media pages. In order to recruit additional experiences from persons with lived experience of homelessness, the CoC also hosts webinars and meetings that allow residents to share personal stories on their experience navigating the continuum of care (e.g., receiving assistance with housing navigation, emergency shelter, permanent supportive housing and others). This information is used by both local projects and the CoC administrative body to help address barriers and develop processes that lead to greater reach and placements into permanent housing. Lastly, many of the staff who work for agencies and providers who receive CoC-funding, are persons with lived experience and regularly attend CoC meetings, CoC standing committees, ad-hocs, and/or are represented on the CoC's Board of Governance.

1D-10a.	Active CoC Participation of Individuals with Lived Experience of Homelessness.	
	NOFO Section V.B.1.q.	

You must upload the Lived Experience Support Letter attachment to the 4B. Attachments Screen.
Enter in the chart below the number of people with lived experience who currently participate in your CoC under the four categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	Routinely included in the decisionmaking processes related to addressing homelessness.	15	15
2.	Participate on CoC committees, subcommittees, or workgroups.	15	15
3.	Included in the development or revision of your CoC's local competition rating factors.	0	0
4.	Included in the development or revision of your CoC's coordinated entry process.	0	0

1D-10b.	Professional Development and Employment Opportunities for Individuals with Lived Experience of Homelessness.	
	NOFO Section V.B.1.q.	

Describe in the field below how your CoC or CoC membership organizations provide professional development and employment opportunities to individuals with lived experience of homelessness.

(limit 2,500 characters)

Professional Development and Employment Opportunities for Individuals with Lived Experience (LE) of Homelessness are strongly encouraged throughout the CoC at all levels. The CES Lead Agency directly onboards persons with LE to serve as peer specialists and play the role of “Community Champions”. They are paired with a behavioral health specialist to provide housing navigation and street outreach services. The CoC Lead Agency actively recruits interns annually and other temporary positions that create entry-level positions for persons with LE to support the Homeless Point-In-Time Count and homeless assistance planning efforts. Our homeless service providers also have long histories of onboarding persons with LE and many of these staff members have progressed into supervisory and management positions. To encourage these efforts, the CoC has added local preference bonus points in its FY 2024 CoC competition for project proposals from organizations with at least one key decision-making position held by minority group or individuals with LE and separate bonus points for commitment to have person(s) with LE in at least 20% of the FTE of staff working under the proposed project. The CoC also works alongside the County's Workforce Development Program to coordinate referrals for employment coaching, resume building, training and job matching for persons experiencing homelessness. As part of the CoC's Encampment Protocols, the CoC has a Workforce Development Coach receiving direct referrals from CoC members for clients who are connected to housing and ready to seek employment. Additionally, persons with LE participating on the CoC’s Youth Action Board, LE Advisory Committee, Residential Panel, Board of Governance and who are directly employed within the CoC are available to support public speaking engagements. Persons with LE, are invited to participate in trainings and conferences such as the National Alliance to End Homelessness to further professional development and knowledge.

1D-10c.	Routinely Gathering Feedback and Addressing Challenges of Individuals with Lived Experience of Homelessness.	
	NOFO Section V.B.1.q.	

	Describe in the field below:
1.	how your CoC gathers feedback from people experiencing homelessness;
2.	how often your CoC gathers feedback from people experiencing homelessness;
3.	how your CoC gathers feedback from people who received assistance through the CoC Program or ESG Program;
4.	how often your CoC gathers feedback from people who have received assistance through the CoC Program or ESG Program; and
5.	steps your CoC has taken to address challenges raised by people with lived experience of homelessness.

(limit 2,500 characters)

1. The CoC gathers feedback from persons with lived experience of homelessness in CoC facilitated meetings, trainings, and surveys and is used to improve local project level and system level processes.
2. While CoC and Board of Governance (BOG) meetings are monthly, open to the public, and strongly encourage persons experiencing homeless to attend, Youth Action Board (YAB) members meet monthly to obtain feedback from other youth who are experiencing homelessness. The PIT Count also provides a yearly opportunity to gather feedback from persons experiences homelessness.
3.Participants assisted through CoC-funded projects participate in exit surveys to help drive suggestions for program improvement and resulted in flexible housing subsidies, increased sheltering opportunities for persons with pets, and more peer-to-peer opportunities.
4. While CoC and BOG meetings are monthly, open to the public, and strongly encourage persons who have received assistance through the CoC or ESG Program, Youth Advisory Council (YAC)/YAB, and Residential Panel members also meet monthly to obtain feedback from who have been housed under Coc or ESG funded programs. As part of the CoC's Annual Gaps Analysis and Homeless Action Plan, the CoC works with persons who have lived experience to obtain information on gaps that currently exist and strategies to strengthen approaches to end homelessness for all persons.
5.Feedback obtained from the PIT Count has resulted in changes to survey questions and direct social service linkages. Direct feedback from persons with lived experience of homelessness who serve on the BOG, the YAC, and Residential Panel have been used to implement system-oriented changes to the CoC's Charter, HMIS and CES that led to increased rates with linkages to outreach teams and navigation staff. Feedback has also been used for funding recommendations that are made for local CoC program competitions and evaluate projects funded under both CoC and ESG programs. Persons with lived experience who have benefited from housing programs are invited to participate in our Multidisciplinary Approaches to End Homelessness webinar where they have shared public testimonies navigating the CoC's homeless continuum of services. This feedback been used to used to help shape the CoC Written Standards used to guide emergency shelter, transitional housing, rapid rehousing, and permanent supportive housing assistance.

1D-11.	Increasing Affordable Housing Supply.	
	NOFO Section V.B.1.s.	

	Describe in the field below at least two steps your CoC has taken in the past 12 months to engage city, county, or state governments that represent your CoC's geographic area regarding the following:
1.	reforming zoning and land use policies to permit more housing development; and
2.	reducing regulatory barriers to housing development.

(limit 2,500 characters)

1)The CoC has made a concerted effort to increase the number of cities, county, and state governments represented in the CoC and participating in regular membership meeting. This effort has proved worthwhile and led to increases in the number of cities who are willing to engage with the CoC to increase the development of housing in their jurisdictions. The Housing Authority of the County of Riverside and other housing advocates and developers are heavily engaged in these discussions on inclusionary zoning policies to require or encourage affordable housing development in certain areas.

2) State funding such as Homekey and No Place Like Home (NPLH) have intensified the number of opportunities the county has to engage with local stakeholders on housing development and directly expedite review and permitting processes for affordable housing developers. As a result of this advocacy, As a result of this advocacy, the County has contributed to the completion of 1,617 units since 2022. As of October 2024, there are 1,906 units under construction throughout the County of Riverside. 537 units are set to start construction in 6 months and 5,158 units are in predevelopment for a total of 5,695 units in the pipeline and an overall total of 9,218 units assisted. The CoC provided Housing Inventory Count, Homeless Count, and HMIS data to cities and county to help shape recommendations to increase the supply of affordable housing including permanent supportive housing. The CoC has also supported the advancement of HOME Investment Partnerships Program (HOME) as a key tool for the production and preservation of affordable rental including permanent supportive housing in entitlement jurisdictions.

1E. Project Capacity, Review, and Ranking–Local Competition

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1E-1.	**Web Posting of Advance Public Notice of Your CoC's Local Competition Deadline, Scoring and Rating Criteria.**	
	NOFO Section V.B.2.a. and 2.g.	

1.	**Enter the date your CoC published its submission deadline and scoring and rating criteria for New Project applicants to submit their project applications for your CoC's local competition.**	08/28/2024
2.	**Enter the date your CoC published its submission deadline and scoring and rating criteria for Renewal Project applicants to submit their project applications for your CoC's local competition.**	08/28/2024

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question and the response in Question 1E-2a along with the required attachments from both questions as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.**	
	NOFO Section V.B.2.a., 2.b., 2.c., 2.d., and 2.e.	

You must upload the Local Competition Scoring Tool attachment to the 4B. Attachments Screen.
Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Provided points for projects that addressed specific severe barriers to housing and services.**	Yes
5.	**Used data from comparable databases to score projects submitted by victim service providers.**	Yes

6.	Provided points for projects based on the degree the projects identified any barriers to participation (e.g., lack of outreach) faced by persons of different races and ethnicities, particularly those over-represented in the local homelessness population, and has taken or will take steps to eliminate the identified barriers.	

You must select a response for elements 1 through 6 in question 1E-2.

1E-2a.	Scored Project Forms for One Project from Your CoC's Local Competition. We use the response to this question and Question 1E-2. along with the required attachments from both questions as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	
	NOFO Section V.B.2.a., 2.b., 2.c., and 2.d.	

You must upload the Scored Forms for One Project attachment to the 4B. Attachments Screen.
Complete the chart below to provide details of your CoC's local competition:

1.	What were the maximum number of points available for the renewal project form(s)?	92
2.	How many renewal projects did your CoC submit?	19
3.	What renewal project type did most applicants use?	PH-PSH

1E-2b.	Addressing Severe Barriers in the Local Project Review and Ranking Process.	
	NOFO Section V.B.2.d.	

	Describe in the field below:
1.	how your CoC analyzed data regarding each project that has successfully housed program participants in permanent housing;
2.	how your CoC analyzed data regarding how long it takes to house people in permanent housing;
3.	how your CoC considered the specific severity of needs and vulnerabilities experienced by program participants preventing rapid placement in permanent housing or the ability to maintain permanent housing when your CoC ranked and selected projects; and
4.	the severe barriers your CoC considered.

(limit 2,500 characters)

1) The CoC's project evaluation & ranking criteria considered vulnerabilities like length of time homeless, retention/obtaining permanent housing & returns to homelessness. Renewal and new project scorecards reflect a thorough evaluation measuring wellness and sustainability of the entire project, HQS, access to mainstream benefits, SSI/SSDI technical assistance, case management and supportive services. Subrecipients must demonstrate ability to address participants' needs such as physical & mental health, substance abuse, DV & other traumas, criminal history & income level. For DV Bonus, the CoC partnered with Lighthouse Social Service Centers and Transgender Health & Wellness Center (THWC) who have long histories of providing housing assistance to survivors of DV and targeting minority groups such as the LGBTQ+ community. The CoC incorporated partnerships with three victim service provider agencies to ensure 100 percent coverage of the CoC service area which include: THWC, Riverside Area Rape Crisis Center, and Shelter from the Storm. Applications were scored for trauma-informed care, cultural competency & use of other interventions such as Harm Reduction.
2) Data from HMIS & other comparable databases were used to evaluate the projects' ability to connect participants efficiently and successfully to housing. For renewal projects, a projects' APR was used and for new projects, records reflecting this measure from internal and external reports were collected.
3) The CoC scorecards include an evaluation of length of time to link persons to housing and awards additional points to projects that have specific initiatives such as implementation of master-leasing and partnerships with other public housing and health care services agencies.
4) The scorecard/ranking tool for new and renewal projects provides additional points to projects that serve households with the most acuity, such as chronically homeless on the by-name list. As part of the Coordinated Entry Process, our CES Lead Agency has two housing navigators stationed at the County's Emergency Room where patients who are ready to be discharged are assessed and screened for CES and housing connections. As participants are added to the by-name list, they are linked to HUD CoC projects with availability. Shelters have similar agreements with hospitals, such as Coachella Valley Rescue Mission, to take patients who are homeless.

1E-3.	**Advancing Racial Equity through Participation of Over-Represented Populations in the Local Competition Review and Ranking Process.**	
	NOFO Section V.B.2.e.	

	Describe in the field below:
1.	**how your CoC used input from persons of different races and ethnicities, particularly those over-represented in the local homelessness population, to determine the rating factors used to review project applications;**
2.	**how your CoC included persons of different races and ethnicities, particularly those over-represented in the local homelessness population in the review, selection, and ranking process; and**
3.	**how your CoC rated and ranked projects based on the degree that proposed projects identified any barriers to participation (e.g., lack of outreach) faced by persons of different races and ethnicities, particularly those over-represented in the local homelessness population, and steps the projects took or will take to eliminate the identified barriers.**

(limit 2,500 characters)

1) The CoC included volunteers of different and overrepresented races, particularly those from groups over-represented in our local homeless population such as Black, Multi-Race and Latinx to form a 4-member Ad hoc Committee to revamp the CoC Program Review and Evaluation Process Policy, Renewal Project Scorecard and created the New Project Scorecard. The committee members provided direct input and determined rating criteria and factors, such as experience with Target Population and Needs of Population, used to review project applications. Feedback from persons of different and overrepresented races and particularly those overrepresented in our homeless population were used to implement a plan to evaluate project performance on a more routine level. This evaluation looks at client-level data more regularly and on a quarterly basis and will evaluate whether agencies are making progress on equitably providing housing outcomes to all persons of color.
2) The CoC included volunteers of different and overrepresented races, particularly those from the Black, Multi-Race and Latinx to form a 15-member FY2024 CoC Project Review and Rank Committee to review, evaluate, score and rank all new and renewal project applications.
3) Project applications were evaluated, scored and ranked by the FY2024 CoC Project Evaluation and Rank Committee using the process and scorecards approved by the Board of Governance. Under the criteria of Experience with Target Population and Needs of Population, committee members were instructed to evaluate projects with strong focus on the needs of local homeless population and racial disparity i.e. Black, Multi-Race and Latinx in our case. Findings from our Racial Disparity report completed show that Black and Multi-Race population experience homelessness at a higher rate while Hispanic/Latinx individuals access homeless services at the lowest rate. Findings were supported by Point-in-Time Count, CES, and HMIS data reports generated by CoC staff. CoC board and staff decided to take steps to eliminate the identified barriers by presenting ongoing data reports to CoC and committees during the months ahead.

1E-4.	**Reallocation–Reviewing Performance of Existing Projects.**	
	NOFO Section V.B.2.f.	

	Describe in the field below:
1.	**your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;**
2.	**whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year;**
3.	**whether your CoC reallocated any low performing or less needed projects during its local competition this year; and**
4.	**why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.**

(limit 2,500 characters)

1) The CoC's Independent Review Panel (IRP) reviewed renewal and new project applications, scorecards and selected not to reallocate any existing projects during this program year. This was largely due to strong existing project performance and major reallocation completed during the FY2021 competition which resulted in 5 reallocated projects that resulted in 7 new projects. The IRP's recommendations were presented to the CoC's Board of Governance (BoG) and were approved. 2) On 10/3/2024, the CoC BoG approved IRP's recommendations of 19 renewal projects, 6 new projects (including CoC Planning project) and the rejection of 10 new project applications due to not meeting threshold and IRP scoring. All approved projects have met threshold and good performance outcomes to support renewal. The IRP determined that there was no low performing or less needed projects amount the renewal projects during our local competition this year that require reallocation. 3) On a scale from 0 to 92 points with a 80% threshold, renewal projects ranged from 80% to 100% and new projects ranged from 83% to 98%. The IRP members recognized the strong need for additional permanent supportive housing projects versus the need for rapid rehousing projects. Each project application had its own strengths and is needed within the CoC in order to meet the housing gaps. As a result, no project reallocation was recommended. 4) There were no low performing or less needed projects amount the renewal projects identified during our local competition this year that would require reallocation.

1E-4a.	**Reallocation Between FY 2019 and FY 2024.**	
	NOFO Section V.B.2.f.	

	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2019 and FY 2024?	Yes

1E-5.	**Projects Rejected/Reduced–Notification Outside of e-snaps.**	
	NOFO Section V.B.2.g.	
	You must upload the Notification of Projects Rejected-Reduced attachment to the 4B. Attachments Screen.	

1.	**Did your CoC reject any project application(s) submitted for funding during its local competition?**	Yes
2.	**Did your CoC reduce funding for any project application(s) submitted for funding during its local competition?**	No
3.	**Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?**	Yes
4.	**If you selected Yes for element 1 or element 2 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps. If you notified applicants on various dates, enter the latest date of any notification. For example, if you notified applicants on 06/26/2024, 06/27/2024, and 06/28/2024, then you must enter 06/28/2024.**	10/09/2024

1E-5a.	Projects Accepted–Notification Outside of e-snaps.	
	NOFO Section V.B.2.g.	
	You must upload the Notification of Projects Accepted attachment to the 4B. Attachments Screen.	

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps. If you notified applicants on various dates, enter the latest date of any notification. For example, if you notified applicants on 06/26/2024, 06/27/2024, and 06/28/2024, then you must enter 06/28/2024.	10/09/2024

1E-5b.	Local Competition Selection Results for All Projects.	
	NOFO Section V.B.2.g.	
	You must upload the Local Competition Selection Results attachment to the 4B. Attachments Screen.	

	Does your attachment include: 1. Project Names; 2. Project Scores; 3. Project Status–Accepted, Rejected, Reduced Reallocated, Fully Reallocated; 4. Project Rank; 5. Amount Requested from HUD; and 6. Reallocated Funds +/-.	Yes

1E-5c.	Web Posting of CoC-Approved Consolidated Application 2 Days Before CoC Program Competition Application Submission Deadline.	
	NOFO Section V.B.2.g. and 24 CFR 578.95.	
	You must upload the Web Posting–CoC-Approved Consolidated Application attachment to the 4B. Attachments Screen.	

	Enter the date your CoC posted the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application; and 2. Priority Listings for Reallocation forms and all New, Renewal, and Replacement Project Listings.	10/28/2024

1E-5d.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on Website.	
	NOFO Section V.B.2.g.	
	You must upload the Notification of CoC-Approved Consolidated Application attachment to the 4B. Attachments Screen.	

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	10/28/2024

2A. Homeless Management Information System (HMIS) Implementation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

2A-1.	HMIS Vendor.	
	Not Scored–For Information Only	

	Enter the name of the HMIS Vendor your CoC is currently using.	Bitfocus Clarity

2A-2.	HMIS Implementation Coverage Area.	
	Not Scored–For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Single CoC

2A-3.	HIC Data Submission in HDX.	
	NOFO Section V.B.3.a.	

	Enter the date your CoC submitted its 2024 HIC data into HDX.	05/09/2024

2A-4.	Comparable Databases for DV Providers–CoC and HMIS Lead Supporting Data Collection and Data Submission by Victim Service Providers.	
	NOFO Section V.B.3.b.	

	In the field below:
1.	describe actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC collect data in HMIS comparable databases; and
2.	state whether DV housing and service providers in your CoC are using a HUD-compliant comparable database–compliant with the FY 2024 HMIS Data Standards.

(limit 2,500 characters)

1) HWS serves as both the CoC and HMIS Lead in Riverside County and meets regularly with victim-service providers, like domestic violence providers who provide both housing and supportive services county-wide. In 2024, HWS developed a DV Collaborative that includes DV serving agencies throughout the county. This group meets monthly for case management and includes HMIS compliance and any HMIS technical assistance that may be needed by a DV provider. 2) The HMIS team works directly with the DV providers to ensure they have a comparable database which collects the necessary data elements required in the HUD published 2024 HMIS Data Standards. The CoC has agreements with DV providers who are using comparable databases so that they regularly submit unduplicated aggregated reports to the CoC HMIS Lead Agency. The submissions include de-identified aggregated system performance measures data for each project from a comparable database and de-identified aggregated data for sheltered point-in-time counts, emergency shelter, transitional housing, and rapid rehousing projects. These reports are included on the Housing Inventory Count (HIC) and are reviewed on a regular basis for review and planning purposes that help shape appropriate recommendations in the CoC strategic plan.

2A-5.	Bed Coverage Rate–Using HIC, HMIS Data–CoC Merger Bonus Points.	
	NOFO Section V.B.3.c. and V.B.7.	

Using the 2024 HDX Competition Report we issued your CoC, enter data in the chart below by project type:

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds [Column F of HDX Report]	Adjusted Total Year-Round, Current VSP Beds [Column K of HDX Report]	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database [Column M of HDX Report]	HMIS and Comparable Database Coverage Rate [Column O of HDX Report]
1. Emergency Shelter (ES) beds	1,467	0	1,057	72.05%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	389	59	139	31.03%
4. Rapid Re-Housing (RRH) beds	830	0	830	100.00%
5. Permanent Supportive Housing (PSH) beds	2,063	0	2,063	100.00%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

2A-5a.	Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.	
	NOFO Section V.B.3.c.	

	For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:
1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,500 characters)

1) All projects funded through our Continuum of Care (CoC) are required to use HMIS and we have achieved 100% participation among these projects. However, during the Point-In-Time (PIT) Count, we work with additional agencies that do not participate in HMIS to ensure a comprehensive view of homelessness across the region. Agencies not funded through the CoC often use different systems due to their unique funding requirements.

2) While agencies not funded through the CoC are not mandated to participate, they are willing to provide their data specifically for the PIT count. We continue advocating for increased HMIS participation by sharing the system's benefits and during regular community calls by allowing trainings, free user licenses and technical support. To minimize duplicative efforts, we are exploring the use of data import tools to integrate data from non-HMIS agencies using other systems and further encourage participation in HMIS.

2A-6.	**Longitudinal System Analysis (LSA) Submission in HDX 2.0.**	
	NOFO Section V.B.3.d.	
	You must upload your CoC's FY 2024 HDX Competition Report to the 4B. Attachments Screen.	

Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 24, 2024, 11:59 p.m. EST?	Yes

2B. Continuum of Care (CoC) Point-in-Time (PIT) Count

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

2B-1.	PIT Count Date.	
	NOFO Section V.B.4.a	

	Enter the date your CoC conducted its 2024 PIT count.	01/24/2024

2B-2.	PIT Count Data–HDX Submission Date.	
	NOFO Section V.B.4.a	

	Enter the date your CoC submitted its 2024 PIT count data in HDX.	05/09/2024

2B-3.	PIT Count–Effectively Counting Youth in Your CoC's Most Recent Unsheltered PIT Count.	
	NOFO Section V.B.4.b.	

	Describe in the field below how your CoC:
1.	engaged unaccompanied youth and youth serving organizations in your CoC's most recent PIT count planning process;
2.	worked with unaccompanied youth and youth serving organizations to select locations where homeless youth are most likely to be identified during your CoC's most recent PIT count planning process; and
3.	included youth experiencing homelessness as counters during your CoC's most recent unsheltered PIT count.

(limit 2,500 characters)

1) Our 2023 Youth Point-in-Time Count (YPITC) planning efforts are led by a wide range of stakeholders including youth from the CoC's Youth Action Board (YAB) and supported by youth serving organizations like Operation Safehouse, Aspirant, mental health & Substance Abuse Agencies like Riverside University Health Systems-Behavioral Health and RUHS-TAY Mental Health Centers , and Workforce Youth Opportunity Centers, collaborates with school districts, libraries, community centers, & adult supporters through the CoC's Youth Advisory Council (YAC). YAC meetings focus on YPITC planning, including awareness, survey tools, and volunteer training. Before the count, we ensure shelter availability for youth aged 11-24 through partnerships with youth-serving organizations. Law enforcement assists when minors refuse shelter, and OSH outreach teams transport accepting minors, discussing homelessness and solutions.

2) Stakeholders including youth, actively contributed to site selection, timing, and mapping for YPITC, participating in focus groups with YAB, Basic Needs Centers, and Operation Safehouse. Experienced outreach personnel lead deployment sites in areas frequented by homeless youth. We also host "Come and Be Connected" events for unsheltered Transition Age Youth (TAY) aged 18-24, functioning as community resource fairs. These events help identify homeless youth meeting YPITC criteria while raising community awareness. They are held across all five County Supervisorial Districts, strategically located at youth centers. Input from the YAC, YAB, & the County's Youth Commission informs event coordination.

3) The YPITC coordinator facilitated YPITC planning meetings, involving stakeholders such as youth with lived experience of homelessness and youth service providers. Volunteers are selected with consideration for their knowledge of the city's layout and experience with homeless youth. Our 2023 YPITC included 7 YAB members & 10 students from Riverside Community College Guardian Scholars, 17 who have experienced homelessness. They contributed to the count's effectiveness while raising awareness about youth housing instability and homelessness. The YPITC planning team worked closely with YAC & YAB to recruit youth-friendly volunteers & implement best practices for engaging homeless youth. This effort involved a collaborative approach with unaccompanied youth, youth with lived experience, YAC, & youth-serving organizations.

2B-4.	PIT Count–Methodology Change–CoC Merger Bonus Points.	
	NOFO Section V.B.5.a and V.B.7.c.	

	In the field below:
1.	describe any changes your CoC made to your sheltered PIT count implementation, including methodology or data quality changes between 2023 and 2024, if applicable;
2.	describe any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2023 and 2024, if applicable;
3.	describe whether your CoC's PIT count was affected by people displaced either from a natural disaster or seeking short-term shelter or housing assistance who recently arrived in your CoCs' geographic; and
4.	describe how the changes affected your CoC's PIT count results; or
5.	state "Not Applicable" if there were no changes or if you did not conduct an unsheltered PIT count in 2024.

(limit 2,500 characters)

Not Applicable

2C. System Performance

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

2C-1.	**Reducing the Number of First Time Homeless–Risk Factors Your CoC Uses.**	
	NOFO Section V.B.5.b.	

	In the field below:
1.	**describe how your CoC determined the risk factors to identify persons experiencing homelessness for the first time;**
2.	**describe your CoC's strategies to address individuals and families at risk of becoming homeless; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time**

(limit 2,500 characters)

1) The 2024 Sheltered Homeless Point-in-Time (PIT) Count reflects that there were1,808 households experiencing sheltered homelessness for the first time. The sheltered Homelessness Reported include 1426 from emergency shelters and 382 from transitional housing. The top three risk factors to identify persons experiencing homelessness for the first time include serious mental health Condition (296 households), substance abuse disorder (211 households), and domestic violence (46 households), while another factor was HIV/AIDs (41 households). The CoC collects information from the PIT, HMIS and CES to identify people becoming homeless for the first time.

2) Households experiencing homelessness for the first time are screened and participate in an assessment to determine the most appropriate intervention. Diversion is first used as a crisis resolution strategy to navigate other options before utilizing an emergency shelter (ES); minimal financial assistance is housing such as rapid rehousing (RRH) for which they are eligible for. In addition, the CoC leverages resources from the Emergency Food and Shelter Program and the Emergency Solutions Grant for homeless prevention to prevent new entries into homelessness. CoC membership body, and its Board of Governance worked with Lesar Development Consultants to complete it's Homeless Action Plan 2022-2027 with strategies to assist individuals/families at-risk of becoming homeless. This plan consists of: a) Working with the local PHA, developers, and other affordable housing partners to create additional affordable housing units to address the 2.6% county-wide rental vacancy rate, b) Implementing a robust Homeless Prevention System to identify those most likely to become homeless and ensure they receive necessary resources to prevent homelessness; c) Creating a Shelter Diversion System to divert households from entering ES through RRH;

3) The Organization responsible for overseeing the strategy to reduce the number of individuals and families experiencing homelessness for the first time is the CoC Lead, HWS.

2C-1a.	**Impact of Displaced Persons on Number of First Time Homeless.**	
	NOFO Section V.B.5.b	

Was your CoC's Number of First Time Homeless [metric 5.2] affected by the number of persons seeking short-term shelter or housing assistance displaced due to:

1.	**natural disasters?**	No
2.	**having recently arrived in your CoC's geographic area?**	No

2C-2.	**Reducing Length of Time Homeless–CoC's Strategy.**	
	NOFO Section V.B.5.c.	

	In the field below:
1.	**describe your CoC's strategy to reduce the length of time individuals and persons in families remain homeless;**
2.	**describe how your CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and**

3.	provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the length of time individuals and families remain homeless.

(limit 2,500 characters)

1) Riverside County CoC continues to implement strategies that will reduce the Length of Time Homeless (LOTH) by: prioritizing the most vulnerable populations; adopting a countywide standard limiting emergency shelter stay to not exceed 90 days with a focus on exiting to a PH destination (CoC Written Standards approved 3/24/21); utilizing new state funding (CESH, HHAP & ESG-CV) for flexible housing subsidies, housing vouchers and RRH; partnering with the local PHA to refer clients through CES and in to permanent housing with EHV; increasing the supply of bridge housing to provide temporary shelter to facilitate housing placement for individuals & families awaiting lease-up; creating a Housing Locator team who solely focus on landlord relationship building, education and securing apartment stock for the CoC funded projects; coordinating street outreach teams for better countywide coverage and smaller caseload with an emphasis on relationship building and starting support services' linkages at engagement and increasing frequency of contact; and reorganizing the Housing Crisis System to include a BH Crisis Response Team in all areas of the County to ensure that outreach teams have adequate support for severe needs engagements.

2) Individuals and persons in families with the longest LOTH are identified through the CES VI-SPDAT triage tool at all entry points/no wrong door. CoC approved LOTH displays criteria in prioritizing chronic and literally homeless for housing. CES Policies and Procedures and CoC Written Standards explain the requirement to prioritize literally homeless & chronic homeless individuals based on vulnerability, with longest lengths of time homeless and score on the community assessment tool. LOTH is also a criterion in scoring renewal project applications.

3) The organization responsible for implementing strategies is the CES Lead (RUHS Behavioral Health).

2C-3.	Successful Permanent Housing Placement or Retention –CoC's Strategy.	
	NOFO Section V.B.5.d.	

	In the field below:
1.	describe your CoC's strategy to increase the rate that individuals and persons in families residing in emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations;
2.	describe your CoC's strategy to increase the rate that individuals and persons in families residing in permanent housing projects retain their permanent housing or exit to permanent housing destinations; and
3.	provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to increase the rate that individuals and families exit to or retain permanent housing.

(limit 2,500 characters)

1) The CoC has implemented the following strategies to increase the efficiency in which individuals and families exit emergency shelter, transitional housing and rapid rehousing programs which include: a) working with a fully functional CES that ensures access to housing/resource referrals, along with providing landlord supports; b) increasing supply of PSH and affordable housing countywide. The County's Housing Authority is partnering with cities to create new affordable housing and has implemented a Moving On Strategy for households that no longer need supportive services to graduate to the HCV program; c) utilizing state funding to increase PH units; d) increasing the number of housing navigators to increase exits to PH & housing locators to identify available units for CES; improving housing navigation services that include developing a housing plan at engagement that addresses housing barriers; and e) enrolling eligible CH persons in new Housing Disability Advocacy Program that assists CH obtain SSI/SSDI benefits and housing.

2) Strategies to increase the rate individuals/families in PH retain their housing include: a) implementation of Housing First to create a stable environment for clients; b) focus on rental counseling and tenants' rights & obligations prior to move-in; c) intensify home-based case management for mainstream benefits linkage and encourage self-sufficiency activities around SAT, BH and employment to help individual/families stabilize & remain in housing (especially within 1st six months) after RRH assistance ends; c) Improve access to healthcare and mainstream benefits by establishing a countywide team to support case managers who will work with a benefits specialist lead at each homeless provider agency to educate recipients on how to maintain their benefits & what to do if benefits are lost or denied, link participants to Workforce Development provide vocational training and job training that will assist client with employment income.

3) Organization that is responsible for overseeing the CoCs strategy to increase the rate that individuals and families exit to and retain permanent housing is the CoC lead, HWS.

2C-4.	Reducing Returns to Homelessness–CoC's Strategy.	
	NOFO Section V.B.5.e.	

	In the field below:
1.	describe your CoC's strategy to identify individuals and families who return to homelessness;
2.	describe your CoC's strategy to reduce the rate that individuals and families return to homelessness; and
3.	provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the rate individuals and persons in families return to homelessness.

(limit 2,500 characters)

1) CoC & HMIS Lead Agency generate reports with outcomes on number of individuals & families who return to homelessness across different interventions. These reports are included in a monthly CoC Staff Report which provide the community with a summary of projects & impact reports with dashboards & infographics so they are easier to interpret by community. HMIS participating agencies use a more detailed report to get info about clients who have exited or are newly enrolled, so they can track enrollments & status.
2) Strategies to reduce rate of returns to homelessness include: a) Homeless Prevention System to identify persons most likely to return to homelessness after being in permanent housing and ensure they receive necessary resources to remain housed. Both EFSP & ESG funds for rental/mortgage assistance to prevent evictions; b) Increase employment opportunities in collaboration with Workforce Development Division & CoC to establish a workforce team to prevent fragmented employment services; c) Develop coordinated discharge planning system with Whole Person Care for those leaving institutions (hospitals, jails, acute/long term facilities, etc.); d) Develop proactive strategies to end the cycle of homelessness including coordination with law enforcement, county agencies/cities to address underlying causes of homelessness, specifically criminalization policies & recidivism, & include countywide encampment response protocol; e) Create a shelter diversion system to divert households from entering emergency shelter; f) Fostering landlord engagement with new Housing Search Team operated by CoC housing provider using ESG funds to support housing locators that focus on identifying affordable housing & cultivating new/existing landlord relationships; & g) Improve access to healthcare/mainstream benefits, including a new state funded Housing & Disability Advocacy Program (HDAP) for eligible chronically homeless individuals to obtain SSI/SSDI with housing assistance.

3) Organization responsible is the CoC Lead, Housing and Workforce Solutions (HWS).

2C-5.	**Increasing Employment Cash Income–CoC's Strategy.**	
	NOFO Section V.B.5.f.	

	In the field below:
1.	**describe your CoC's strategy to access employment cash sources;**
2.	**describe how your CoC works with mainstream employment organizations to help individuals and families experiencing homelessness increase their employment cash income; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase income from employment.**

(limit 2,500 characters)

1) The CoC makes a concerted effort to work with service providers to access workforce training, resume building and linkages to employers to create internships, job shadowing, and entry level jobs. CoC also works to increase its resource capacity and ensure ease of access of job placement training by partnering with private agencies and service providers. In the last 24 months, the CoC has utilized new state funding to pilot Employment Service Programs targeting homeless with severe barriers to employment.

2) The CoC has established an agreement with the Riverside County Workforce Development Division, a Workforce Innovation Opportunity Agency (WIOA) which provides a full-range of employment services under the Workforce Investment Act program including career assessment and planning assistance, vocational training, and on-the-job training for job seekers. The agreement outlines a broad vision that supports an integrated service delivery system within the CoC. The CoC supports service provider partnerships with employment agencies such as the Goodwill Riverside WorkSource Center which offers one-on-one career counseling, job-search assistance, resume writing, computer skills training, and interview workshops. CoC also works in connection with the Workforce Development Division to strengthen partnerships with local employers to increase access & placement in sustainable jobs. This strategy provides supportive employment work environments that includes personal support, case management, job readiness, recruiting, and working with employers to hire hard-to-serve individuals with nontraditional backgrounds. Efforts include working with small, localized employers and building partnerships with the faith-based communities, community colleges & adult education providers on developing homeless job training programs. Service providers take their clients to job fairs and hiring events and assist in completing application and required documents.

3) The organization responsible is the CoC Lead, HWS.

2C-5a.	Increasing Non-employment Cash Income–CoC's Strategy	
	NOFO Section V.B.5.f.	

	In the field below:
1.	describe your CoC's strategy to access non-employment cash income; and
2.	provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase non-employment cash income.

(limit 2,500 characters)

1) The CoC has implemented effective strategies to access non-employment cash income for its program participants & makes these services available to non-CoC funded providers. The CoC executed a new agreement with DPSS's Housing and Disability Advocacy Program (HDAP), which trains certified specialists to assist homeless individuals who are disabled and needing assistance applying for SSI/SSDI. HDAP specialists are readily available to take referrals from CES, street outreach and housing teams & other CoC providers. In addition to providing assistance with completing SSI/SSDI applications, HDAP also financially assists participants with temporary housing until their benefits are approved and/or permanent housing can be identified. CoC partners are also strongly encouraged to participate in the SSI/SSDI Outreach, Access, and Recovery (SOAR) Training, to increase the number of staff providers in-house to assist disabled adults with applying for SSI/SSDI. CoC partners with DPSS to access cash benefits for individuals experiencing homelessness. These programs are: Cash Assistance Programs for Immigrants (CAPI), Cal-Fresh, General Assistance and other safety net programs such as Temporary Assistance to Needy Families (TANF). CoC also works closely with Veteran Service Office to determine and maximize financial benefits for homeless veterans. Training is made available regularly to countywide street outreach & housing teams on the various non-employment and cash benefits available to ensure they have the tools to successfully facilitate these linkages. The CoC also partners with the Riverside University Health System –Population Health to implement the state-funded, Whole Person Care Program (WPC) which provides targeted services to help link individuals experiencing homelessness and existing jails to benefits and housing.
2) CoC Lead Agency, HWS, is the organization responsible for overseeing the strategy to increase non-employment cash income.

3A. Coordination with Housing and Healthcare

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

3A-1.	**New PH-PSH/PH-RRH Project–Leveraging Housing Resources.**	
	NOFO Section V.B.6.a.	
	You must upload the Housing Leveraging Commitment attachment to the 4B. Attachments Screen.	

	Is your CoC applying for a new PH-PSH or PH-RRH project that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness?	Yes

3A-2.	**New PH-PSH/PH-RRH Project–Leveraging Healthcare Resources.**	
	NOFO Section V.B.6.b.	
	You must upload the Healthcare Formal Agreements attachment to the 4B. Attachments Screen.	

	Is your CoC applying for a new PH-PSH or PH-RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	Yes

3A-3.	**Leveraging Housing/Healthcare Resources–List of Projects.**	
	NOFO Sections V.B.6.a. and V.B.6.b.	

If you selected yes to questions 3A-1. or 3A-2., use the list feature icon to enter information about each project application you intend for HUD to evaluate to determine if they meet the criteria.

Project Name	Project Type	Rank Number	Leverage Type
2024 Illumination...	PH-PSH	20	Both

3A-3. List of Projects.

1. What is the name of the new project?	2024 Illumination Foundation PSH
2. Enter the Unique Entity Identifier (UEI):	KUA8LPUW9TK9
3. Select the new project type:	PH-PSH
4. Enter the rank number of the project on your CoC's Priority Listing:	20
5. Select the type of leverage:	Both

3B. New Projects With Rehabilitation/New Construction Costs

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

3B-1.	Rehabilitation/New Construction Costs–New Projects.	
	NOFO Section V.B.1.r.	

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction?	No

3B-2.	Rehabilitation/New Construction Costs–New Projects.	
	NOFO Section V.B.1.r.	

	If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:
1.	Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and
2.	HUD's implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.

(limit 2,500 characters)

Not Applicable

3C. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

3C-1.	**Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serve Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section V.F.	

	Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?	No

3C-2.	**Cost Effectiveness of Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section V.F.	

	You must upload the Project List for Other Federal Statutes attachment to the 4B. Attachments Screen.
	If you answered yes to question 3C-1, describe in the field below:
1.	**how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and**
2.	**how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.**

(limit 2,500 characters)

Not Applicable

4A. DV Bonus Project Applicants for New DV Bonus Funding

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2024 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

4A-1.	**New DV Bonus Project Applicants.**	
	NOFO Section I.B.3.j.	

	Did your CoC submit one or more new project applications for DV Bonus Funding?	Yes

4A-1a.	**DV Bonus Project Types.**	
	NOFO Section I.B.3.j.	

Select yes or no in the chart below to indicate the type(s) of new DV Bonus project(s) your CoC included in its FY 2024 Priority Listing.

	Project Type	
1.	SSO Coordinated Entry	No
2.	PH-RRH or Joint TH and PH-RRH Component	Yes

You must click "Save" after selecting Yes for element 1 SSO Coordinated Entry to view questions 4A-2, 4A-2a. and 4A-2b.

4A-3.	**Data Assessing Need for New DV Bonus Housing Projects in Your CoC's Geographic Area.**	
	NOFO Section I.B.3.j.(1)(c) and I.B.3.j.(3)(c)	

1.	**Enter the number of survivors that need housing or services:**	2,387
2.	**Enter the number of survivors your CoC is currently serving:**	1,375
3.	**Unmet Need:**	1,012

4A-3a.	How Your CoC Calculated Local Need for New DV Bonus Housing Projects.	
	NOFO Section I.B.3.j.(1)(c)	

	Describe in the field below:
1.	how your CoC calculated the number of DV survivors needing housing or services in question 4A-3 element 1 and element 2; and
2.	the data source (e.g., comparable databases, other administrative data, external data source, HMIS for non-DV projects); or
3.	if your CoC is unable to meet the needs of all survivors please explain in your response all barriers to meeting those needs.

(limit 2,500 characters)

1)Comparing the number of persons identified as Domestic Violence Survivors (DVS) in the HMIS and CES system (2,387) and the DV dedicated beds (285) evidences a minimum need for 2,672 survivors. With dedicated resources for only 12% of the DVS known to the CoC, and no dedicated beds for unaccompanied youth, or child-only households, the need for additional DV housing and services is clear. External sources (openjustice.doj.ca.gov) reported in 2023, when the most recent data was collected, more than 7,672 calls were made from Riverside County for domestic violence assistance, a number which is continuing to trend upward. These calls were made by DVS in need, accenting the COC number as a minimum, with potential need more than twice the minimum.
2)Data source comes from HMIS, Domestic Violence comparable databases, CES, and external source, openjustice.doj.ca.gov.
3)DV Survivors are often too scared to come forward to seek services and disclose their DV situation. When they do, they need extremely high level of confidentiality and privacy that mainstream shelters and housing solutions may not offer. Homeless and housing services dedicated and equipped to serve DV population are very limited. This is why our CoC is encouraging project applicants to apply for projects dedicated to serve DV population.

4A-3b.	Information About Unique Project Applicant Requesting New DV Bonus Housing Project(s).	
	NOFO Section I.B.3.j.(1)	

Use the list feature icon to enter information on each unique project applicant applying for New PH-RRH and Joint TH and PH-RRH Component DV Bonus projects–only enter project applicant information once, regardless of how many DV Bonus projects that applicant is applying for.

Applicant Name
His Daughters House

Project Applicants Applying for New PH-RRH and Joint TH and PH-RRH DV Bonus Projects

4A-3b.	Information About Unique Project Applicant Requesting New DV Bonus Housing Project(s).	
	NOFO Section I.B.3.j.(1)	

Enter information in the chart below on the project applicant that applied for one or more New DV Bonus housing projects included on your CoC's FY 2024 Priority Listing for New Projects:

1.	Applicant Name	His Daughters House
2.	Rate of Housing Placement of DV Survivors–Percentage	70%
3.	Rate of Housing Retention of DV Survivors–Percentage	99%

4A-3b.1.	Applicant's Housing Placement and Retention Data Explanation.	
	NOFO Section I.B.3.j.(1)(d)	

	For the rate of housing placement and rate of housing retention of DV survivors reported in question 4B-3b., describe in the field below:
1.	how the project applicant calculated the rate of housing placement;
2.	whether the rate for housing placement accounts for exits to safe housing destinations;
3.	how the project applicant calculated the rate of housing retention; and
4.	the data source (e.g., comparable databases, other administrative data, external data source, HMIS for non-DV projects).

(limit 1,500 characters)

1) His Daughters House (HDH) calculated rate of housing placement of DV Survivors – Percentage by taking the number of participants housed/number of participants served.
2) The rate for housing placement accounts for exits to safe housing destinations.
3) His Daughters House calculated rate of housing retention of DV Survivors – Percentage by taking the number of participants remained in same housing at the end of 6 months follow up period/number of participants housed.
4) The data source(s) used for calculating rates is HDHs internal client resource management system, a comparable database to HMIS, and other administrative data.

4A-3c.	Applicant's Experience Housing DV Survivors.	
	NOFO Section I.B.3.j.(1)(d)	

	Describe in the field below how the project applicant:
1.	ensured DV survivors experiencing homelessness were quickly moved into safe affordable housing;
2.	prioritized survivors–you must address the process the project applicant used, e.g., Coordinated Entry, prioritization list, CoC's emergency transfer plan;

3.	determined survivors' supportive services needs;
4.	connected survivors to supportive services; and
5.	moved survivors from assisted housing to housing they could sustain–address housing stability after the housing subsidy ends.

(limit 2,500 characters)

When DV survivors contact HDH for rapid rehousing, the intake coordinator works with the survivor to locate emergency housing, rather through local shelters based upon the most recent open shelter list derived from CES/CoC or from internal research conducted by HDH staff. HDH also works to coordinate care from local agencies for motel vouchers and transitional housing. Locating safe affordable housing can take up to two months (60 days) so HDH ensures the survivor is in a safe location while RRH is established. HDH prioritizes survivors based upon need, and VI-SPDAT score, the VI-SPDAT is conducted during the initial intake. In addition to the VI-SPDAT and the internal intake questions, HDH conducts a needs-based assessment, this assessment determines what mainstream benefits the survivor is already receiving as well as what supportive services the survivor may benefit from.

HDH will make recommendations to needed services, i.e., mental and behavioral health, legal, childcare, food/clothing etc., and link the survivor to those services by facilitating the connection to said agency directly to survivor to ensure they receive the needed assistance. This services in which the survivor opted for are also added to the case management monthly plan to guarantee the survivor Is benefiting from the supportive services. During the case management process, the case manager determines the length of time in which the survivor needs assistance, this is based upon income, mental health capacity and future ability to sustain independent living.

At the end of their eligibility period for housing assistance the case manager determines the survivor's ability to maintain housing independently, which is determined by factors such as earning potential, financial sustainability, and their history of maintaining their portion of the rent. If the survivor can evidence their readiness for financial sustainability (increased their income since the beginning of program, is paying 75-90% of rent at end of eligibility period, evidence of financial stability). If housing is sustainable the case manager will follow up monthly for 6 months after program exit to ensure the survivor has linkages to supportive services and can still maintain housing. If the survivor is unable to evidence housing sustainability after the 12-months of rental assistance, then the case manager works to locate long-term rental assistance or additional programs that can supplement rent.

4A-3d.	Applicant's Experience in Ensuring DV Survivors' Safety.	
	NOFO Section I.B.3.j.(1)(d)	

	Describe in the field below examples of how the project applicant ensured the safety and confidentiality of DV survivors experiencing homelessness by:
1.	taking steps to ensure privacy/confidentiality during the intake and interview process to minimize potential coercion of survivors;
2.	making determinations and placements into safe housing;
3.	keeping survivors' information and locations confidential;
4.	training staff on safety and confidentially policies and practices; and

5.	taking security measures for units (congregate or scattered site), that support survivors' physical safety and location confidentiality.

(limit 2,500 characters)

As survivors are entered into HDH's client resource management system, they are assigned a unique identifier for anonymity based upon the HMIS identifier provided. This is the number used for all documents and claim reporting purposes. In the intake process interviews are only conducted by qualified staff, and in the privacy of an office without others present. During the housing navigation process survivors are requested to fill out a housing preference list that is adhered to in terms of locality preferences and locations in which the survivor would like to avoid. This also helps determine where the survivor would feel safest and still receive the support required to thrive.

When inspecting and approving the location for move in, we ensure that the place is well lit, the neighborhood has a high safety rating, there is privacy measures such as a fence or a gate code for entry and that security cameras can be affixed on or around property (ring doorbell, peep hole, cameras etc.).

When initiating the housing agreement, we keep the files confidential and only allow qualified personnel access, additionally the location of the placement is redacted and only available to the case manager. All staff are required to take 40 hours of DV training which informs staff on how to maintain anonymity, how to deal with various DV scenarios including a combative or abusive spouse, the agencies to utilize that will assist with maintaining anonymity and how to ensure the continual safety of survivors. Under VAWA, HDH also honors emergency re-location for survivors whose location has been revealed to their abusers for immediate placement into another unit or temporary facility until a new unit is located.

4A-3d.1.	Applicant's Experience in Evaluating Its Ability to Ensure DV Survivors' Safety.	
	NOFO Section I.B.3.j.(1)(d)	

Describe in the field below how the project evaluated its ability to ensure the safety of DV survivors the project served in the project, including any areas identified for improvement throughout the project's operation.

(limit 2,500 characters)

At the onset of the housing navigation stage, we set metrics in place to ensure that HDH is connecting each participant with a local SAFE Family Justice Center and other outside agencies to make every attempt to ensure safety. At that point, a personalized safety plan is set up and provided to HDH to work with the participant to find housing based on the preference sheet completed. During the Case Management meeting case managers discuss alternative options should their aggressor locate them. HDH aims to improve policies, identify promising practices, and strengthen collaborations to enhance safety, stability, and well-being for survivors and their dependents. Participants must sign a confidentiality form as well when entering the program. If a participant is located by their aggressor HDH will relocate the individual or family and we will have a relocation rate calculated for reporting purposes at the end of the program year. Depending on that rate it will help us determine if we have been successful in putting safety in place adequately and effectively. This also allows us to view program safety practices at various intervals throughout the program year, which lends itself to course corrections if needed. It also allows us at the end of the program to assess our ability to meet our program safety metrics or not.

In addition, if outcomes are met it allows us the opportunity to expand our services and at the end of the program, we perform an evaluation on how we can improve and what barriers we face while providing services. Once we gather the demographic and propose policy changes for process improvement. HDH takes pride that no safety incident has been reported.

4A-3e.	Applicant's Experience in Placing and Stabilizing Survivors in Permanent Housing Using Trauma-Informed, Survivor-Centered Approaches.	
	NOFO Section I.B.3.j.(1)(d)	

	Describe in the field below the project applicant's experience in:
1.	prioritizing placement and stabilization of survivors;
2.	placing survivors in permanent housing;
3.	placing and stabilizing survivors consistent with their preferences; and
4.	placing and stabilizing survivors consistent with their stated needs.

(limit 2,500 characters)

HDH DV Rapid Rehousing Program prioritizes housing placement based on urgency and current housing situations. The program focuses on assisting individuals and families with securing and stabilizing safe permanent housing, which is why we stand on the housing first model to identify a unit in a community of the individual's choice. HDH has developed an internal participation agreement that outlines the responsibilities and expectations of the participants and HDH staff as it relates to interaction and engagement among both parties. This policy is reviewed and signed during the initial case management meeting.

During the intake process, the Intake Coordinator completes the VI-SPDAT, and at the end of the assessment, supportive services are recommended and offered, specifically for trauma-informed counseling. HDH staff initiates the counseling sessions by connecting the participants with the providing agency to access extended trauma-informed, client-centered care. Also, during the initial process participants are advised that the program offers a variety of services including but not limited to; childcare, legal services, and trauma-informed parenting classes.

Case Managers assist participants with developing goals using a 90-Day Housing Stability Plan and using a Monthly Housing Stability Plan. Case Managers work with the participants to create a timeline for addressing domestic violence issues and maintain a plan that aims toward self-sufficiency.

HDH offers other support services to help strengthen the participant's chances to overcome barriers that would delay the progress of meeting their short- and long-term goals, such as; job development, workforce training, vocational guidance, financial planning and literacy, and life skills workshops.

As a mission to provide culturally responsive support and services, survivors are provided education and awareness of all forms of domestic violence. HDH provides all participants with The Violence Again Women Act form to ensure understanding and knowledge of their rights a survivors and a tenant. HDH connects participants with peer and support groups to help restore control of their lives, reduce feelings of isolation, develop healthy coping skills, and establish healthier relational boundaries in a facilitated environment, where the cooperation and insight of similarly situated individuals can contribute to longer-term care and support.

4A-3f.	**Applicant's Experience in Trauma-Informed, Survivor-Centered Approaches.**	
	NOFO Section I.B.3.j.(1)(d)	

	Describe in the field below examples of the project applicant's experience using trauma-informed, victim-centered approaches to meet needs of DV survivors by:
1.	**establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures survivors and staff interactions are based on equality, and minimize power differentials;**
2.	**providing survivors access to information on trauma, e.g., training staff on providing survivors with information on the effects of trauma;**
3.	**emphasizing survivors' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans worked towards survivor-defined goals and aspirations;**

4.	centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination, language access, improving services to be culturally responsive, accessible, and trauma-informed;
5.	providing a variety of opportunities for survivors' connections, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
6.	offering support for survivor parenting, e.g., trauma-informed parenting classes, childcare, connections to legal services.

(limit 5,000 characters)

HDH DV Rapid Rehousing Program will continue to extend services as usual especially when it comes to prioritizing housing placement based on participant's needs and desired location. We also take into consideration the employment and school locations to be a factor. In addition, we will utilize our landlord participant list to find permanent housing conducive to participants' needs and all are based on urgency.

The program will continue to maintain ongoing communication with the participants to respect their privacy, treat them with dignity, and recognize their value. The program will include participants in community events that can potentially drive self-sufficiency and increase personal growth. HDH will continue to provide employment lead opportunities such as job fair information to participants as we are notified.

HDH staff will continue to initiate the counseling sessions by connecting the participants with the providing agency to access extended trauma-informed, client-centered care. We will ensure and maintain the visibility of trauma-related assistance on our website.

Case Managers will continue to develop goals using a Housing Stability Plan and work with the participants to create a timeline for addressing domestic violence barriers and maintain a plan to meet the participants' objectives.
HDH leans on community resources and support to ensure the most vulnerable of our clients are supported, protected, and provided with a fair opportunity to thrive. HDH does this by helping strengthen the participant chances to overcome barriers by promoting job development training, and life skills workshops.
HDH staff will continue to enforce the requirement that all staff are to take a Domestic Violence course, which entails; training on cultural responsiveness and inclusivity, training on equal access, cultural competence, and nondiscrimination to continually improve services to be culturally responsive, and accessible, on trauma-informed needs. This allows us to provide culturally responsive support and services and survivors are provided education and awareness of all forms of domestic violence with understanding.
Additionally, mentors will also be assigned to DV participants who share the same experience or are connected to external groups to best meet the needs of that individual or family. Essentially, HDH will continue to assist participants with goal formation, strategy plans, and tools that have been mentioned in previous responses that focus on the success of the participants.

4A-3g.	Applicant's Experience Meeting Service Needs of DV Survivors.	
	NOFO Section I.B.3.j.(1)(d)	

Describe in the field below examples of supportive services the project provided to domestic violence survivors while quickly moving them into permanent housing and addressing their safety needs.

(limit 5,000 characters)

Once HDH receives a call or email concerning an individual or family, we make our first contact within 24 hours to determine their location to measure their safety. If we are informed that they are in a place that's unhabitable for living, we immediately try to identify available shelters or transitional housing for safety purposes. In the meantime, HDH assists with short-term motel stays, food, clothing, hygiene products, and transportation to get the shelter once accepted. If we are informed that the individuals or the families are currently couch-surfing or have already been placed in a transitional home, we would provide any needed services determined during intake. HDH provides resources for counseling services immediately, and it involves 30 days of counseling pre-housing to establish reassurance and stabilization, along with any emergency services and needs. HDH also connects qualified participants with DPSS, Family Stabilization Program on emergency resources which is inclusive of three (3) initial weeks of motel vouchers, and an additional extension of 3 more weeks for an approximate total of 42 days. HDH connects participants with an agency that offers domestic violence training and self-defense.

HDH realizes that fleeing a domestic violence situation causes a financial strain and therefore, most funding comes through us allowing the opportunity to assist with food, legal services, child services, financial assistance, utility resources, mental health and behavior health services, and again other immediate services.

The safety of domestic violence victims is HDH's priority. Our location is private and fully secured and provides adequate privacy. Staff controls on entry/exit are provided. HDH has confidentiality protocols that are directed at enhancing victim safety. These include conflict of interest, confidentiality, intake procedures, and case management services. During the intake process, every program participant is advised of HDH's safety procedures and policies, and a copy is placed in each file by the Intake Coordinator. All HDH's staff and volunteers function as advocates with a focus on client safety. All safety plans are developed with participants' and case managers' input and are discussed at every contact.

HDH strongly believes that victims of domestic violence must be encouraged to make their own choices and that Case Managers must understand their role and responsibilities in assessing and facilitating participants' safety and promoting autonomy. HDH will continue to put the safety of domestic violence participants first in the delivery of all our programs and services. HDH will also continue to promote autonomy by encouraging program participants to establish their own case plans.

4A-3h.	Applicant's Plan for Placing and Stabilizing Survivors in Permanent Housing Using Trauma-Informed, Survivor-Centered Approaches in the New DV Bonus Housing Project(s).	
	NOFO Section I.B.3.j.(1)(e)	

	Describe in the field below how the project(s) will:
1.	prioritize placement and stabilization of program participants;

2.	place program participants in permanent housing;
3.	place and stabilize program participants consistent with their preferences; and
4.	place and stabilize program participants consistent with their stated needs.

(limit 2,500 characters)

With the assistance of our landlord and property management network the housing specialist can quickly identify, work with the landlord and coordinate move in of participants without landlord consideration of participants rental barriers.

Matching participants to the “right” housing option from the start of the program is the first step that leads to a positive supportive housing placement and successful exit. HDH case management can be described in three phases: obtaining and moving into permanent housing; supporting stabilization in housing; and closing the case. The process of providing housing assistance is not just about ensuring a household gets into housing, but making sure that the connections and resources are in place for them to successfully stay housed.

HDH¿understands that¿Prioritizing program participant choice¿is essential for ensuring that individuals have a say in their housing options. When participants are actively involved in decision-making, it leads to better outcomes and increased satisfaction. The Housing Specialist¿will provide personalized assistance to participants in navigating housing options. In addition to offering information about available units, neighborhoods, and amenities.¿By allowing participants to¿search for suitable units of their choice, within the service area and HUD market value range. This approach promotes autonomy and flexibility.

Collaboration with Landlords: 1) Engage landlords and property owners to expand housing options.
2) Encourage landlords to participate in the program. 3) Build positive relationships to enhance participant choice.

Participant Preferences: 1) Gather information about participants’ preferences, such as location, unit size, and amenities. 2) Consider cultural, familial, and health-related factors. 3) Tailor housing options accordingly.

4A-3i.	Applicant's Plan for Administering Trauma-Informed, Survivor-Centered Practices in the New DV Bonus Housing Project(s).	
	NOFO Section I.B.3.j.(1)(e)	

	Describe in the field below examples of how the new project(s) will:
1.	establish and maintain an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant and staff interactions are based on equality, and minimize power differentials;
2.	provide program participants access to information on trauma, e.g., training staff on providing program participants with information on the effects of trauma;
3.	emphasize program participants' strengths–for example, strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans work towards survivor-defined goals and aspirations;
4.	center on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination, language access, improving services to be culturally responsive, accessible, and trauma-informed;
5.	provide a variety of opportunities for program participants' connections, e.g., groups, mentorships, peer-to-peer, spiritual needs; and

6.	offer support for survivor parenting, e.g., trauma-informed parenting classes, childcare, connections to legal services.

(limit 5,000 characters)

A respectful and empowering environment benefits both participants and staff, leading to better outcomes and stronger communities. HDH involves program participants in decisions related to their housing, services, and goals.¿Our case managers and participants will work together to address challenges.¿ Creating a safe environment where participants feel heard and respected. HDH wants participants to know they have a say in their journey.¿ This happens by minimizing power differentials by avoiding punitive measures or condescension. We align our staff and participant goals for mutual success.

HDH case managers use a trauma-informed and strengths-based approach. Rapidly re-housing a household requires case managers who understand the impact of trauma and stress on participants and their emotional, behavioral, and cognitive capacity. All case managers are required to attend a 40-hour trauma informed training class and show proof of certification within 90 days (about 3 months) of hire. HDH realizes the complexities in dealing with trauma affected participants and takes particular care to be sensitive to the participants needs and experiences. This comprehensive approach ensures that the case manager is considering all aspects of the participants potential barriers. Case managers must also consider that some households may face various traumas and/or traumas related to other aspects of their identity. Certain personal issues, such as mental health or substance use, may be exacerbated by the stress of experiencing homelessness and should not be a reason for the case manager to assume that someone is not able to obtain or sustain housing. Directing participants to our website as well regarding trauma care.

Strength-based approaches¿are essential in empowering program participants and fostering positive outcomes.¿¿Coaching¿that focuses on participants' existing strengths and abilities. HDH case managers encourage participants to recognize their own capabilities and build upon them. Empowerment coaching¿helps individuals set achievable goals and overcome challenges. We provide¿Strength-Based Questionnaires and Assessments that¿highlight participants' strengths, skills, and resources. Case managers collaborate with participants to create personalized plans.
Our case plans incorporate participants' strengths such as: 1) Identify areas where they excel.
2) Leverage existing resources. 3) Align goals with their desires.

HDH utilizes goal-oriented approaches emphasizing strengths foster resilience, self-efficacy, and positive outcomes.

Cultural competence and fostering inclusivity are essential in developing a trusting, respectful partnership with our participants. Acknowledging and respecting diverse backgrounds and experiences is a key to everyone's success. HDH strives to develop nuanced forms of support for more marginalized and vulnerable participants. Understanding participants' situations from a systematic and historical perspective instead of an individual perspective.
His Daughters House staff attend an online training course that provides knowledge of equal access, cultural historic competency, non-discrimination, and unconscious biases. Fostering partnerships with community organizations and engaging those from diverse backgrounds enriches and strength our organization. HDH embraces cultural diversity and promotes inclusivity, we can cultivate an environment where all staff and participants feel valued, respected, and empowered to succeed.

Social interaction¿is important for the physical and mental well-being of program participants. Wellness calls, inviting participants to social events that the organization has been invited to.¿ HDH Ambassador program, reaches out to participants to see if they have any additional supportive services that we can provide, mentoring from someone who has experience the same or similar circumstance as theirs. Having social events hosted by His Daughters House provides a sense of caring and partnership through their journey.

Supporting parents is essential for healthy child development. His Daughters House partners with other organizations and colleges to offer¿parenting education programs¿as a supportive service to participants. Offering valuable insights and practical skills to parents. Classes will cover topics such as child development, effective communication, discipline strategies, and nurturing healthy relationships with children. HDH also assists with childcare and childcare expenses when needed.

4A-3j.	**Applicant's Plan for Involving Survivors in Policy and Program Development, Operations, and Evaluation in the New DV Bonus Housing Project(s).**	
	NOFO Section I.B.3.j.(1)(f)	

	Describe in the field below how the new project will involve survivors:
1.	**with a range of lived expertise; and**
2.	**in policy and program development throughout the project's operation.**

(limit 2,500 characters)

HDH is mindful to include survivors with lived experience on both the board and in staffing decisions. This also includes volunteers and interns looking to collaborate with HDH. The vast lived experience helps HDH to craft programs and policies that are sensitive to survivors of DV and takes account their needs from individuals who have firsthand experience.

HDH uses this feedback and involves such individuals in the monthly decision-making process, the quarterly lesson learned meetings, and the annual post-program improvement conversations and solicits best practices from those with first-hand experience to help create a robust program.

The lived expertise that HDH looks for are those previously homeless, those who have worked in a social service capacity as well as those who have experienced DV, Stalking or Trafficking. HDH has been successful in employing survivors and using their specific experience to create standard operating procedures as well as leveraging the resources they used in the past. This has helped us provide the same resources to current survivors/participants. HDH also works with relators, landlords, and individuals that have worked in housing in some capacity or other to provide an accurate landscape of the housing market. This analysis assists HDH in determining how many families can be realistically assisted during a program year.

We also task interns and volunteers with collecting real time information on the current national DV issues, and new or emerging resources which also help HDH to improve program offerings, increase their responsiveness and modify policies. Policies are also updated based upon new legislation and regulations at the county and state level so that staff training and operating procedures are updated accordingly which in turn provides survivors and program participants the best change for long term success.

4B. Attachments Screen For All Application Questions

	We have provided the following guidance to help you successfully upload attachments and get maximum points:
1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.
3.	We prefer that you use PDF files, though other file types are supported–please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.
4.	Attachments must match the questions they are associated with.
5.	Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.
6.	If you cannot read the attachment, it is likely we cannot read it either.
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).
	. We must be able to read everything you want us to consider in any attachment.
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.
8.	Only use the "Other" attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.

Document Type	Required?	Document Description	Date Attached
1C-7. PHA Homeless Preference	No	1C-7. PHA Homeles...	10/11/2024
1C-7. PHA Moving On Preference	No	1C-7. PHA Moving ...	10/11/2024
1D-10a. Lived Experience Support Letter	Yes	1D-10a. Lived Exp...	10/16/2024
1D-2a. Housing First Evaluation	Yes	1D-2a. Housing Fi...	10/16/2024
1E-2. Local Competition Scoring Tool	Yes	1E-2. Local Compe...	10/28/2024
1E-2a. Scored Forms for One Project	Yes	1E-2a. Scored For...	10/16/2024
1E-5. Notification of Projects Rejected-Reduced	Yes	1E-5. Notificatio...	10/16/2024
1E-5a. Notification of Projects Accepted	Yes	1E-5a. Notificati...	10/16/2024
1E-5b. Local Competition Selection Results	Yes	1E-5b. Local Comp...	10/16/2024
1E-5c. Web Posting–CoC-Approved Consolidated Application	Yes		
1E-5d. Notification of CoC-Approved Consolidated Application	Yes		

2A-6. HUD's Homeless Data Exchange (HDX) Competition Report	Yes	2A-6. HDX Report	10/17/2024
3A-1a. Housing Leveraging Commitments	No	Leveraging Commit...	10/23/2024
3A-2a. Healthcare Formal Agreements	No	Healthcare Agreem...	10/28/2024
3C-2. Project List for Other Federal Statutes	No		
Other	No		

Attachment Details

Document Description: 1C-7. PHA Homeless Preference

Attachment Details

Document Description: 1C-7. PHA Moving On Preference

Attachment Details

Document Description: 1D-10a. Lived Experience Support Letter

Attachment Details

Document Description: 1D-2a. Housing First Evaluation

Attachment Details

Document Description: 1E-2. Local Competition Scoring Tool

Attachment Details

Document Description: 1E-2a. Scored Forms for One Project

Attachment Details

Document Description: 1E-5. Notification of Projects Rejected-Reduced

Attachment Details

Document Description: 1E-5a. Notification of Projects Accepted

Attachment Details

Document Description: 1E-5b. Local Competition Selection Results

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: 2A-6. HDX Report

Attachment Details

Document Description: Leveraging Commitment-Housing

Attachment Details

Document Description: Healthcare Agreements

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

Ensure that the Project Priority List is complete prior to submitting.

Page	Last Updated
1A. CoC Identification	09/11/2024
1B. Inclusive Structure	10/22/2024
1C. Coordination and Engagement	10/28/2024
1D. Coordination and Engagement Cont'd	10/28/2024
1E. Project Review/Ranking	Please Complete
2A. HMIS Implementation	10/23/2024
2B. Point-in-Time (PIT) Count	10/22/2024
2C. System Performance	10/24/2024
3A. Coordination with Housing and Healthcare	10/28/2024
3B. Rehabilitation/New Construction Costs	10/18/2024
3C. Serving Homeless Under Other Federal Statutes	10/18/2024

4A. DV Bonus Project Applicants	10/28/2024
4B. Attachments Screen	Please Complete
Submission Summary	No Input Required

Chapter 4

SELECTION OF FAMILIES FROM WAITING LIST

4.1 INTRODUCTION

It is the HA's objective to ensure that the families are placed in the proper order on the waiting list so that an offer of assistance is not delayed to any family, or made to any family prematurely. This chapter defines the eligibility criteria for the HA, and it explains the waiting list order which the HA has adopted to meet local housing needs.

By maintaining an accurate waiting list, the HA will be able to perform the activities which ensure that an adequate pool of qualified registrants will be available so that program funds are used in a timely manner.

4.2 WAITING LIST PREFERENCES

The HA has implemented the following preferences for selecting families from the waiting list. In accordance with California State Law [Health and Safety Code Section 34322.2 (b)], at each level of preference, families meeting the definition of a veteran according to either the United States Code, Title 38 (38 U.S.C.), Section 101 or the California Military and Veterans Code, Section 980, will have priority. In accordance with Federal Regulations [24 CFR 982.201 (b) (2)], at each level below, from the families that meet the preferences, the Housing Authority will select from families to result in a lease up of: 75% of the families will be at or below 30% of the area median income (extremely low income), and 25% of the families will be between 30% and 50% of the area median income (very low income). Any Project-Based Voucher (PBV) development under HAP Contract will observe preferences outlined in the Housing Assistance Payments (HAP) Contract (i.e. veterans, elderly or families receiving supportive services). If the first level selections do not satisfy the regulations regarding extremely low income families, selections will be done at the second level of preferences until the 75% extremely low income requirement is met.

In order to be compliant with applicable regulatory requirements, the Housing Authority will select families to result in a lease up of 75% of the families being at or below 30% of the area median income (extremely low income). If a family has a change in income that results in the family exceeding the 30% income limits but not more than 50% for the family size at the time of verification and up until voucher issuance and/or prior to lease up, the family's income will be updated and they will be returned to the waiting list and notified in writing and the family will be eligible for a future selection between 30% and 50% of the area median income limits (very low income). However, for the Project Based Voucher (PBV) Program, an applicant whose annual income exceeds the maximum income limit for the specific region and/or development will be withdrawn from the waiting list for the specific PBV development and/or site-based waiting list from which they were selected.

4.2.1 EXTRAORDINARY LOCAL PREFERENCE

Up to a total of 15% of annual admissions will be targeted for an extraordinary local preference for the following registrants: referrals from the "HomeConnect", County of Riverside Continuum of Care Coordinated Entry System Lead Agency, Behavioral Health, for those who are not eligible for HUD funded long-term housing through the Continuum of Care and are able to live independently with minimal support (the "HomeConnect" system assesses a person's vulnerability in order to direct them to the best housing option that meets their needs); and registrants displaced by government action or emergency as certified by a city, county or state agency official (executive level or above), etc. The

approval of the Director or designee is necessary for an extraordinary local preference. These admissions must meet the County of Riverside Residency Preference except for those who are displaced by government action. **24 CFR 982.204 (a) and 24 CFR 982.207 (a) (2) and (3).**

FIRST LEVEL
County of Riverside Residency Preference, and

1) Qualified veterans; or
2) Families whose head of household, spouse or co-head is 70 years of age and older; or
3) A client referred by Adult Protective Services (APS), a division within the County of Riverside Department of Public Social Services (DPSS), who is 62 years or older and homeless or at-risk of being homeless ; or
4) Families or Foster Care Youth referred to the HA by the Riverside County Public Child Welfare Agency (PCWA) for admission through
   the Family Unification Program (currently awarded 180 HUD designated special purpose vouchers)
   b. Family Unification Program (FUP) Youth or Foster Youth to Independence Initiative (FYI) Youth (currently awarded 100 HUD designated special purpose vouchers).
5) Participants who have utilized a special rental assistance program administered by (or under contract/Memorandum of Understanding (MOU) with) the Housing Authority of the County of Riverside for a minimum of a six (6) month term and no longer require supportive services; or
6) Participants transitioning or "moving on" who have been assisted through a Permanent Supportive Housing Program administered by a partnering agency and no longer require intensive supportive services; or
7) Non-elderly persons at least 18 years of age and less than 62 years of age with disabilities who are transitioning out of institutional and other segregated settings, at serious risk of institutionalization, homeless, or at risk of becoming homeless; or
8) Family Unification Program (FUP) Youth or Foster Youth to Independence Initiative (FYI) Youth whose FUP/FYI youth assistance is expiring and will have a lack of adequate housing as a result of their termination from the program.

SECOND LEVEL
County of Riverside Residency Preference, and

1) Families with minors or Elderly Families or Disabled Families

THIRD LEVEL
County of Riverside Residency Preference, and

1) Families without minors

The Housing Authority will exhaust all families at each preference level before selecting from the next lower level except as noted above. Date of registration for registrants with equal preferences will determine order of selection.

4.2.2 CHANGE IN CIRCUMSTANCES

Changes in a registrant's circumstances while on the waiting list may affect the family's entitlement

to a preference. Registrants are required to inform the HA of changes in family composition, income, and address, as well as any changes in the preference status using the Housing Authority's web-based portal.

When a registrant claims an additional preference, she/he will maintain the original date of registration and will be updated on the waiting list in the appropriate order determined by the newly claimed preference. The qualification for preference must exist at the time the preference is verified regardless of the length of time an applicant has been on the waiting list because the preference is based on current status. Preference eligibility is verified at the time of completion of the HCV Program Application and Eligibility Questionnaire up until voucher issuance.

4.3 EXCEPTIONS FOR SPECIAL ADMISSIONS (24 CFR 982.203)

If HUD awards program funding that is targeted for a specific group, the HA will admit these families under a special admission procedure. The families will be selected in accordance with the Notice of Funding Availability and the HA's application for funding. Special admissions families who are income eligible (Very Low) will be admitted outside of the regular waiting list process. They do not have to qualify for any preferences, nor are they required to be on the program waiting list. The HA maintains separate records of these admissions.

4.4 TARGETED FUNDING

When HUD awards special funding for certain family types, families who qualify are placed on the regular waiting list. When a specific type of funding becomes available, the waiting list is searched for the first family meeting the targeted funding criteria, based on date of registration or by a referral through an established MOU.

Examples of targeted programs are:

- Mainstream
- Family Unification Program (FUP)
- Foster Youth to Independence (FYI)
- Emergency Housing Voucher (EHV)

4.5 ORDER OF SELECTION

Income eligible families are selected from the waiting list and sent a HCV Program Application and Eligibility Questionnaire based on the waiting list preferences listed in Section 4.2 of this Chapter. The waiting list will be organized by date among registrants with equal preference status regardless of family size. Preference information will be verified when families complete a HCV Program Application and Eligibility Questionnaire and the qualification for preference must exist at the time the preference is verified up until voucher issuance regardless of the length of time an applicant has been on the waiting list because the preference is based on current status.

4.6 IF PREFERENCES ARE NOT MET

If the applicant does not qualify for a preference, the HA will return the family to the waiting list. The HA will notify the applicant in writing of the reasons why the preference was denied and inform the applicant that they have been returned to the waiting list with their original registration date before they were selected. If the applicant falsifies documents or makes false statements in order to qualify for any preference they will be denied assistance (lifetime ineligible) and offered an opportunity to request an informal review in writing within 30 calendar days. Applicants may exercise other rights if they believe they have been discriminated against.

4.7 REMOVAL FROM WAITING LIST AND PURGING

If a registrant fails to respond in writing (preferred) or by phone (case-by-case) within 30 calendar days to a mailing from the HA, the registrant will be removed from the waiting list. If a letter is returned by the U.S. Post Office without a forwarding address, the registrant will be removed from all waiting lists without further notice, and a record will be maintained on the computer. Reasonable accommodations will be made for persons with disabilities.

Between October 1st and December 31st of every year, registrants are required to update their waiting list registration once annually using the Housing Authority's web-based list at www.harivco.org. An annual update is required, regardless of whether there are any changes to their registration. Failure to do so will result in the withdrawal of all waiting list registrations. Reasonable Accommodation (RA) requests will be accommodated should a registrant who is a person with disabilities be unable to use the web-based portal but RA requests must be made during the October-December update period. Failure to update their registration during the annual update period will result in the registrant being removed from all waiting lists.

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County of Riverside Continuum of Care (CoC)

Lived Experience Working Group

Letter of Support

Purpose

This letter of support from the Lived Experience Working Group outlines a broad vision that supports an integrated service delivery system within the **Riverside County Continuum of Care (CoC).** Prioritizing Individuals and families experiencing homelessness with severe service needs is a key issue within this region. **The Lived Experience Working Group** is committed to better addressing homelessness among individuals and households with severe service needs. The purpose of this letter is to support the priorities for serving individuals and families experiencing homelessness with severe service needs in the Riverside County CoC's geographic area.

The Role of the Lived Experience Working Group

The Lived Experience Working Group is a group of individuals who have a background with lived expertise of homelessness who are participating in the Youth Action Board (YAB) to create equitable goals for the Continuum of Care (CoC).

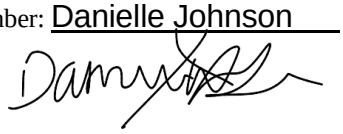
The YAB is a group of youth members who have experienced some form of homelessness and/or justice involved. YAB members are included in policy making decisions of the CoC, with focus on policies that relate to preventing and ending youth homelessness. The CoC developed YAB membership by recruiting young people from existing working groups and from boards and other leadership positions within local youth serving organizations in the community.

YAB members also serve as ambassadors to strengthen relationships among all members of the community, promote youth activism in governmental affairs, and hold a seat on the CoC Board of Governance (BoG) to vote on items pertaining to youth. In addition, YAB members are highly encouraged to attend and participate in the Youth Advisory Committee (YAC) meetings, CoC meetings, special events, and other sub-committees to gain knowledge, share their experiences and serve as a youth advocate to the community.

The YAB empowers young voices to lead in Riverside County's efforts to prevent and end youth homelessness. The board advocates for positive change with unwavering honesty, fostering a culture of accountability through collaborative efforts, and promotes deep understanding in future endeavors.

This letter is made by the Lived Experience Working Group in support of the priorities for serving individuals and families experiencing homelessness **with severe service needs** in the Riverside County CoC's geographic area. This letter shall be supported through the duration of the CoC application and grant.

Member: Danielle Johnson Date: 10/15/2024 Last date homeless Unsheltered / Sheltered: 07/22/2022



Member: Shontel Bullard Date: 10/15/2024 Last date homeless Unsheltered / Sheltered: 05/09/2023

Member: Savannah Brown Date: 10/15/2024 Last date homeless Unsheltered / Sheltered: 10/16/2024

Provider Information

Please complete the information below on the organization being assessed.

Provider Information	
Provider's Legal Name	**County of Riverside, Riverside University Health Systems**
Acronym (If Applicable)	RUHS-BH
Year Incorporated	1989
EIN	95-600930
Street Address	4095 County Circle Drive
Zip Code	92503

Project Information	
Project Name	HHOPE PSH Consolidated
Project Budget	$1,672,596
Grant Number	CA0935L9D082112
Name of Project Director	Marcus Cannon
Project Director Email Address	mcannon@ruhealth.org
Project Director Phone Number	951-955-7263
Which best describes the project *	**Permanent Supportive Housing**
If project is a Safe Haven, please choose project type that it most operates like, e.g. shelter, transitional housing, or permanent housing	
Are your services targeted to any of the following populations specifically? Please select one if so, as this impacts your assessment questions.	**People in Recovery**

*Please note that when you select a project type, particular standards may not be relevant.

Management Information	
Name of CEO	Matthew Chang
CEO Email Address	matthew.chang@ruhealth.org
CEO Phone Number	951-358-4501
Name of Staff Member Guiding Assessment	Marcus Cannon
Staff Email Address	mcannon@ruhealth.org
Staff Phone Number	951-955-7263

Assessment Information	
Name of Assessor	Marcus Cannon
Organizational Affiliation of Assessor	RUHS-BH
Assessor Email Address	mcannon@ruhealth.org
Assessor Phone Number	951-955-7263
Date of Assessment	**Sep 17 2024**

Housing First Standards

For each standard, please use the drop down boxes in the three columns to the right to select “Not at all” or “Sometimes” or "Always". Marking "Always" signifies full compliance for the standard.

No.	Standard	Access Definition / Evidence	Say It	Document it	Do it
Access 1	Projects are low-barrier	Admission to projects is not contingent on pre-requisites such as abstinence of substances, minimum income requirements, health or mental health history, medication adherence, age, criminal justice history, financial history, completion of treatment, participation in services, “housing readiness,” history or occurrence of victimization, survivor of sexual assault or an affiliated person of such a survivor or other unnecessary conditions unless required by law or funding source. *Optional notes here*	Always	Always	Always
Access 2	Projects do not deny assistance for unnecessary reasons	Procedures and oversight demonstrate that staff do everything possible to avoid denying assistance or rejecting an individual or family for the reasons listed in Access Standard #1. *Optional notes here*	Always	Always	Always
Access 3	Access regardless of sexual orientation, gender identity, or marital status	Equal access is provided in accordance with the 2012 and 2016 Equal Access Rules, meaning that any project funded by HUD must ensure equal access for persons regardless of one’s sexual orientation or marital status, and in accordance with one’s gender identity. Adult only households, regardless of marital status, should have equal access to projects (if these project types are not available within a CoC, the CoC should conduct an assessment to determine if these project types are needed and work with providers to accommodate the need). Please see Equal Access Rules here: https://www.hudexchange.info/resource/1991/equal-access-to-housing-final-rule/ *Optional notes here*	Always	Always	Always
Access 4	Admission process is expedited with speed and efficiency	Projects have expedited admission processes, to the greatest extent possible, including helping participants obtain documentation required by funding sources, as well as processes to admit participants regardless of the status of their eligibility documentation whenever applicable. *Optional notes here*	Always	Always	Somewhat

Access 5	Intake processes are person-centered and flexible	Intake and assessment procedures are focused on the individual's or family's strengths, needs, and preferences. Projects do not require specific appointment times, but have flexible intake schedules that ensure access to all households. Assessments are focused on identifying household strengths, resources, as well as identifying barriers to housing that can inform the basis of a housing plan as soon as a person is enrolled in the project. *Optional notes here*	Always	Always	Always
Access 6	The provider/project accepts and makes referrals directly through Coordinated Entry	Projects actively participate in the CoC-designated Coordinated Entry processes as part of streamlined community-wide system access and triage. If these processes are not yet implemented, projects follow communities' existing referral processes. Referrals from Coordinated Entry are rarely rejected, and only if there is a history of violence, the participant does not want to be in the project, there are legally valid grounds (such as restrictions regarding sex offenders) or some other exceptional circumstance that is well documented. *Optional notes here*	Always	Always	Always
Access 7	Exits to homelessness are avoided	Projects that can no longer serve particular households utilize the coordinated entry process, or the communities' existing referral processes if coordinated entry processes are not yet implemented, to ensure that those individuals and families have access to other housing and services as desired, and do not become disconnected from services and housing. Households encounter these exits under certain circumstances, such as if they demonstrate violent or harassing behaviors, which are described within agencies' regulation-adherent policies. *Optional notes here*	Always	Always	Always

Name		Participant Input Definition / Evidence	Say It	Document it	Do it
Participant Input 1	Participant education is ongoing	Project participants receive ongoing education on Housing First principles as well as other service models employed in the project. In the beginning of and throughout tenancy, participants are informed about their full rights and responsibilities as lease holders, including the potential causes for eviction. *Optional notes here*	Always	Always	Always
Participant Input 2	Projects create regular, formal opportunities for participants to offer input	Input is welcomed regarding the project's policies, processes, procedures, and practices. Opportunities include involvement in: quality assurance and evaluation processes, a participant leadership/advisory board, processes to formally communicate with landlords, the design of and participation in surveys and focus groups, planning social gatherings, integrating peer specialists and peer-facilitated support groups to compliment professional services. *Optional notes here*	Always	Always	Always

Housing First Standards

For each standard, please use the drop down boxes in the three columns to the right to select “Not at all” or “Sometimes” or "Always". Marking "Always" signifies full compliance for the standard.

	Standard	Lease and Occupancy Definition / Evidence	Say It	Document It	Do It
Leases 1	Housing is considered permanent (not applicable for Transitional Housing)	Housing is not time-limited (though rent assistance may be) and leases are automatically renewable upon expiration, except with prior notice by either party. *Optional notes here*	Always	Always	Always
Leases 2	Participant choice is fundamental	A participant has, at minimum, choices in deciding the location and type of housing based on preferences from a range of housing types and among multiple units, as available and as practical. In project-based settings, participants should be offered choice of units within a particular building, or within the portfolio of single site properties. In projects that use shared housing, i.e. housing with unrelated roommates, participants should be offered choice of roommates, as available and as practical. Additionally, as applicable, participants are able to choose their roommates when sharing a room or unit. *Optional notes here*	Always	Always	Always
Leases 3	Leases are the same for participants as for other tenants	Leases do not have any provisions that would not be found in leases held by any other tenant in the property or building and is renewable per the participants’ and owner’s choice. People experiencing homelessness who receive help moving into permanent housing should have leases that confer the full rights, responsibilities, and legal protections under Federal, state, and local housing laws. For transitional housing, there may be limitations on length of stay, but a lease/occupancy agreement should look like a lease that a person would have in the normal rental market. *Optional notes here*	Always	Always	Always
Leases 4	Participants receive education about their lease or occupancy agreement terms	Participants are also given access to legal assistance and encouraged to exercise their full legal rights and responsibilities. Landlords and providers abide by their legally-defined roles and responsibilities. *Optional notes here*	Always	Always	Always

Leases 5	Measures are used to prevent eviction	Property or building management, with services support, incorporates a culture of eviction avoidance, reinforced through practices and policies that prevent lease violations and evictions among participants, and evict participants only when they are a threat to self or others. Clear eviction appeal processes and due process is provided for all participants. Lease bifurcation is allowed so that a tenant or lawful occupant who is a victim of a criminal act of physical violence committed against them by another tenant or lawful occupant is not evicted, removed or penalized if the other is evicted. *Optional notes here*	Always	Always	Always
Leases 6	Providing stable housing is a priority	Providers engage in a continued effort to hold housing for participants, even if they leave their housing for short periods due to treatment, illness, or any other temporary stay outside of the unit. *Optional notes here*	Always	Always	Always
Leases 7	Rent payment policies respond to tenants' needs (as applicable)	While tenants are accountable to the rental agreement, adjustments may be needed on a case by case basis. As necessary, participants are given special payment arrangements for rent arrears and/or assistance with financial management, including representative payee arrangements. *Optional notes here*	Always	Always	Always

Housing First Standards

For each standard, please use the drop down boxes in the three columns to the right to select “Not at all” or “Sometimes” or "Always". Marking "Always" signifies full compliance for the standard.

	Standard	Services Definition / Evidence	Say it	Document it	Do it
Services 1	Projects promote participant choice in services	Participants are able to choose from an array of services. Services offered are housing focused and include the following areas of support: employment and income, childhood and education, community connection, and stabilization to maintain housing. These should be provided by linking to community-based services. *Optional notes here*	Always	Always	Always
Services 2	Person Centered Planning is a guiding principle of the service planning process	Person-centered Planning is a guiding principle of the service planning process *Optional notes here*	Always	Always	Always
Services 3	Service support is as permanent as the housing	Service connections are permanently available and accessible for participants in Permanent Supportive Housing. Rapid Re-Housing projects should, at a minimum, be prepared to offer services for up to 6 months after the rental assistance ends. In emergency shelter and transitional housing, services are available as long as the participant resides in the unit or bed – and up to 6 months following exit from transitional housing. *Optional notes here*	Always	Always	Always
Services 4	Services are continued despite change in housing status or placement	Wherever possible, participants continue to be offered services even if they lose their housing unit or bed (for congregate projects), or if they are placed in a short-term inpatient treatment. Ideally, the service relationship should continue, despite a service hiatus during some institutional stays. *Optional notes here*	Always	Always	Always

Services 5	Participant engagement is a core component of service delivery	Staff provide effective services by developing relationships with participants that provide immediate needs and safety, develop trust and common ground, making warm hand-offs to other mainstream service providers, and clearly explain staff roles. Engagement is regular and relationships are developed over time. *Optional notes here*	Always	Always	Always
Services 6	Services are culturally appropriate with translation services available, as needed	Project staff are sensitive to and support the cultural aspects of diverse households. Wherever possible, staff demographics reflect the participant population they serve in order to provide appropriate, culturally-specific services. Translation services are provided when needed to ensure full comprehension of the project. Projects that serve families with children should have family-friendly rules that allow for different schedules based on work and school hours and have services that allow parents to participate in activities without having to constantly supervise their children themselves (i.e. can use the bathroom or take a shower without their children being in the bathroom with them). *Optional notes here*	Always	Always	Always
Services 7	Staff are trained in clinical and non-clinical strategies (including harm reduction, motivational interviewing, trauma-informed approaches, strength-based)	Services support a participant's ability to obtain and retain housing regardless of changes in behavior. Services are informed by a harm-reduction philosophy, such as recognizing that substance use and addiction are a part of some participants' lives. Participants are engaged in non-judgmental communication regarding their behavior and are offered education regarding how to avoid risky behaviors and engage in safer practices. *Optional notes here*	Always	Always	Always

	Standard	Housing Definition / Evidence	Say It	Document It	Do It
Housing 1	Housing is not dependent on participation in services	Participation in permanent and temporary housing settings, as well as crisis settings such as emergency shelter, is not contingent on participating in supportive services or demonstration of progress made on a service plan. Services must be offered by staff, but are voluntary for participants. *Optional notes here*	Always	Always	Always
Housing 2	Substance use is not a reason for termination	Participants are only terminated from the project for violations in the lease or occupancy agreements, as applicable. Occupancy agreements or an addendum to the lease do not include conditions around substance use or participation in services. If the project is a recovery housing model focused on people who are in early recovery from drugs or alcohol (as outlined in HUD's Recovery Housing Brief), different standards related to use and subsequent offer of treatment may apply. See HUD's Recovery Housing brief here: https://www.hudexchange.info/resource/4852/recovery-housing-policy-brief/	Always	Always	Always

		Optional notes here			
Housing 3	The rules and regulations of the project are centered on participants' rights	Project staff have realistic expectations and policies. Rules and regulations are designed to support safe and stable communities and should never interfere with a life in the community. Participants have access to the project at all hours (except for nightly in and out shelter) and accommodation is made for pets. *Optional notes here*	Always	Always	Always
Housing 4	Participants have the option to transfer to another project	Transfers should be accommodated for tenants who reasonably believe that they are threatened with imminent harm from further violence if the tenant remains in the same unit. Whenever possible, transfers occur before a participant experiences homelessness. *Optional notes here*	Always	Always	Always

Housing First Standards

For each standard, please use the drop down boxes in the three columns to the right to select “Not at all” or “Sometimes” or "Always". Marking "Always" signifies full compliance for the standard.

	Standard	Project -Specific Standards	Say It	Document it	Do it
Project 1	Quick access to RRH assistance	A permanent supportive housing project ensures quick linkage to a unit and wrap around services, based on participant needs, preferences, and resource availability. *Optional notes here*	Always	Always	Always
Project 2	PSH is focused on ending homelessness for those with the most severe barriers to maintaining housing	Participants and staff understand that a primary goal of permanent supportive housing is to end homelessness for people with the most severe service needs and help participants stay housed, regardless of other perceived barriers. *Optional notes here*	Always	Always	Always
Project 3	Property Management duties are separate and distinct from services/case management	In order to provide clear roles of staff for participants in terms of lease and rules enforcement as well as tenant advocacy, property management and service provider staff should be separate roles. However, they should work together on a regular basis through regular communications and meetings regarding Participants to address tenancy issues in order to preserve tenancy. *Optional notes here*	Always	Always	Always
		No additional standards *Optional notes here*			

		No additional standards			
		Optional notes here			
		No additional standards			
		Optional notes here			
		No additional standards			
		Optional notes here			
		No additional standards			
		Optional notes here			
Standard		**Population Specific Standards**	**Say It**	**Document It**	**Do It**
Population 1	Recovery housing is offered as one choice among other housing opportunities	Connection to recovery housing reflects individual choice for this path toward recovery. Abstinence-only spaces are incorporated into a Housing First model wherever possible, thus providing this type of recovery option to those who choose it. Recovery supports are offered, particularly connections to community-based treatment options.	Always	Always	Always

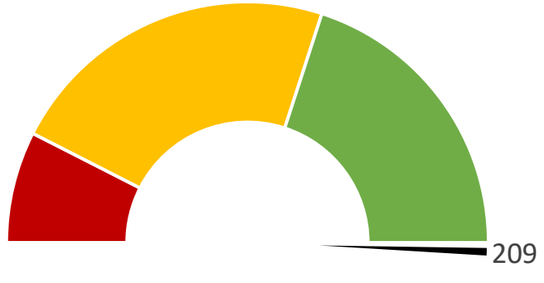
		Optional notes here			
Population 2	Services include relapse support	Housing and services include relapse support that does not automatically evict or discharge a participant from the project for temporary relapse. Relapse support might include referrals to outpatient treatment or direct provision of outpatient services or the ability to hold a unit for a certain period of time (30-90 days) while the participant undergoes residential treatment. *Optional notes here*	Always	Always	Always
Population 3	Services support sustained recovery	Recovery housing projects provide services that align with participants' choice and prioritization of recovery, including but not limited to abstinence from substances (if that is a personal goal), long-term permanent housing stability, and stable income through employment or benefits. Support is offered through connections to community-based treatment options. *Optional notes here*	Always	Always	Always
Population 4	Population	No additional standards *Optional notes here*			

Housing First Standards: Assessment Summary

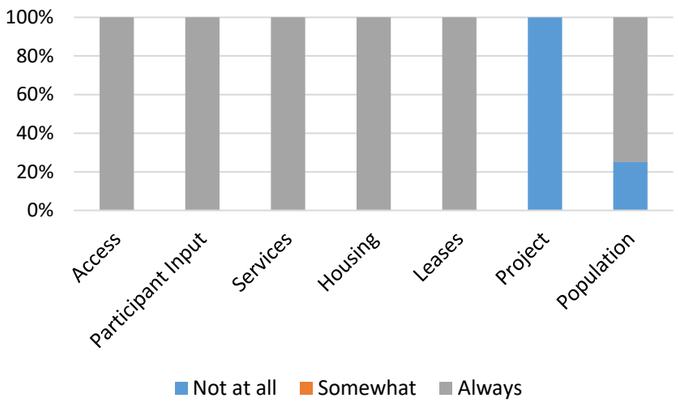
County of Riverside, Riverside University Health Systems
17-Sep-24

Your score:	**209**
Max potential score:	*204*

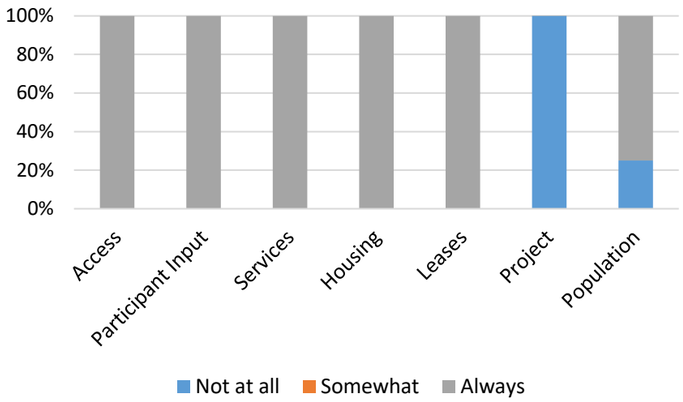
Score is calculated by awarding 1 point for standards answered 'sometimes' and 2 points for standards answered 'always'. Categories that are not applicable for your project are not included in the maximum potential score.



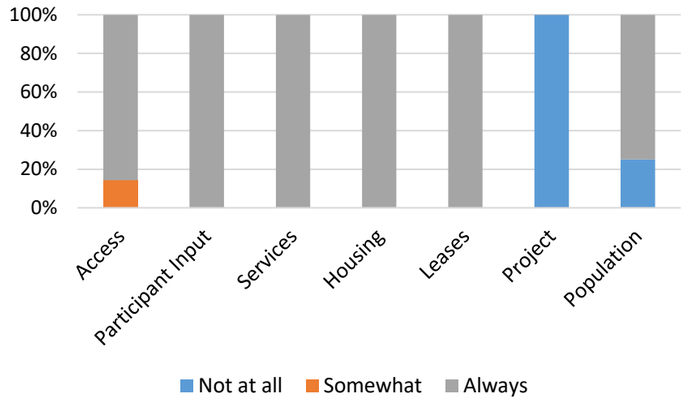
Percentage of Standards "Said"



Percentage of Standards "Documented"



Percentage of Standards "Done"



Non-Compliant Standards ("Not at all" to Whether Standard is Said)

Category	*No.*	*Name*	*Standard*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Population	4	0	No additional standards *Optional notes here*

Non-Documented Standards ("Not at All" to Whether Standard is Documented)

Category	*No.*	*Name*	*Standard*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Population	4	0	No additional standards *Optional notes here*

Non-Evidenced Standards ("Not at All" to Whether Standard is Done")

Category	*No.*	*Name*	*Standard*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Project-specific			No additional standards *Optional notes here*
Population	4	0	No additional standards *Optional notes here*

County of Riverside Continuum of Care

HUD CoC Program Review and Evaluation Process Policy

May 24, 2023

1. BACKGROUND

At the request of the Board of Governance (BoG), the Riverside County Continuum of Care (CoC) Standards and Evaluation Committee at its April 18, 2019, meeting created a Working Group to develop a review and evaluation process policy for distributing grant funds.

The purpose of the review and evaluation policy is to ensure that the Riverside County CoC maximizes the use of grant funds from the federal and state governments to address the needs of the CoC.

In developing this policy, the committee strived for transparency, accountability, and timely response.

Implementation of this policy is to:

- establish threshold evaluation;
- create and implement a Continuum of Care Review and Rank Committee;
- establish a project review and scoring criteria; and
- establish a project and selection appeals process.

After the County departmental restructuring with the move of the CoC Division from the Department of Public Social Services (DPSS) to the Department of Housing and Workforce Solutions (HWS) in March 2020. Every year we activate an ad HOC to review and approve revisions to this policy and the project scorecards.

2. CREATION OF THE EVALUATION PANEL

A. Interested evaluators will be recruited by the CoC and evaluators will remain anonymous.
B. Applications will be presented to the Ad hoc Committee for the upcoming CoC Program Competition for review to ensure the applicant meets the criteria. Selected applicants will be notified by CoC staff.
C. The Review and Rank Committee members must attend a mandatory orientation and training on how to review and rank the applications, including funding priorities and requirements.

3. PROJECT REVIEW AND SCORING CRITERIA

Evaluation Committee will review proposals using the following criteria:

A. Board of Governance Funding Principles

B. Performance Measures

C. Program and Fiscal Compliance

D. HUD CoC and all HUD Priorities and Requirements

E. HEARTH Act Compliance

4. PROJECT SELECTION AND APPEALS PROCESS

An appeals group will be created from the same pool of volunteers used to create the Evaluation Panel and not directly involved in the original rating of project(s) under appeal. Appeals must be submitted in the form of a written letter addressed to CoC Division.

A formal protest must contain the following to be considered. See Appeal Process for full details.

- A specific identification of the statutory or regulatory provision(s) that the alleged action is in violation.
- A specific description of each act alleged to have violated the statutory or regulatory provision(s).
- A precise statement of the relevant facts, and identification of the issue or issues to be resolved.
- Complaints about events or decisions made before the solicitation deadline.
- Complaints that the solicitation unduly constrains competition through improper minimum qualifications or specifications.

A detailed copy of the Review and Evaluation Process Policy is attached.

Riverside County CoC
HUD CoC Program Review & Evaluation Process Policy

Part I: Threshold Evaluation

Any applicant must meet these HUD mandated criteria in order to receive grant funds. New and Renewal project applicants must meet these conditions to be included in application scoring.

Application Threshold Review	Applicant has met all terms and conditions specified in the RFP. Applications must include all documents including attachments and information required by the application deadline. NO EXCEPTIONS will be granted.
Applicant Eligibility Review	Applicant has met all agency eligibility criteria identified by HUD. Verification documents have been provided on: • Registration in System of Award Management (SAMs), • Valid Unique Entity Identifier (UEI), • No outstanding or delinquent federal or state debt, • Not barred or suspended from doing business with federal or state agencies, • Meeting accounting system and financial management system standards, and • Disclosure of violations of federal criminal law, • Housing First (HF) implementation (HUD-CoC Priorities and Requirements), • Participation in Coordinated Entry System (HUD-CoC Priorities and Requirements), • Participation of homeless in decision-making (HEARTH Act Compliance), • Participation of homeless through employment or volunteerism (HEARTH Act Compliance), • Engagement in religious activities (HEARTH Act Compliance), • Involuntary family separation (HEARTH Act Compliance), • Discrimination Policy (HEARTH Act Compliance), • Continuum of Care participation (HEARTH Act Compliance).
Program Eligibility	Project addresses an immediate homelessness challenge. Project will serve individuals or families that meet the definition of homeless in 24 CFR 578.3.
Alignment with HUD Housing First Policies	The applicant uses a project entry process that prioritizes rapid placement and stabilization in permanent housing that meets HUD's Housing First criteria: • The eligibility criteria for the supportive housing meet the minimum that the funder(s) or landlord require (without additional criteria imposed). • Sobriety is not an entrance requirement. • Medication compliance is not an entrance requirement. • Agreement to participate in services is not an entrance requirement. • There is no minimum income requirement.
Homeless Management Information System (HMIS)	The applicant commits to use of HMIS, including timeliness and data quality standards, demonstrates adequate capacity for data collection and reporting.

Coordinated Entry System (CES)	The applicant commits to participate in CES and complies with CES Policies and Procedures.
Financial Feasibility and Capacity	The applicant must show they have the financial capacity to carry out the project and project cost must be reasonable and feasible.
Match Requirement (if applicable)	Must provide documentation for proof of match. (Nonpayment of match could jeopardize future funding or funding renewal).

Part II: Continuum of Care Review and Rank Committee

Review and Rank Committee (Member Composition, Qualifications, Application and Selection)

There will be an open recruitment for an evaluation panel where HWS CoC Division will accept applications. All qualified volunteer names will consist of individuals who represent both CoC members and Non-CoC affiliated individuals.

- Review committee volunteers should meet the following qualifications:
  - non-conflicted (per the HEARTH ACT)
  - knowledgeable of the local homeless situation
  - complete evaluators training
  - commitment of time
  - complete training on HUD and HEARTH Act policies, procedures, regulations, requirements, etc.
  - complete a qualification form to ensure all the above requirements are met prior to entering the pool.
  - has expert knowledge in serving subpopulations such as Domestic Violence, Veterans, Youth, etc.
  - has multi-geographic and multi-sector representation

Part III-A: Renewal Project Review and Scoring Criteria *(80% threshold)*

Board of Governance Funding Principles

- Invest in programs that will immediately impact reduction of homeless youth, individuals and families, or prevent them from becoming homeless.
- Invest in programs that demonstrate ongoing, long-term, or sustainable results.
- Invest in programs addressing significant service gaps by targeting high-need communities (identified through the annual Homeless Point-In-Time Count), under-served or hard-to-serve geographic or special subpopulations.
- Invest in programs that emphasize a comprehensive service delivery approach or wraparound services to ensure successful housing and self-sufficiency outcomes.
- Invest in solutions to address the unique needs of homeless individuals living in encampments.
- Invest in programs that support Riverside County's Action Plan emphasizing the expansion of: system coordination housing resources outreach, navigation, and supportive services.

System Performance Measures

1. Length of Time Person Remain Homeless	• Measures the average number of days from project entry to residential move-in.
2. Housing Stability (Obtain & maintain permanent housing)	• Measures the average percentage of participants that remain in or move to permanent housing (goal is at least 90%). (RRH % moved to PH and PSH % retained and/or moved to PH)
3. Return to Homelessness	• Measures the average percentage of participants that return to homelessness at exit (goal is no more than 10.99%).

4. Income Growth	• Measures the average percentage of adult participants who increased their total income (from all sources). (For Stayers: use Q19 A1; and for Leavers: use Q19 A2)
Program Compliance	
5. Annual Performance Reports (APR)	• Measures whether sub-recipients submit their APR to HWS CoC Division for review within 60 days after the project ends.
6. Monitoring Reports (Program)	• Measures whether the project has had any findings during the 12-month period based on the most recent monitoring report by the Collaborative Applicant (HWS).
7. Housing Quality (ENSPIRE)	• Measures whether the project meets applicable housing standards. ○ If housing inspections are completed prior client entering a unit ○ If housing inspections are completed annually
8. Bed Utilization	• Measures occupancy rates beds/units supported by the project.
9. Access to Mainstream Benefits	• Measures whether the project provides regular or as needed transportation assistance to mainstream and community resources, including appointments, employment training, educational programs, or jobs.
10. Mainstream Benefits Applications	• Measures whether the project uses a single application form that allows program participants to sign up for four or more mainstream programs.
11. SSI/SSDI Technical Assistance	• Measures whether program participants have access to SSI/SSDI technical assistance. The assistance can be provided by the applicant, a sub-recipient, or a partner agency through a formal or informal relationship. Subrecipients may choose to have their own process or utilize arrangement set forth in the MOU between Riverside County CoC and DPSS.
12. Supportive Services Follow Up	• Measures whether the project regularly follows-up with program participants to ensure that they have applied for, are receiving their mainstream benefits, and renew benefits when required: PSH – at least annually - RRH – at least monthly.
Fiscal Compliance	
13. Monthly Submission of Claims	• Measures whether the project submits monthly claims on time (within 30 days after the end of the service month) and correctly (no major disallowances, deferments, or changes) as required. Evaluated using the 12 most recent monthly claims as of the date of scoring.
14. Recaptured Funds (unspent funds)	• Measures whether the project returned any funds in the last 2 completed grant years. Based on percentage of total project budget. *(Note: Any unspent funds are subject to being reallocated regardless of amount or score).*
15. Cost-effectiveness	• Measures percentage of rental assistance costs per successful housing placement. Cost effectiveness will be based on the median of the total rental assistance costs per successful housing placement.

HMIS Compliance	
16. HMIS Timeliness	Measures the timeliness of HUD-required data entry. • Client entry and exit must be recorded within 7 days
17. HMIS Data Quality	• Measures the accuracy and completeness of HUD-required universal data elements and program specific data elements. Information entered must be valid and accurately represent client information.

Part III-B: New Project Review and Scoring Criteria

Board of Governance Funding Principles

- Invest in programs that will immediately impact reduction of homeless youth, individuals and families, or prevent them from becoming homeless.
- Invest in programs that demonstrate ongoing, long-term, or sustainable results.
- Invest in programs addressing significant service gaps by targeting high-need communities (identified through the annual PIT Count), under-served or hard-to-serve geographic or special subpopulations.
- Invest in programs that emphasize a comprehensive service delivery approach or wraparound services to ensure successful housing and self-sufficiency outcomes.
- Invest in solutions to address the unique needs of homeless individuals living in encampments.
- Invest in programs that support Riverside County's Action Plan
- Funding priorities with weight to address gaps and needs. Use the annual PIT Count and CES By-Name List to help identify gaps and needs.

Applicant Experience	
1. Experience with targeted population	• Measures the experience of the applicant and sub-recipients (if any) in working with the proposed population and in providing housing similar to that proposed in the application.
2. Financial Management: Utilization of federal or state Funds	• Measures the experience in effectively utilizing federal or state funds including HUD grants and other public funding, including satisfactory drawdowns and performance for existing grants as evidenced by timely reimbursement of subrecipients (if applicable), regular drawdowns, timely resolution of monitoring findings, and timely submission of required reporting on existing grants.
Project Design	
3. Needs of population	• Assesses description of key characteristics, needs, and extent of population targeted in project based on appropriate data.
4. Housing Design	• Assesses appropriateness of type, scale, and location match the needs of population targeted for housing in the project.
5. Services Plan	• Measures inclusion of best practices for identified target population. Monthly case management is made available.
6. Measurable Goals	• Measures performance plan for housing and income that are objective, measurable, trackable, and meet or exceed local benchmarks.
7. Bed Utilization	• Measures proposed occupancy rates beds/units proposed by the project.
8. Support Services Follow-up	• Measures project plan for follow-up with program participants to ensure that they have applied for, are receiving their mainstream benefits, and renew benefits when required: PSH – at least annually - RRH – at least monthly.

9. Access to Mainstream Services	• Measures whether the project plan has evidence of formal agreements, policies, or procedures to link participants with mainstream services and resources. • Assesses whether the project plan includes transportation assistance to mainstream and community resources, including appointments, employment training, educational programs, or jobs.
10. Mainstream Benefits Applications	• Measures whether the project uses a single application form that allows program participants to sign up for four or more mainstream programs.
11. SSI/SSDI Technical Assistance	• Measures whether program participants have access to SSI/SSDI technical assistance. The assistance can be provided by the applicant, a sub-recipient, or a partner agency through a formal or informal relationship. Subrecipients may choose to have their own process or utilize arrangement set forth in the MOU between Riverside County CoC and DPSS.
System Compliance	
12. Program Monitoring	• Measures whether the applicant has had any negative findings from program monitoring by any funding source during the prior 2 years.
13. Housing Quality (NSPIRE)	• Measures whether the project meets applicable housing standards. o Commitment to housing inspections being completed prior client entering a unit. o Plan includes regular housing inspections are completed annually.
14. Documentation of Supportive Services	• Measures whether the project will regularly enter data into HMIS (or comparable data tracking mechanism) to report receipt of mainstream benefits or external resources, and renew benefits when required: PSH – at least annually - RRH – at least monthly.
Fiscal Management	
15. Effective Use of Funds - Regular Submittal of Claims	• Measures whether the project plans to submit monthly claims on a regular basis. Evaluated during most recently completed fiscal year for agency.
16. Use of External Funding	• Measures effective management of non-public funds.
17. Recaptured Funds (unspent funds)	• Measures whether the agency had unspent funds from grant sources during the past 2 years. Based on percentage of total project budget.
18. Cost-effectiveness	• Measures percentage of rental assistance costs per successful housing placement. Cost effectiveness will be based on the median of the total rental assistance costs per successful housing placement.
HMIS Compliance	
20. HMIS Timeliness	• Measures the commitment to timeliness of HUD-required data entry plan. Client entry and exit must be recorded within 7 days.
21. HMIS Accuracy and Completeness	• Measures the accuracy and completeness of HUD-required universal data elements and program specific data elements. Information entered must be valid and accurately represent client information. If not a current HMIS participant, measures data completeness in an alternate data base.

Part IV: Project Selection and Appeals Process	
BoG Review and Selection Process	• Prior to making final decisions, the Board of Governance will receive a full presentation and overview of the Review and Ranking Committee's funding recommendations.

Appeals Process	An appeals group will be created from the Review and Rank Committee through a lottery process. HWS CoC Division will provide the same information that was provided to the Review and Rank Committee during their review process. Appeals must be submitted in the form of a written letter to HWS CoC Division.
	
	• A formal protest must contain the following to be considered:
	  • A specific identification of the statutory or regulatory provision(s) that the alleged action is in violation.
	  • A specific description of each act alleged to have violated the statutory or regulatory provision(s).
	  • A precise statement of the relevant facts, and identification of the issue or issues to be resolved.
	  • Complaints about events or decisions made before the solicitation deadline
	  • Complaints that the solicitation unduly constrains competition through improper minimum qualifications or specifications.
	  • Complaints that the pre-bid conference was not fair or accessible. (Please note that bidders must attend in person all mandatory pre-bid conferences).
	  • Complaints that questions were not fully or properly addressed by the Procurement Contract Specialist/Buyer.
	  • Complaints that the Request for Proposal/Quote/Qualification did not provide adequate information or contained an improper criterion.
	  • Other matters known or that should have been known, to interested bidders by reading the solicitation document.

2024 HUD CoC Program Competition Project Scorecard

New Projects

Any applicant must meet these HUD mandated criteria in order to receive grant funds.

New and Renewal project applicants must meet these conditions to be included in application scoring.

Section 1: Applicant Eligibility Threshold

Organization:_____ Project Name:_____ Project Type:_____ Eligibility Threshold Score: _____

Eligibility Threshold – HUD Mandates				
Criteria	Description	Data Source	Meets Criteria	Score
Registration in System of Award Management (SAMS)	Agency has active registration with current information in Grants Management System	Print out of Registration in SAMS on-line	Meets Standard = 1 No = 0	
Valid Unique Entity Identifier (UEI)	Agency has been assigned a UEI in SAMs	Print out from SAMS showing item.	Meets Standard = 1 No = 0	
No outstanding or delinquent federal or state debt	Applicant has no outstanding or delinquent federal or state debt.	Independent Audit	Meets Standard = 1 No = 0	
Not barred or suspended from doing business with federal or state agencies	Per 2CFR2424	Registry of Debarred and suspended organizations	Meets Standard = 1 No = 0	
Accounting System and financial management system	Applicant accounting system meets standard in 2 CFR200.302	Independent Audit/Review per requirement	Meets Standard = 1 No = 0	
Disclosure of violations of Federal criminal law	Applicant must disclose to HUD in writing violations involving fraud, bribery, or gratuity.	Certification statement from Applicant	Meets Standard = 1 No = 0	
Housing First (HF) Implementation (HUD-CoC Priorities and Requirements)	Describe experience with utilizing Housing First. Measures commitment to Housing First implementation that meets the HUD conditions. Verifies the project's entry process that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such income, sobriety, criminal history).	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Participation in Coordinated Entry System (HUD-CoC Priorities and Requirements)	The applicant commits to participate in CES and complies with CES Policies and Procedures.	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	

Participation of homeless in decision-making (HEARTH Act Compliance)	Measures whether the agency provides for the participation of not less than one homeless individual or formerly homeless on the board of directors or other equivalent policymaking entity.	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Participation of homeless through employment or volunteerism (HEARTH Act Compliance)	Measures whether the agency involves homeless individuals and families through employment; volunteer services; or operating the project, and in providing supportive services for the project.	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Engagement in religious activities (HEARTH Act Compliance)	Measures whether the agency plans to use direct program funds to support or engage in any explicitly religious activities. Any federal and state funds distributed by the CoC can only be spent on non-religious social services activities and cannot mandate participation in religious activities to receive services.	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Involuntary family separation (HEART Act Compliance)	Measures whether the project accepts all families with children under age 18 without regard to the age of any child as appropriate per project target population The age and gender of a child under the age 18 must not be used as a basis for denying any family's admission to project receives funds under this part (24CFR§578.93).	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Discrimination Policy (HEARTH Act Compliance)	Measures whether the project does not discriminate for project entry.	Agency letter and policy	Letter and Policy received / Meets Standard= 1 pt Policy not received / No = 0 pts	
Continuum of Care Participation (HEARTH Act Compliance)	Measures whether the agency participates as a CoC member in good standing. As required in the Board of Governance Charter for the CoC, each agency must have a designated representative who is required to attend fifty percent plus one (50% + 1) CoC meetings per year.	CoC Attendance Records	Met the minimum requirement = 1 pt Did not meet the minimum requirement = 0 pts	

Section 2: Project Scoring

Applicant Name: _____Project Name: _____ Project Type: _____ Project Score: _____

APPLICANT EXPERIENCE (10 points)				
Scoring Criteria		**Data Source**	**Possible Score**	**Score**
1. Experience with targeted population	Describe the experience of the applicant and sub-recipients (if any) in working with the proposed population and in providing housing similar to that proposed in the application.	Application Attachments	Over 5 years = 5 pts 3-5 years = 3 pts 1-2 years = 1 pt Less than one year or, no experience= 0 pts	
2. Financial Management: Utilization of federal or state Funds	Describe experience in effectively utilizing federal or state funds including HUD grants and other public funding, including satisfactory drawdowns and performance for existing grants as evidenced by timely reimbursement of subrecipients (if applicable), regular drawdowns, timely resolution of monitoring findings, and timely submission of required reporting on existing grants.	Fiscal report External Monitoring reports submitted	Over 5 years = 5 pts 3-5 years = 3 pts 1-2 years = 1 pt Less than one year or, no experience= 0 pts	
PROJECT DESIGN: HOUSING AND SERVICES (30 points)				
3. Needs of population	Identifies key characteristics, needs, and extent of population targeted in project based on appropriate data.	Includes PIT, AHAR, or LSA or other verified Local Data;	Includes 2 or more CoC data sources to describe needs = 5 pts Includes 1 CoC data source = 2 pts Uses non-local data source = 1 pt No data sources = 0 pts	
4. Housing Design	Housing design: type, scale, location match needs of population targeted for housing in the project.	Application	Details for all 3 elements of housing design =5pt General description of all 3 elements design = 2 pts Does not address all 3 elements = 0 pts	
5. Services Plan	Identifies and incorporates best practices for identified target population. Monthly case management is made available.	Application	Includes best practices and offers monthly case management = 5 pts Either best practices or case management are planned = 2 pts Neither included = 0 pts	
6. Measurable Goals	Establish performance measures for housing and income that are objective, measurable, trackable, and meet or exceed local benchmarks.	Application	Includes both Housing and Income goals = 2 pts Includes only housing goals = 1 pt No measurable goals = 0 pt	
7. Bed Utilization	Measures proposed occupancy rates beds/units proposed by the project.	Application	95% - 100% = 10 pts 90% - 94.99% = 8 pts 85% - 89.99% = 6 pts 84.99% or below = 0 pts	
8. Support Services Follow-up	Identifies project plan for follow-up with program participants to ensure that they have applied for, are receiving their mainstream benefits, and renew benefits when required: PSH – at least annually - RRH – at least monthly	HMIS (or comparable data tracking) Agency report	Evidence of Follow-up = 1 pt No evidence provided = 0 pts	

9. Access to Mainstream Services	• Measures whether the project plan with evidence of formal agreements to link participants with mainstream services and has formal linkages with mainstream resources. • Assesses whether the project plan includes transportation assistance to mainstream and community resources, including appointments,employment training, educational programs, or jobs.	Written Agreements Contracts, Letters	Written agreement, policies or procedures to link participants to mainstream services and resources = 1 pt Plan includes transportation assistance to mainstream services and resources = 1 pt No formal agreement, policies, procedures or transportation to link participants to mainstream services and resources = 0 pts (max. 2 pts)	
10. Mainstream Benefits Applications	Measures whether the project uses a single application form that allows program participants to sign up for four or more mainstream programs.	Letter of Intent Agency Intake Form	Uses single application for 4 or more services = 2 pts Does not use a single application for 4 or more services = 0 pts	
10. SSI/SSDI Technical Assistance	Measures whether program participants have access to SSI/SSDI technical assistance. The assistance can be provided by the applicant, a sub-recipient, or a partner agency through a formal or informal relationship. Subrecipients may choose to have their own process or utilize arrangement set forth in the MOU between Riverside County CoC and DPSS.	Agency Letter	It is evident that program participants have access to SSI/SSDI technical assistance = 1 pt It is NOT evident that program participants have access to SSI/SSDI technical assistance = 0 pts	
SYSTEM COMPLIANCE (20 points)				
11. Program Monitoring	Measures whether the applicant has had any negative findings from program monitoring by any funding source during the prior 2 years.	Monitoring Report From Funding Source	No Finding = 10 pts Finding with correction = 5 pts Finding with no correction = 0 pts	
12. Housing Quality (NSPIRE)	Measures whether the project meets applicable housing standards. • Commitment to housing inspections being completed prior client entering a unit • Plan includes regular housing inspections are completed annually	Application Agency Policy	Includes commitment to housing inspections = 3 pts Includes plan for regular housing inspections = 2 pts No reference = 0 pts (max. 5 pts)	
13. Documentation of Supportive Services	Measures whether the project will regularly enter data into HMIS (or comparable data tracking mechanism) to report receipt of mainstream benefits or external resources and renew benefits when required: PSH – at least annually - RRH – at least monthly.	Commitment Letter HMIS (or comparable data tracking mechanism)	Includes supportive services data entry plan = 5 pts No Supportive services plan or less than monthly= 0 pts	
Fiscal Management (30 points)				
14. Effective Use of Funds – Regular Submittal of Claims	Measures whether the project plans to submit claims on a regular basis. Evaluated during most recently completed fiscal year for agency.	Fiscal Report from a Funding Agency	3 points for plan and 4 points for evidence of billings regularly submitted during the contract period. (max. 7 pts)	
15. Use of External Funding	Measures effective management of non-public funds	Evidence of private funding award(s); Report on use and outcomes	3 or more various sources, over 5 years = 5 pts 1 source Over 5 years = 4 pts 1 source over 3-5 years = 3 pts 1 source over 1-2 years = 1 pt	

			No sources or less than one year = 0 pts	
16. Recaptured Funds (unspent funds)	Measures whether the agency had unspent funds from grant sources during the past 2 years. Based on percentage of total project budget.	Fiscal Report Audit	0% unspent funds = 13 pts 1% to 4% unspent funds = 8 pts 5%+ unspent funds = 0 pts	
17. Cost-effectiveness	Measures percentage of rental assistance costs per successful housing placement. Cost effectiveness will be based on the median of the total rental assistance costs per successful housing placement.	Fiscal Report	At or below median cost of successful housing placement (per bed) = 5 pts 0.01% - 9.99% higher median cost of successful housing placement (per bed) = 4 pts 10.00% - 14.99% higher median cost of successful housing placement (per bed) = 3 pts 15.00% - 19.99% higher median cost of successful housing placement (per bed) = 2 pts 20.00% - 24.99% higher median cost of successful housing placement (per bed) = 1 pt 25.00% or higher median cost of successful housing placement (per bed) = 0 pts	
HMIS Compliance (2 points)				
18. HMIS Timeliness	Measures the commitment to timeliness of HUD-required data entry plan. Client entry and exit must be recorded within 7 days	Agency Letter and/or Policy	7 days = 1 pt More than 7 days = 0 pts	
19. HMIS Accuracy and Completeness	Measures the accuracy and completeness of HUD-required universal data elements and program specific data elements. Information entered must be valid and accurately represent client information. If not a current HMIS participant, measures data completeness in an alternate data base.	HMIS Data Quality Report or agency report from comparable Data Base	0% - 4.99% = 1 pt 6% or higher = 0 pts	

Total Possible Score: 92 **Total Project Score: _____**

Applicant Experience: 10 points

Project Design: 30 points

System Compliance: 20 points

Fiscal Management: 30 points

HMIS or Data Compliance: 2 points

2024 HUD CoC Program Competition Project Scorecard

Renewal Projects

Any applicant must meet these HUD mandated criteria in order to receive grant funds.

New and Renewal project applicants must meet these conditions to be included in application scoring.

Section 1: Applicant Eligibility Threshold

Organization:_____ Project Name:_____ Project Type:_____ Eligibility Threshold Score: _____

Scoring Criteria	Description	Data Source	Possible Score	Score
Eligibility Threshold – HUD Mandates				
Housing First (HF) (HUD-CoC Priorities and Requirements)	Measures the project's entry process that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as income, sobriety, criminal history).	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Participation in Coordinated Entry System (HUD-CoC Priorities and Requirements)	The subrecipient participates in CES and complies with CES Policies and Procedures.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Participation of homeless in Decision-making (HEARTH Act Compliance)	Measures whether the agency provides for the participation of not less than one homeless individual or formerly homeless on the board of directors or other equivalent policymaking entity.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Participation of homeless through employment or volunteerism (HEARTH Act Compliance)	Measures whether the agency involves homeless individuals and families through employment; volunteer services; or operating the project, and/or in providing supportive services for the project.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Engagement in religious activities (HEARTH Act Compliance)	Measures whether the agency uses direct program funds to support or engage in any explicitly religious activities. Any federal and state funds distributed by the CoC can only be spent on non-religious social services activities and cannot mandate participation in religious activities to receive services.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Involuntary family separation (HEARTH Act Compliance)	Measures whether the project accepts all families with children under age 18 without regard to the age of any child as appropriate per project target population. The age and gender of a child under the age 18 must not be used as a basis for denying any family's admission to project receives funds under this part (24CFR§578.93).	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	

JG Updated: 6/21/2024

Discrimination Policy (HEARTH Act Compliance)	Measures whether the project does not discriminate for project entry.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	
Continuum of Care Participation (HEARTH Act Compliance)	Measures whether the agency participates as a CoC member in good standing. As required in the Board of Governance Charter for the CoC, each agency must have a designated representative who is required to attend fifty percent plus one (50% + 1) CoC meetings per year.	CoC Attendance Records	Met the minimum requirement = 1 Did not meet the minimum requirement = 0	

Section 2: Project Scoring

Applicant Name: _____Project Name: _____ Project Type: _____ Project Score: _____

System Performance Measures (20 points)				
1. Length of Time Persons Remain Homeless	Measures the average number of days from project entry to residential move-in.	SPM/HMIS Report	0 - 70 days = 5 pts 71 days or above = 0 pts	
2. Housing Stability (Obtain and maintain Permanent Housing)	Measures the average percentage of participants that remain in or move to permanent housing (goal is at least 90%). (RRH % moved to PH and PSH % retained and/or moved to PH)	SPM/HMIS Report	90.00% + = 5 pts 80.00% -89.99% = 4 pts 75.00% - 79.99% = 3 pts 74.99% or below = 0 pts	
3. Return to Homelessness	Measures the average percentage of participants that return to homelessness at exit (goal is no more than 10.99%).	SPM/HMIS Report	0.00%-0.99% = 5 pts 1.00% - 5.99% = 4 pts 6.00% - 10.99% = 3 pts 11.00% or more = 0 pts	
4. Income Growth	Measures the average percentage of adult participants who increased their total income (from all sources). (For Stayers: use Q19 A1; and for Leavers: use Q19 A2)	SPM/HMIS Report	12.00% and above = 5 pts 8.00% -11.99% = 4 pts 5.00% - 7.99% = 3 pts 1.00% - 4.99% = 2 pts 0.00% - 0.99% = 1 pt Decrease = 0 pts	
Program Compliance (40 points)				
5. Annual Performance Report (APR)	Measures whether sub-recipients submit their APR to HWS CoC Division for review within 60 days after the project ends.	HWS/SAGE Report	Timely submission = 5 pts Late submission = 0 pts	
6. Monitoring Report (Program)	Measures whether the project has had any findings during the 12-month period based on the most recent monitoring report by the Collaborative Applicant (HWS).	Monitoring Report	No Findings = 10 pts Finding with correction = 5 pts Finding with no correction = 0 pts	
7. Housing Quality (NSPIRE)	Measures whether the project meets applicable housing standards. • If housing inspections are completed prior client entering a unit • If housing inspections are completed annually	Monitoring Report	No HQ Finding = 3 pts Finding = 0 pts	

8. Bed Utilization	Measures occupancy rates beds/units supported by the project.	APR	95% - 100% = 10 pts 90% - 94.99% = 8 pts 85% - 89.99% = 6 pts 84.99% or below = 0 pts	
9. Access to Mainstream Benefits	Measures whether the project provides regular or as needed transportation assistance to mainstream and community resources, including appointments, employment training, educational programs, or jobs.	Monitoring Report	No Access to Services Finding = 3 pts Finding = 0 pts	
10. Mainstream Benefits Applications	Measures whether the project uses a single application form that allows program participants to sign up for four or more mainstream programs.	Letter of Intent Agency Intake Form	Uses single application for 4 or more services = 3 pts Does not use a single application for 4 or more services = 0 pts	
11. SSI/SSDI Technical Assistance	Measures whether program participants have access to SSI/SSDI technical assistance. The assistance can be provided by the applicant, a sub-recipient, or a partner agency through a formal or informal relationship. Subrecipients may choose to have their own process or utilize arrangement set forth in the MOU between Riverside County CoC and DPSS.	Letter of Intent and Monitoring Report	Access to SSI/SSDI = 3 pts No access to SSI/SSDI = 0 pts	
12. Supportive Services Follow Up	Measures whether the project regularly follows-up with program participants to ensure that they have applied for, are receiving their mainstream benefits, and renew benefits when required: PSH – at least annually - RRH – at least monthly.	Monitoring Report	No supportive services finding = 3 pts Supportive services finding = 0 pts	
Fiscal Compliance (30 points)				
13. Monthly Submission of Claims	Measures whether the project submits monthly claims on time (within 30 days after the end of the service month) and correctly (no major disallowances, deferments, or changes) as required. Evaluated using the 12 most recent monthly claims as of the date of scoring.	Fiscal Report	1 point per monthly claim submitted on time with no major corrections. 0 points per monthly claim submitted that was late and/or had major corrections. (up to 12 points)	
14. Recaptured Funds (unspent funds)	Measures whether the project returned any funds in the last 2 completed grant years. Based on percentage of total project budget. ***Note: Any unspent funds are subject to being reallocated regardless of amount or score.***	HUD Closeouts Unspent Report	Less than 1.00% unspent funds = 13 pts 1.00% to 4.99% unspent funds = 8 pts 5.00%+ unspent funds = 0 pts	

15. Cost-effectiveness	Measures percentage of rental assistance costs per successful housing placement. Cost effectiveness will be based on the median of the total rental assistance costs per successful housing placement.	Fiscal Report	At or below median cost of successful housing placement (per bed) = 5 pts 0.01% - 9.99% higher median cost of successful housing placement (per bed) = 4 pts 10.00% - 14.99% higher median cost of successful housing placement (per bed) = 3 pts 15.00% - 19.99% higher median cost of successful housing placement (per bed = 2 pts 20.00% - 24.99% higher median cost of successful housing placement (per bed) = 1 pt 25.00% or higher median cost of successful housing placement (per bed) = 0 pts	
HMIS Compliance (2 points)				
16. HMIS Timeliness	Measures the timeliness of HUD-required data entry. Client entry and exit must be recorded within 7 days	HMIS Data Quality Report	7 days = 1 pt More than 7 days = 0 pts	
17. HMIS Data Quality	Measures the accuracy and completeness of HUD-required universal data elements and program specific data elements. Information entered must be valid and accurately represent client information.	HMIS Data Quality Report	0.00% - 4.99% = 1 pt 5.00% or higher = 0 pts	

Total Possible Score: 92

Total Project Score: _____

System Performance Measures: 20 points

Program Compliance: 40 points

Fiscal Compliance: 30 points

HMIS Compliance: 2 points

2024 HUD CoC Program Competition Project Scorecard

Renewal Projects

Any applicant must meet these HUD mandated criteria in order to receive grant funds.

New and Renewal project applicants must meet these conditions to be included in application scoring.

Section 1: Applicant Eligibility Threshold

Organization: Jewish Family Services **Project Name: JFS PSH Consolidation** **Project Type: PSH** **Eligibility Threshold Score: 8**

Scoring Criteria	Description	Data Source	Possible Score	Score
Eligibility Threshold – HUD Mandates				
Housing First (HF) (HUD-CoC Priorities and Requirements)	Measures the project's entry process that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as income, sobriety, criminal history).	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Participation in Coordinated Entry System (HUD-CoC Priorities and Requirements)	The subrecipient participates in CES and complies with CES Policies and Procedures.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Participation of homeless in Decision-making (HEARTH Act Compliance)	Measures whether the agency provides for the participation of not less than one homeless individual or formerly homeless on the board of directors or other equivalent policymaking entity.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Participation of homeless through employment or volunteerism (HEARTH Act Compliance)	Measures whether the agency involves homeless individuals and families through employment; volunteer services; or operating the project, and/or in providing supportive services for the project.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Engagement in religious activities (HEARTH Act Compliance)	Measures whether the agency uses direct program funds to support or engage in any explicitly religious activities. Any federal and state funds distributed by the CoC can only be spent on non-religious social services activities and cannot mandate participation in religious activities to receive services.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Involuntary family separation (HEARTH Act Compliance)	Measures whether the project accepts all families with children under age 18 without regard to the age of any child as appropriate per project target population. The age and gender of a child under the age 18 must not be used as a basis for denying any family's admission to project receives funds under this part (24CFR§578.93).	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1

JG Updated: 6/21/2024

Discrimination Policy (HEARTH Act Compliance)	Measures whether the project does not discriminate for project entry.	Letter of Intent Agency Policies	Policy received / Meets standard = 1 Policy not received / No = 0	1
Continuum of Care Participation (HEARTH Act Compliance)	Measures whether the agency participates as a CoC member in good standing. As required in the Board of Governance Charter for the CoC, each agency must have a designated representative who is required to attend fifty percent plus one (50% + 1) CoC meetings per year.	CoC Attendance Records	Met the minimum requirement = 1 Did not meet the minimum requirement = 0	1

Section 2: Project Scoring

Applicant Name: Jewish Family Services **Project Name: JFS PSH Consolidation** **Project Type: PSH** **Project Score: 92**

System Performance Measures (20 points)				
1. Length of Time Persons Remain Homeless	Measures the average number of days from project entry to residential move-in.	SPM/HMIS Report	0 - 70 days = 5 pts 71 days or above = 0 pts	5
2. Housing Stability (Obtain and maintain Permanent Housing)	Measures the average percentage of participants that remain in or move to permanent housing (goal is at least 90%). (RRH % moved to PH and PSH % retained and/or moved to PH)	SPM/HMIS Report	90.00% + = 5 pts 80.00% -89.99% = 4 pts 75.00% - 79.99% = 3 pts 74.99% or below = 0 pts	5
3. Return to Homelessness	Measures the average percentage of participants that return to homelessness at exit (goal is no more than 10.99%).	SPM/HMIS Report	0.00%-0.99% = 5 pts 1.00% - 5.99% = 4 pts 6.00% - 10.99% = 3 pts 11.00% or more = 0 pts	5
4. Income Growth	Measures the average percentage of adult participants who increased their total income (from all sources). (For Stayers: use Q19 A1; and for Leavers: use Q19 A2)	SPM/HMIS Report	12.00% and above = 5 pts 8.00% -11.99% = 4 pts 5.00% - 7.99% = 3 pts 1.00% - 4.99% = 2 pts 0.00% - 0.99% = 1 pt Decrease = 0 pts	5
Program Compliance (40 points)				
5. Annual Performance Report (APR)	Measures whether sub-recipients submit their APR to HWS CoC Division for review within 60 days after the project ends.	HWS/SAGE Report	Timely submission = 5 pts Late submission = 0 pts	5
6. Monitoring Report (Program)	Measures whether the project has had any findings during the 12-month period based on the most recent monitoring report by the Collaborative Applicant (HWS).	Monitoring Report	No Findings = 10 pts Finding with correction = 5 pts Finding with no correction = 0 pts	10
7. Housing Quality (NSPIRE)	Measures whether the project meets applicable housing standards. • If housing inspections are completed prior client entering a unit • If housing inspections are completed annually	Monitoring Report	No HQ Finding = 3 pts Finding = 0 pts	3

8. Bed Utilization	Measures occupancy rates beds/units supported by the project.	APR	95% - 100% = 10 pts 90% - 94.99% = 8 pts 85% - 89.99% = 6 pts 84.99% or below = 0 pts	10 (128.49%)
9. Access to Mainstream Benefits	Measures whether the project provides regular or as needed transportation assistance to mainstream and community resources, including appointments, employment training, educational programs, or jobs.	Monitoring Report	No Access to Services Finding = 3 pts Finding = 0 pts	3
10. Mainstream Benefits Applications	Measures whether the project uses a single application form that allows program participants to sign up for four or more mainstream programs.	Letter of Intent Agency Intake Form	Uses single application for 4 or more services = 3 pts Does not use a single application for 4 or more services = 0 pts	3
11. SSI/SSDI Technical Assistance	Measures whether program participants have access to SSI/SSDI technical assistance. The assistance can be provided by the applicant, a sub-recipient, or a partner agency through a formal or informal relationship. Subrecipients may choose to have their own process or utilize arrangement set forth in the MOU between Riverside County CoC and DPSS.	Letter of Intent and Monitoring Report	Access to SSI/SSDI = 3 pts No access to SSI/SSDI = 0 pts	3
12. Supportive Services Follow Up	Measures whether the project regularly follows-up with program participants to ensure that they have applied for, are receiving their mainstream benefits, and renew benefits when required: PSH – at least annually - RRH – at least monthly.	Monitoring Report	No supportive services finding = 3 pts Supportive services finding = 0 pts	3
Fiscal Compliance (30 points)				
13. Monthly Submission of Claims	Measures whether the project submits monthly claims on time (within 30 days after the end of the service month) and correctly (no major disallowances, deferments, or changes) as required. Evaluated using the 12 most recent monthly claims as of the date of scoring.	Fiscal Report	1 point per monthly claim submitted on time with no major corrections. 0 points per monthly claim submitted that was late and/or had major corrections. (up to 12 points)	12
14. Recaptured Funds (unspent funds)	Measures whether the project returned any funds in the last 2 completed grant years. Based on percentage of total project budget. ***Note: Any unspent funds are subject to being reallocated regardless of amount or score.***	HUD Closeouts Unspent Report	Less than 1.00% unspent funds = 13 pts 1.00% to 4.99% unspent funds = 8 pts 5.00%+ unspent funds = 0 pts	13

15. Cost-effectiveness	Measures percentage of rental assistance costs per successful housing placement. Cost effectiveness will be based on the median of the total rental assistance costs per successful housing placement.	Fiscal Report	At or below median cost of successful housing placement (per bed) = 5 pts 0.01% - 9.99% higher median cost of successful housing placement (per bed) = 4 pts 10.00% - 14.99% higher median cost of successful housing placement (per bed) = 3 pts 15.00% - 19.99% higher median cost of successful housing placement (per bed = 2 pts 20.00% - 24.99% higher median cost of successful housing placement (per bed) = 1 pt 25.00% or higher median cost of successful housing placement (per bed) = 0 pts	5
HMIS Compliance (2 points)				
16. HMIS Timeliness	Measures the timeliness of HUD-required data entry. Client entry and exit must be recorded within 7 days	HMIS Data Quality Report	7 days = 1 pt More than 7 days = 0 pts	1
17. HMIS Data Quality	Measures the accuracy and completeness of HUD-required universal data elements and program specific data elements. Information entered must be valid and accurately represent client information.	HMIS Data Quality Report	0.00% - 4.99% = 1 pt 5.00% or higher = 0 pts	1

Total Possible Score: 92

Total Project Score: 92

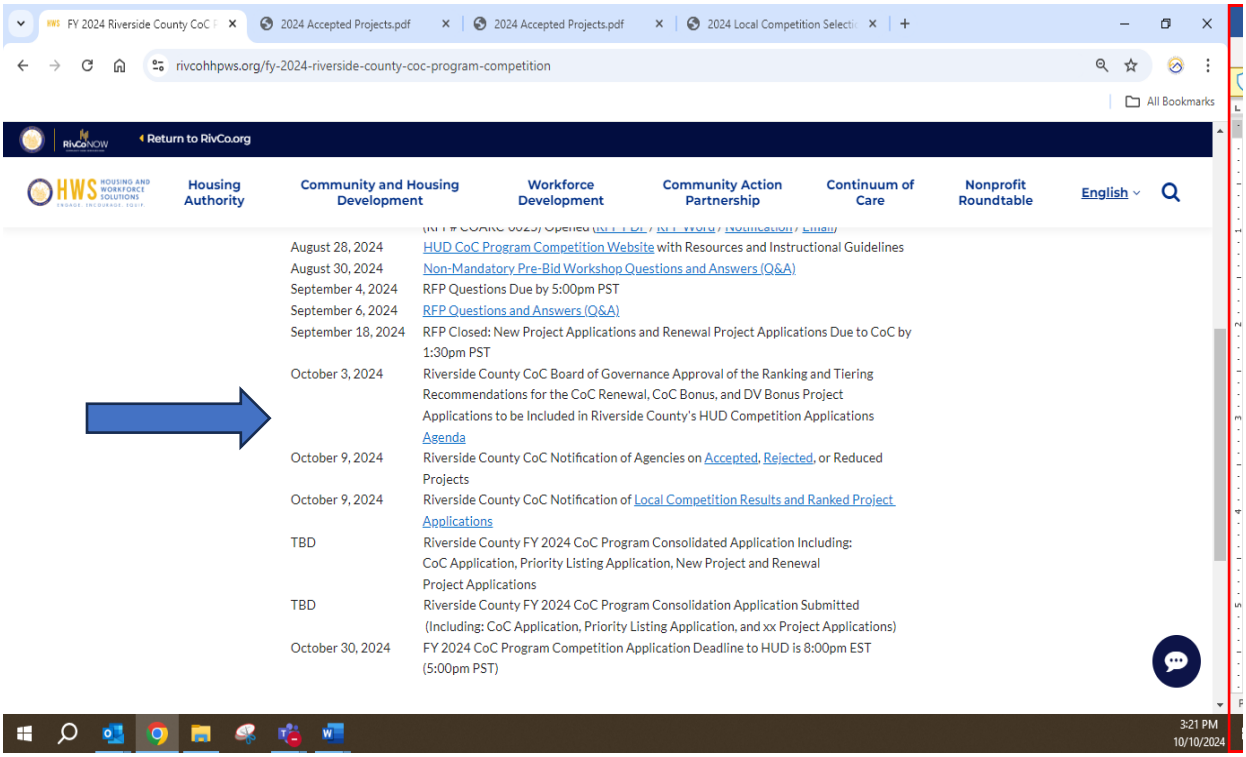
System Performance Measures: 20 points

Program Compliance: 40 points

Fiscal Compliance: 30 points

HMIS Compliance: 2 points

1E-5. Notification of Projects Rejected-Reduced



FY2024 Riverside County CoC Program Competition- Rejected Projects

Ranking #	Project Details							
	Agency	Project Name	Grant Amount	Project Status	Project Type	# of Units	# of Beds	Supervisorial Districts
N/A	RUHS-Behavioral Health	2024 CA0935 RUHS-BH PSH-SS EXPANSION	$619,287	New	PSH	25	28	All
N/A	His Daughters House	2024 His Daughters House CH RRH	$1,389,233	New	RRH	32	72	All
N/A	Inland Compassion	2024 Inland Compassion RRH	$640,906	New	RRH	19	39	All
N/A	Dept. of Public Social Services	2024 DPSS-ASD RRH	$736,776	New	RRH	30	30	All
N/A	Jewish Family Services	CA1900 JFSSD Desert Rose PSH EXPANSION	$247,601	New	PSH	8	12	4
N/A	Lutheran Social Services	2024 Lutheran Social Service Centers RRH	$731,192	New	RRH	25	53	1,2,3,5
N/A	Transgender Health and Wellness Center	2024 Transgender Health & Wellness Center TH-RRH	$351,582	New	RRH	3	6	All
N/A	Step Up On Second	2024 Step Up On Second PSH	$2,104,424	New	PSH	90	90	All
N/A	Coachella Valley Rescue Mission	2024 CVRM RRH	$561,752	New	RRH	30	46	4
N/A	Pride Pathways	2024 Pride Pathways PSH	$5,597,934	New	PSH	50	101	All

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:27 AM
To: Teri Ortiz
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - CVRM.pdf

Dear Teri Ortiz,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 CVRM RRH	Rejected	New	30	46	$561,752	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

Please do not let this experience deter you from submitting applications and proposals to our future funding opportunities. Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Coachella Valley Rescue Mission
Teri Ortiz

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Teri Ortiz,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 CVRM RRH	Rejected	New	30	46	$561,752	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

Please do not let this experience deter you from submitting applications and proposals to our future funding opportunities. Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:31 AM
To: Wolbeck, Erin; Salas, Linda; Ortiz, Karen
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - DPSS-ASD.pdf

Dear Erin Wolbeck,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 DPSS-ASD RRH	Rejected	New	30	30	$736,776	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

DPSS-ASD
Erin Wolbeck

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Erin Wolbeck,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:35 AM
To: Adrianne Mason; Tolia Terrell
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - HDH.pdf

Dear Dr. Adrianne Mason,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 HDH RRH CH	Rejected	New	32	72	$1,389,233	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

His Daughters House
Dr. Adrianne Mason

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Dr. Adrianne Mason,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:38 AM
To: James Armour
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - Inland Compassion.pdf

Dear James Armour,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 Inland Compassion RRH	Rejected	New	19	39	$640,906	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Inland Compassion
James Armour

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear James Armour,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:42 AM
To: Mike Phillips; beckyr@jfssd.org; Joel Craddock; elisav@jfssd.org
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - JFS.pdf

Dear Mike Phillips,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
CA1900 JFSSD Desert Rose PSH Expansion	Rejected	New	8	12	$247,601	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Jewish Family Services
Mike Phillips

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Mike Phillips,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:45 AM
To: Ly-Bach Truong
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - LSSC.pdf

Dear Ly-Bach Truong,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 Lutheran Social Service Center RRH	Rejected	New	25	53	$731,192	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Lutheran Social Services
Ly-Bach Truong

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Ly-Bach Truong,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:47 AM
To: Brenton Lipscomb
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - Pride Pathways.pdf

Dear Brenton Lipscomb,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 Pride Pathways PSH	Rejected	New	50	101	$5,597,934	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Pride Pathways
Brenton Lipscomb

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:50 AM
To: Marcus Cannon; Lorissa Villarreal; Monique Rodriguez-Torres; Solinda Ly
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - RUHS-BH.pdf

Dear Marcus Cannon,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
CA0935 RUHS-BH PSH-SS Expansion	Rejected	New	25	28	$619,287	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

RUHS-Behavioral Health
Marcus Cannon

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Marcus Cannon,

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:52 AM
To: Kim Williams
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - SUOS.pdf

Dear Kim Williams,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 Step Up On Second PSH	Rejected	New	90	90	$2,104,424	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Step Up On Second
Kim Williams

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Kim Williams,

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 8:54 AM
To: Thomi Clinton; Marisol Leos; Jocelyn Kennedy; Finance Finance
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Rejection - THWC.pdf

Dear Thomi Clinton,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

Project Name	Acceptance Status	Project Status	# of Units	# of Beds	Amount ($)	Reasons for Rejection
2024 Transgender Health & Wellness Center TH-RRH	Rejected	New	3	6	$351,582	Did not pass panel review

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities. More information on this funding opportunity can be found on the CoC NOFO webpage.

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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 8, 2024

Transgender Health & Wellness Center
Thomi Clinton

RE: **FY 2024 Riverside County Continuum of Care Program Competition – Letter of Rejection**

Dear Thomi Clinton,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. While we appreciate your efforts, we regret to inform you that your proposed project was not selected for inclusion in the FY 2024 Riverside County CoC Program Competition application.

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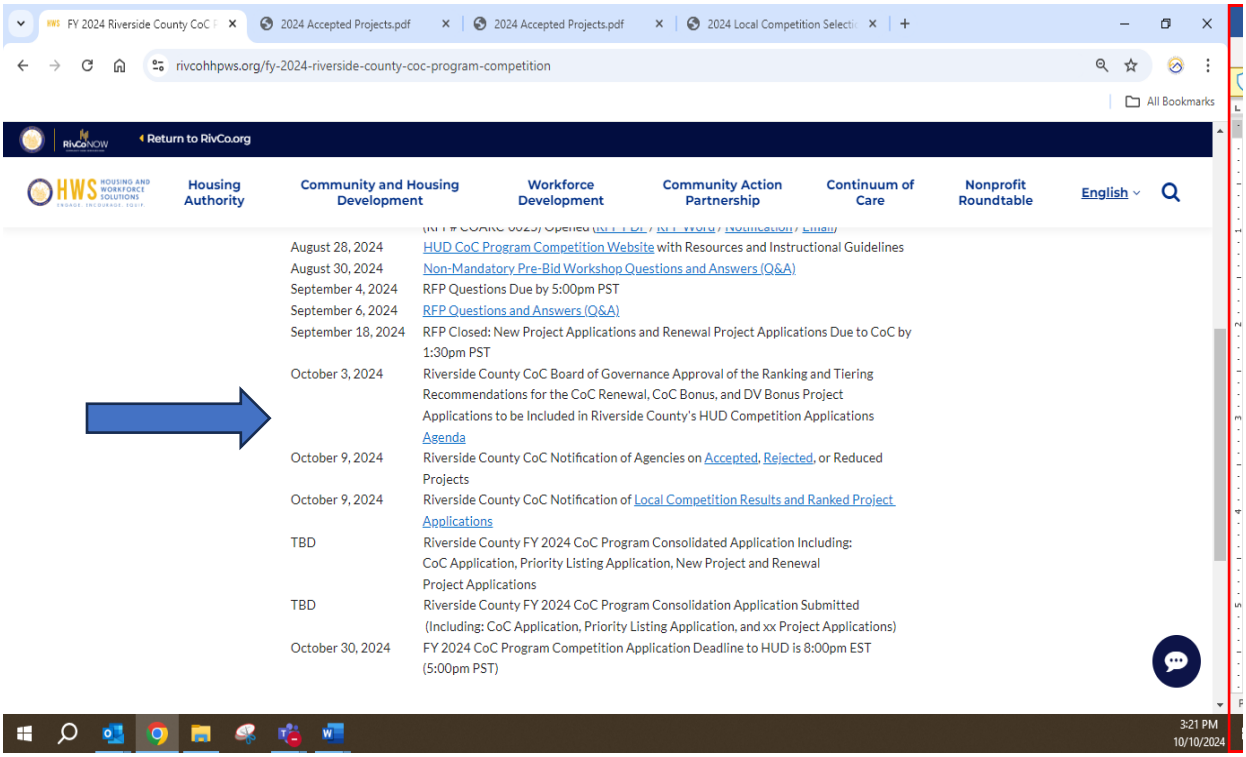
Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

1E-5a. Notification of Projects Accepted



FY2024 Riverside County CoC Program Competition- Accepted Projects

Ranking #	Project Details							
	Agency	Project Name	Grant Amount	Project Status	Project Type	# of Units	# of Beds	Supervisorial Districts
N/A	County of Riverside HWS	2024 Riverside County Planning	$876,843	Renewal	Planning	N/A	N/A	All
1	RUHS-Behavioral Health	CA1449 RUHS-BH CES SSO-CE	$1,150,000	Renewal	CES	N/A	N/A	All
2	County of Riverside HWS	CA0672 HMIS	$344,072	Renewal	HMIS	N/A	N/A	All
3	Lighthouse Social Service Centers	CA2049 LHSSC PSH	$408,194	Renewal	PSH	15	18	All
4	Mercy House	CA2050 Mercy House PSH-SS	$64,099	Renewal	PSH	24	29	1
5	Valley Restart Shelter	CA2051 VRS RRH	$433,030	Renewal	RRH	10	30	3,5
6	City of Riversde	CA2052 City of Riverside RRH	$208,762	Renewal	RRH	10	10	1
7	RUHS-Behavioral Health	CA2053 RUHS-BH PSH	$830,423	Renewal	PSH	43	43	All
8	RUHS-Behavioral Health	CA2054 RUHS-BH H&HC PSH	$135,392	Renewal	PSH	4	4	All
9	County of Riverside HWS Subcontractors: - Lighthouse Social Service Center - Transgender Health & Wellness Center	CA2055 Riverside County DV RRH	$2,084,563	Renewal	RRH	100	120	All
10	His Daughters House	CA2182 HDH H2H RRH	$467,460	Renewal	RRH	32	45	1,3,5
11	Jewish Family Services of San Diego	CA0670 JFSSD PSH	$2,253,629	Renewal	PSH	73	93	4
12	Lighthouse Social Service Centers	CA0665 LHSSC PSH DWWC	$327,837	Renewal	PSH	12	36	1,2,3,5
13	Lighthouse Social Service Centers	CA1708 LHSSC Riverside PSH	$459,918	Renewal	PSH	22	29	All
14	Path of Life Ministries	CA1364 POLM PSH	$1,776,714	Renewal	PSH	80	92	1,2,4,5
15	RUHS-Behavioral Health	CA0935 RUHS-BH PSH-SS	$1,818,722	Renewal	PSH	98	185	All
16	Jewish Family Services of San Diego	CA1900 JFSSD Desert Rose PSH (Total $1,313,065 btw Tier 1 & Tier 2)	$501,057	Renewal	PSH	42	55	4
17	Lighthouse Social Service Centers	CA1367 LHSS SSC RRH	$343,302	Renewal	RRH	12	40	All
18	City of Riverside	CA1055 CoR PSH-SS CH	$158,376	Renewal	PSH	8	8	1
19	City of Riverside	CA0936 CoR PSH-SS for Disabled	$160,077	Renewal	PSH	9	12	All
20	Illumination Foundation	2024 Illumination Foundation PSH	$867,681	New	PSH	25	30	1,2,5
21	Path of Life Ministries	2024 CA1364 POLM PSH Expansion	$569,275	New	PSH	10	27	1,2,4,5
22	RUHS-BH	CA2053 RUHS-BH PSH Expansion	$619,287	New	PSH	25	28	All
23	His Daughters House	2024 HDH DV TH-RRH	$979,701	New	RRH	22	58	All
24	His Daughters House	2024 HDH DV RRH	$1,448,624	New	RRH	32	82	All

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 6:43 AM
To: Davis, Michelle; Chatlos, Lisa
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - CoR.pdf

Dear Michelle Davis,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0936 CoR PSH-SS for Disabled	Accepted - Renewal	9	12	$160,077
CA1055 CoR PSH-SS CH	Accepted - Renewal	8	8	$158,376
CA2052 CoR RRH	Accepted - Renewal	10	10	$208,762

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

City of Riverside
Michelle Davis

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Michelle Davis,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0936 CoR PSH-SS for Disabled	Accepted - Renewal	9	12	$160,077
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 6:48 AM
To: Adrianne Mason; Tolia Terrell
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - HDH.pdf

Dear Dr. Adrianne Mason,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2182 HDH H2H RRH	Accepted - Renewal	32	45	$467,460
2024 HDH DV TH-RRH	Accepted - New	22	58	$979,701
2024 HDH DV RRH	Accepted - New	32	82	$1,448,624

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

His Daughters House
Dr. Adrianne Mason

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Dr. Adrianne Mason,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2182 HDH H2H RRH	Accepted - Renewal	32	45	$467,460
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 1:02 PM
To: Ng, Kin Tat Natalis
Cc: HMISSupport; Torno, Tanya C; Walker, Raushanah; Perez-Singh, Emma; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - HWS HMIS.pdf

Dear Natalis Ng,

We are pleased to inform you that your agency's project proposal below has been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0672 HMIS	Accepted - Renewal	N/A	N/A	$344,072

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Housing & Workforce Solutions – HMIS Lead Agency
Natalis Ng

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Natalis Ng,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0672 HMIS	Accepted - Renewal	N/A	N/A	$344,072

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 6:51 AM
To: Carol Slezak
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - IF.pdf

Dear Carol Slezak,

We are pleased to inform you that your agency's project proposal below has been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
2024 Illumination Foundation PSH	Accepted - New	25	30	$867,681

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Illumination Foundation
Carol Slezak

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Carol Slezak,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
2024 Illumination Foundation PSH	Accepted - New	25	30	$867,681

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 6:55 AM
To: Mike Phillips; beckyr@jfssd.org; Joel Craddock; Elisa Villarreal
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - JFS.pdf

Dear Mike Phillips,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0670 JFSSD PSH	Accepted - Renewal	73	93	$2,253,629
CA1900 JFSSD Desert Rose PSH	Accepted - Renewal	42	55	$1,313,065

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Jewish Family Services
Mike Phillips

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Mike Phillips,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:00 AM
To: Karyn Young-Lowe; Tania Johnson; Heather Burroughs; Jesse Gross; Danielle Banks
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - LHSSC.pdf

Dear Karyn Young-Lowe,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0665 LHSSC PSH DWWC	Accepted - Renewal	12	36	$327,837
CA1708 LHSSC Riverside PSH	Accepted - Renewal	22	29	$459,918
CA1367 LHSSC SSC RRH	Accepted - Renewal	12	40	$343,302
CA2049 LHSSC PSH	Accepted - Renewal	15	18	$408,194
CA2055 Riverside County DV RRH	Accepted - Renewal	80	96	$1,667,650

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Lighthouse Social Service Center
Karyn Young-Lowe

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Karyn Young-Lowe,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0665 LHSSC PSH DWWC	Accepted - Renewal	12	36	$327,837
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CA1367 LHSSC SSC RRH	Accepted - Renewal	12	40	$343,302
CA2049 LHSSC PSH	Accepted - Renewal	15	18	$408,194
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:02 AM
To: Allison Davenport; Charles Chatman; Kaitlin Noyes; Isaac Hernandez
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - Mercy House.pdf

Dear Allison Davenport,

We are pleased to inform you that your agency's project proposal below has been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2050 Mercy House PSH-SS	Accepted - Renewal	24	29	$64,099

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Mercy House
Allison Davenport

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Allison Davenport,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:07 AM
To: coberg@thepathoflife.com; Victor Beecham; Jennifer Phaller
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - POLM.pdf

Dear Chris Oberg,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA1364 POLM PSH	Accepted - Renewal	80	92	$1,776,714
CA1364 POLM PSH Expansion	Accepted - New	10	27	$569,275

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Path of Life Ministries
Chris Oberg

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Chris Oberg,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

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CA1364 POLM PSH	Accepted - Renewal	80	92	$1,776,714
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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:10 AM
To: Marcus Cannon; Lorissa Villarreal; Monique Rodriguez-Torres; Solinda Ly
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - RUHS-BH.pdf

Dear Marcus Cannon,

We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0935 RUHS-BH PSH-SS	Accepted - Renewal	98	185	$1,818,722
CA1449 RUHS-BH CES SSO-CE	Accepted - Renewal	N/A	N/A	$1,150,000
CA2053 RUHS-BH PSH	Accepted - Renewal	43	43	$830,423
CA2053 RUHS-BH PSH Expansion	Accepted - New	25	28	$619,287
CA2054 RUHS-BH H&HC PSH	Accepted - Renewal	4	4	$135,392

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

RUHS-Behavioral Health
Marcus Cannon

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Marcus Cannon,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA0935 RUHS-BH PSH-SS	Accepted - Renewal	98	185	$1,818,722
CA1449 RUHS-BH CES SSO-CE	Accepted - Renewal	N/A	N/A	$1,150,000
CA2053 RUHS-BH PSH	Accepted - Renewal	43	43	$830,423
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Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:14 AM
To: Thomi Clinton; Marisol Leos; Jocelyn Kennedy; Finance Finance
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - THWC.pdf

Dear Thomi Clinton,

We are pleased to inform you that your agency's project proposal below has been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2055 Riverside County DV RRH	Accepted - Renewal	20	24	$416,913

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Transgender Health & Wellness Center
Thomi Clinton

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Thomi Clinton,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2055 Riverside County DV RRH	Accepted - Renewal	20	24	$416,913

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

Goodner, Jamie

From: CoC
Sent: Wednesday, October 9, 2024 7:16 AM
To: Javier Lopez; quinnslq1@verizon.net
Cc: Torno, Tanya C; Perez-Singh, Emma; Walker, Raushanah; Wormley, Katherine; Goodner, Jamie
Subject: 2024 HUD CoC Program Project Application - Result Notification
Attachments: FY 2024 CoC Program Letter of Acceptance - VRS.pdf

Dear Javier Lopez,

We are pleased to inform you that your agency's project proposal below has been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2051 VRS RRH	Accepted - Renewal	10	30	$433,030

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

Our team will be working with you to finalize your project application(s) to meet HUD's application submission deadline by October 30, 2024. Award announcements from HUD are anticipated in early 2025 and you will be notified of HUD's decision at that time. More information on this funding opportunity can be found on the CoC NOFO webpage.

Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

October 9, 2024

Valley Restart Shelter
Javier Lopez

RE: FY 2024 Riverside County Continuum of Care Program Competition – Letter of Acceptance

Dear Javier Lopez,

Thank you for your proposal in response to the Request For Proposal (RFP) #COARC-0025 FY 2024 Continuum of Care (CoC) Program Competition. We are pleased to inform you that your agency's project proposals below have been accepted for inclusion in the FY 2024 Riverside County Continuum of Care (CoC) Program Competition application.

Project Name	Project Status	# of Units	# of Beds	Amount
CA2051 VRS RRH	Accepted - Renewal	10	30	$433,030

There was a total of 34 project applications (19 renewal and 15 new) ranked by the CoC's Independent Review Panel of which 10 new projects were not selected. During the Riverside County CoC Board of Governance (BoG) Meeting on October 3, 2024, the ranking and tiering recommendations for these CoC Renewal, CoC Bonus, and DV Bonus project applications were approved to be included in Riverside County's HUD CoC Competition application. Please click here to view the BoG Meeting agenda with the full project ranking and priorities.

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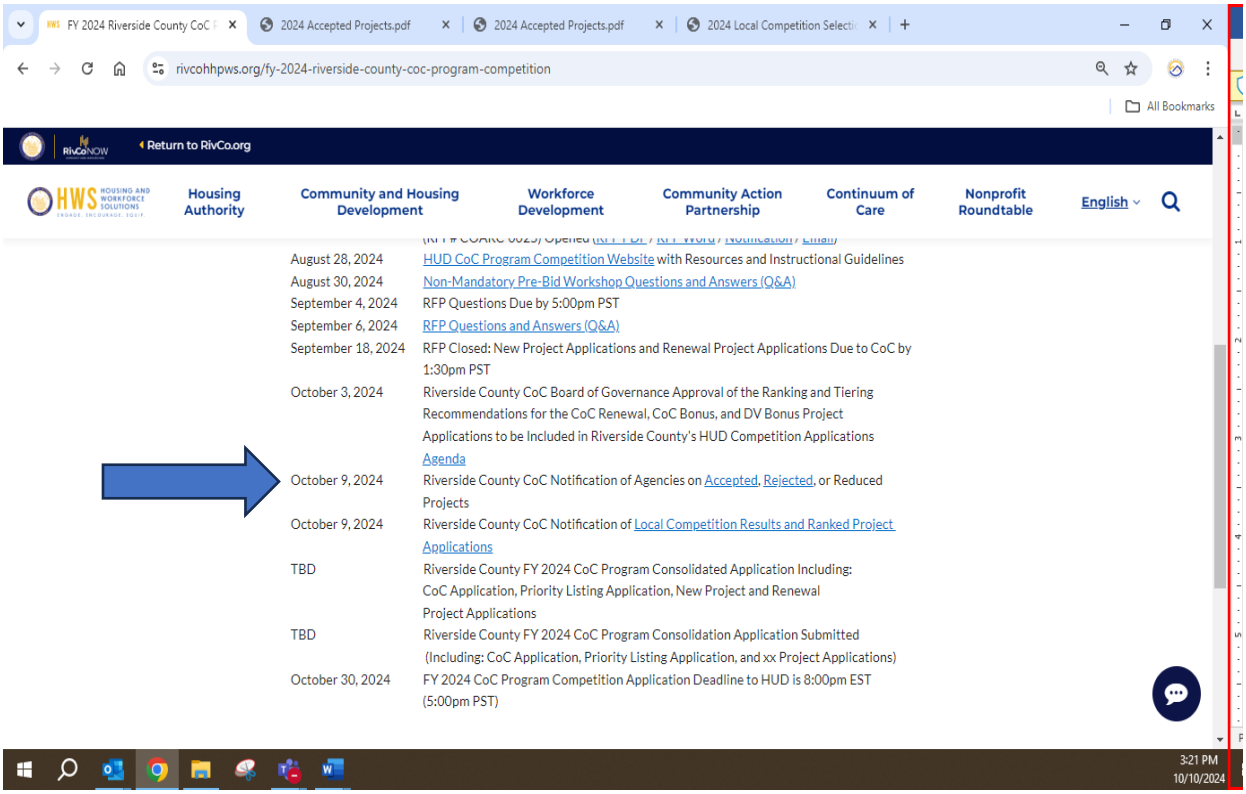
Should you have any questions or need further information, please contact us at CoC@rivco.org.

Sincerely,

Tanya Torno
Deputy Director
Continuum of Care

1E-5b. Local Competition Selection Results



Riverside County Continuum of Care Project Listing - Local Competition Results

Item No.	Project Name	Score	Accepted or Rejected	Rank (If Accepted)	Requested Funding Amount	Reallocated Funds
1	2024 Riverside County Planning	N/A*	Accepted	N/A*	$876,843	$0
2	CA1449 RUHS-BH CES SSO-CE	N/A**	Accepted	1	$1,150,000	$0
3	CA0672 HMIS	N/A**	Accepted	2	$344,072	$0
4	CA2049 LHSSC PSH	N/A***	Accepted	3	$408,194	$0
5	CA2050 Mercy House PSH-SS	N/A***	Accepted	4	$64,099	$0
6	CA2051 VRS RRH	N/A***	Accepted	5	$433,030	$0
7	CA2052 City of Riverside RRH	N/A***	Accepted	6	$208,762	$0
8	CA2053 RUHS-BH PSH	N/A***	Accepted	7	$830,423	$0
9	CA2054 RUHS-BH H&HC PSH	N/A***	Accepted	8	$135,392	$0
10	CA2055 Riverside County DV RRH	N/A***	Accepted	9	$2,084,563	$0
11	CA2182 HDH H2H RRH	N/A***	Accepted	10	$467,460	$0
12	CA0670 JFSSD PSH	100%	Accepted	11	$2,253,629	$0
13	CA0665 LHSSC PSH DWWC	95%	Accepted	12	$327,837	$0
14	CA1708 LHSSC Riverside PSH	95%	Accepted	13	$459,918	$0
15	CA1364 POLM PSH	92%	Accepted	14	$1,776,714	$0
16	CA0935 RUHS-BH PSH-SS	75%	Accepted	15	$1,818,722	$0
17	CA1900 JFSSD Desert Rose PSH (Between Tier 1 & Tier 2)	91%	Accepted	16	$501,057	$0
18	CA1367 LHSS SSC RRH	87%	Accepted	17	$343,302	$0
19	CA1055 CoR PSH-SS CH	92%	Accepted	18	$158,376	$0
20	CA0936 CoR PSH-SS for Disabled	83%	Accepted	19	$160,077	$0
21	2024 Illumination Foundation PSH	98%	Accepted	20	$867,681	$0
22	2024 CA1364 POLM PSH Expansion	97%	Accepted	21	$569,275	$0
23	CA2053 RUHS-BH PSH Expansion	86%	Accepted	22	$619,287	$0
24	2024 HDH DV TH-RRH	90%	Accepted	23	$979,701	$0
25	2024 HDH DV RRH	84%	Accepted	24	$1,448,624	$0
26	2024 CA0935 RUHS-BH PSH-SS EXPANSION	84%	Rejected	N/A****	$619,287	$0
27	2024 His Daughters House CH RRH	100%	Rejected	N/A****	$1,389,233	$0
28	2024 Inland Compassion RRH	81%	Rejected	N/A****	$640,906	$0
29	2024 DPSS-ASD RRH	80%	Rejected	N/A****	$736,776	$0
30	CA1900 JFSSD Desert Rose PSH EXPANSION	102%	Rejected	N/A****	$247,601	$0
31	2024 Lutheran Social Service Centers RRH	75%	Rejected	N/A****	$731,192	$0
32	2024 Transgender Health & Wellness Center TH-RRH	72%	Rejected	N/A****	$351,582	$0
33	2024 Step Up On Second PSH	71%	Rejected	N/A****	$2,104,424	$0
34	2024 CVRM RRH	68%	Rejected	N/A****	$561,752	$0
35	2024 Pride Pathways PSH	49%	Rejected	N/A****	$5,597,934	$0

Legend:

N/A* CoC Planning - Not Scored - Not Ranked

N/A** CES & HMIS - HUD Required - Not Scored

N/A*** Not Scored - Renewal projects with first term not yet completed - Basic Review Passed

N/A**** Rejected Project - Not Ranked - No Funding Requested

2024 HDX Competition Report

2024 Competition Report - Summary

CA-608 - Riverside City & County CoC

HDX Data Submission Participation Information

Government FY and HDX Module Abbreviation	Met Module Deadline*	Data From	Data Collection Period in HDX 2.0
2023 LSA	Yes	Government FY 2023 (10/1/22 - 9/30/23).	November 2023 to January of 2024
2023 SPM	Yes	Government FY 2023 (10/1/22 - 9/30/23).**	February 2024 to March 2024
2024 HIC	Yes	Government FY 2024. Exact HIC and PIT dates will vary by CoC. For most CoCs, it will be last Wednesday in January of 2024.	March 2024 to May 2024
2024 PIT	Yes	Government FY 2024. Exact HIC and PIT dates will vary by CoC. For most CoCs, it will be last Wednesday in January of 2024.	March 2024 to May 2024

1) FY = Fiscal Year
2) *This considers all extensions where they were provided.
2) **"Met Deadline" in this context refers to FY23 SPM submissions. Resubmissions from FY 2022 (10/1/21 - 9/30/22) were also accepted during the data collection period, but these previous year's submissions are voluntarily and are not required.

2024 Competition Report - LSA Summary & Usability Status

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

LSA Usability Status 2023

Category	EST AO	EST AC	EST CO	RRH AO	RRH AC	RRH CO	PSH AO	PSH AC	PSH CO
Fully Usable				☑	☑	☑			
Partially Usable									
Not Usable	☑	☑	☑				☑	☑	☑

EST

Category	2021	2022	2023
Total Sheltered Count	3,872	4,630	5,240
AO	2,828	3,323	3,899
AC	837	1,080	1,105
CO	228	259	263

RRH

Category	2021	2022	2023
Total Sheltered Count	2,959	3,013	3,856
AO	710	1,010	1,396
AC	2,249	2,003	2,472
CO	4	11	4

2024 Competition Report - LSA Summary & Usability Status

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

PSH

Category	2021	2022	2023
Total Sheltered Count	1,447	1,319	1,582
AO	1,046	947	1,145
AC	404	373	439
CO	0	1	0

1) Glossary: EST = Emergency Shelter, Save Haven, & Transitional Housing; RRH = Rapid Re-housing; PSH = Permanent Supportive Housing; AO = Persons in Households without Children; AC = Persons in Households with at least one Adult and one Child; CO=Persons in Households with only Children
2) Because people have multiple stays in shelter over the course of a year and stay in different household configurations, a single person can be counted in more than one household type. Therefore, the sum of the number of people by household type may be greater than the unique count of people.
3) Total Sheltered count only includes those served in HMIS participating projects reported by your CoC.
4) For CoCs that experienced mergers during any of these reporting periods, historical data will include only the original CoCs.

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than the look back stop date or client's date of birth, whichever is later.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.

Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, and SH	5,118	76.9	42.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	5,271	81.4	44.0

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

b. This measure is based on data element 3.917

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, SH, and PH (prior to "housing move in")	6,876	560.2	214.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to "housing move in")	7,036	561.7	216.0

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 2: Returns to Homelessness for Persons who Exit to Permanent Housing (PH) Destinations

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range. Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

	Total # of Persons Exited to a PH Destination (2 Yrs Prior)	Returns to Homelessness in Less than 6 Months (0 - 180 days)		Returns to Homelessness from 6 to 12 Months (181 - 365 days)		Returns to Homelessness from 13 to 24 Months (366 - 730 days)		Number of Returns in 2 Years	
Metric	**Count**	**Count**	**% of Returns**	**Count**	**% of Returns4**	**Count**	**% of Returns6**	**Count**	**% of Returns8**
Exit was from SO	122	14	11.5%	5	4.1%	7	5.7%	26	21.3%
Exit was from ES	1,355	174	12.8%	89	6.6%	103	7.6%	366	27.0%
Exit was from TH	46	3	6.5%	0	0.0%	2	4.4%	5	10.9%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	1,139	36	3.2%	33	2.9%	51	4.5%	120	10.5%
TOTAL Returns to Homelessness	2,662	227	8.5%	127	4.8%	163	6.1%	517	19.4%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

Please refer to PIT section for relevant data.

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

Metric	Value
Universe: Unduplicated Total sheltered homeless persons	5,383
Emergency Shelter Total	5,229
Safe Haven Total	0
Transitional Housing Total	176

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

This measure is divided into six tables capturing employment and non-employment income changes for system leavers and stayers. The project types reported in these metrics are the same for each metric, but the type of income and universe of clients differs. In addition, the projects reported within these tables are limited to CoC-funded projects.

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	401
Number of adults with increased earned income	16
Percentage of adults who increased earned income	4.0%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	401
Number of adults with increased non-employment cash income	128
Percentage of adults who increased non-employment cash income	31.9%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	401
Number of adults with increased total income	142
Percentage of adults who increased total income	35.4%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	172
Number of adults who exited with increased earned income	12
Percentage of adults who increased earned income	7.0%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Metric 4.5 – Change in non-employment cash income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	172
Number of adults who exited with increased non-employment cash income	24
Percentage of adults who increased non-employment cash income	14.0%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	172
Number of adults who exited with increased total income	33
Percentage of adults who increased total income	19.2%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 5: Number of Persons who Become Homeless for the First Time

This measures the number of people entering the homeless system through ES, SH, or TH (Metric 5.1) or ES, SH, TH, or PH (Metric 5.2) and determines whether they have any prior enrollments in the HMIS over the past two years. Those with no prior enrollments are considered to be experiencing homelessness for the first time.

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	4,755
Of persons above, count those who were in ES-EE, ES-NbN, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1,045
Of persons above, count those who did not have entries in ES-EE, ES-NbN, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	3,710

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	7,438
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1,453
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	5,985

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Measure 6 is not applicable to CoCs in this reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

This measures positive movement out of the homeless system and is divided into three tables: movement off the streets from Street Outreach (Metric 7a.1); movement into permanent housing situations from ES, SH, TH, and RRH (Metric 7b.1); and retention or exits to permanent housing situations from PH (other than PH-RRH).

Metric 7a.1 – Change in SO exits to temp. destinations, some institutional destinations, and permanent housing destinations

Metric	Value
Universe: Persons who exit Street Outreach	3,522
Of persons above, those who exited to temporary & some institutional destinations	970
Of the persons above, those who exited to permanent housing destinations	374
% Successful exits	38.2%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Metric 7b.1 – Change in ES, SH, TH, and PH-RRH exits to permanent housing destinations

Metric	Value
Universe: Persons in ES-EE, ES-NbN, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	5,915
Of the persons above, those who exited to permanent housing destinations	2,351
% Successful exits	39.8%

Metric 7b.2 – Change in PH exits to permanent housing destinations or retention of permanent housing

Metric	Value
Universe: Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project	1,880
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	1,826
% Successful exits/retention	97.1%

2024 Competition Report - SPM Data

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

System Performance Measures Data Quality

Data coverage and quality will allow HUD to better interpret your SPM submissions.

Metric	All ES, SH	All TH	All PSH, OPH	All RRH	All Street Outreach
Unduplicated Persons Served (HMIS)	5,229	176	2,071	4,000	5,159
Total Leavers (HMIS)	4,267	87	207	2,552	3,385
Destination of Don't Know, Refused, or Missing (HMIS)	215	2	12	245	631
Destination Error Rate (Calculated)	5.0%	2.3%	5.8%	9.6%	18.6%

2024 Competition Report - SPM Notes

CA-608 - Riverside City & County CoC

FY 2023 Reporting Year: 10/1/2022 - 9/30/2023

Notes For Each SPM Measure

Note: Cells may need to be resized to accomodate notes with lots of text.

Measure	Notes
Measure 1	No notes.
Measure 2	No notes.
Measure 3	No notes.
Measure 4	No notes.
Measure 5	No notes.
Measure 6	No Notes. Measure 6 was not applicable to CoCs in this reporting period.
Measure 7	No notes.
Data Quality	No notes.

2024 Competition Report - HIC Summary

CA-608 - Riverside City & County CoC

For HIC conducted in January/February of 2024

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current Beds in HMIS or Comparable Database	Total Year-Round, Current, Non-VSP Beds	Removed From Denominator: OPH EHV† Beds or Beds Affected by Natural Disaster*	Adjusted Total Year-Round, Current, Non-VSP Beds	Adjusted HMIS Bed Coverage Rate for Year-Round, Current Beds
ES	1,467	1,057	1,467	0	1,467	72.1%
SH	0	0	0	0	0	NA
TH	448	139	389	0	389	35.7%
RRH	830	830	830	0	830	100.0%
PSH	2,063	2,063	2,063	0	2,063	100.0%
OPH	0	0	0	0	0	NA
Total	**4,808**	**4,089**	**4,749**	**0**	**4,749**	**86.1%**

2024 Competition Report

CA-608 - Riverside City & Coun

For HIC conducted in January/I

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV† Beds or Beds Affected by Natural Disaster**	Adjusted Total Year-Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds
ES	1,467	0	0	0	0	NA
SH	0	0	0	0	0	NA
TH	448	0	59	0	59	0.00%
RRH	830	0	0	0	0	NA
PSH	2,063	0	0	0	0	NA
OPH	0	0	0	0	0	NA
Total	**4,808**	**0**	**59**	**0**	**59**	**0.00%**

2024 Competition Report

CA-608 - Riverside City & Coun

For HIC conducted in January/I

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS-Comparable Database	Adjusted Total Year-Round, Current, Non-VSP and VSP Beds	HMIS and Comparable Database Coverage Rate
ES	1,467	1,057	1,467	72.05%
SH	0	0	0	NA
TH	448	139	448	31.03%
RRH	830	830	830	100.00%
PSH	2,063	2,063	2,063	100.00%
OPH	0	0	0	NA
Total	**4,808**	**4,089**	**4,808**	**85.05%**

2024 Competition Report - HIC Summary

CA-608 - Riverside City & County CoC

For HIC conducted in January/February of 2024

Rapid Re-housing Beds Dedicated to All Persons

Metric	2020	2021	2022	2023	2024
RRH beds available to serve all pops. on the HIC	318	465	309	710	830

1) † EHV = Emergency Housing Voucher
2) *This column includes Current, Year-Round, Natural Disaster beds not associated with a VSP that are not HMIS-participating. For OPH Beds, this includes beds that are Current, Non-HMIS, and EHV-funded.
3) **This column includes Current, Year-Round, Natural Disaster beds associated with a VSP that are not HMIS-participating or HMIS-comparable database participating. For OPH Beds, this includes beds that are Current, VSP, Non-HMIS, and EHV-funded.
4) Data included in these tables reflect what was entered into HDX 2.0.
5) In the HIC, "Year-Round Beds" is the sum of "Beds HH w/o Children", "Beds HH w/ Children", and "Beds HH w/ only Children". This does not include Overflow ("O/V Beds") or Seasonal Beds ("Total Seasonal Beds").
6) In the HIC, "Current" beds are beds with an "Inventory Type" of "C" and not beds that are Under Development ("Inventory Type" of "U").
7) For historical data: Aggregated data from CoCs that merged are not displayed if HIC data were created separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.

2024 Competition Report - PIT Summary

CA-608 - Riverside City & County CoC

For PIT conducted in January/February of 2024

Submission Information

Date of PIT Count	Received HUD Waiver
1/24/2024	Not Applicable

Total Population PIT Count Data

Category	2019	2020	2021	2022	2023	2024
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered-Only Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered-Only Count
Emergency Shelter Total	723	670	950	1,111	1,015	1,426
Safe Haven Total	0	0	0	0	0	0
Transitional Housing Total	43	59	48	225	269	382
Total Sheltered Count	766	729	998	1,336	1,284	1,808
Total Unsheltered Count	2,045	2,155	0	1,980	2,441	0
Total Sheltered and Unsheltered Count*	2,811	2,884	998	3,316	3,725	1,808

1) *Data included in this table reflect what was entered into HDX 1.0 and 2.0. This may differ from what was included in federal reports if the PIT count type was either sheltered only or partial unsheltered count.
2) Aggregated data from CoCs that merged is not displayed if PIT data were entered separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.
3) In 2021, for CoCs that conducted a "Sheltered and partial unsheltered count", only aggregate and not demographic data were collected.

2024 Competition Report - PIT Summary

CA-608 - Riverside City & County CoC

For PIT conducted in January/February of 2024

October 24, 2024

To the County of Riverside Department of Housing and Workforce Solutions on behalf of the Riverside County Continuum of Care:

On behalf of the Inland Empire Health Plan, we would like to express our strong support for Illumination Foundation's Riverside Support Housing Program application to the Riverside Continuum of Care.

IEHP is a Knox-Keene licensed Health Plan located in Rancho Cucamonga, California. IEHP is a not-for-profit public agency serving low income and vulnerable populations in Riverside and San Bernardino counties and has more than 1.3 million Members. Through a dynamic partnership with providers, award-winning service and innovative products, IEHP is fully committed to providing our members with quality, accessible and wellness-based healthcare services. By partnering with providers, we deliver high quality health care coverage to low-income working families with children, adults, seniors, and people with disabilities.

IEHP has partnered with Illumination Foundation since 2015 to coordinate and facilitate IEHP Members' recuperative care after hospital discharge, including providing intensive case management services, transportation to and from medical appointments, and connection to housing. We currently partner with Illumination Foundation in Riverside County for recuperative care, Short-Term Post Hospitalization, and CalAIM Enhanced Care Management and Community Supports services, giving them the ability to move these vulnerable clients along the Continuum of Care into housing.

Since 2008, Illumination Foundation has provided a diverse array of services to the homeless community in Southern California, beginning in Orange County and growing to include the Inland Empire and Los Angeles County. Illumination Foundation's pioneering efforts integrating housing healthcare services have made a positive difference in the lives of individuals and families experiencing homelessness in Southern California.

In our work with Illumination Foundation, we have found its executive team to possess a deep commitment to the organization's mission of disrupting the cycle of homelessness. Again, we strongly support Illumination Foundation's Riverside Support Housing Program application.

Sincerely,

Takashi Wada, MD, MPH
Chief Medical Officer
10801 e Sixth St. Rancho Cucamonga, CA
Administration
Wada-t@iehp.org

INLAND EMPIRE HEALTH PLAN
ENHANCED CARE MANAGEMENT PROVIDER AGREEMENT

THIS ENHANCED CARE MANAGEMENT PROVIDER AGREEMENT ("Agreement") is made and entered into this First day of _____, by and between (i) **INLAND EMPIRE HEALTH PLAN** ("IEHP" or "IEHP Health Plan") and (ii) **THE ILLUMINATION FOUNDATION** ("PROVIDER"), with reference to the following facts:

WHEREAS, IEHP is a public entity organized and licensed as a health care service plan under the laws of the State of California; and

WHEREAS, IEHP operates a Health Maintenance Organization (HMO) that arranges for quality preventive, medical and hospital services to be provided to persons who are enrolled as Members in the IEHP Health Plan in a manner consistent with the laws of the United States and the State of California; and

WHEREAS, IEHP Health Plan has entered into Agreements with the California Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Centers for Medicare and Medicaid Services (CMS) through which IEHP Health Plan shall arrange for the provision of Health Care Services for San Bernardino and Riverside County residents who are eligible for health coverage and who enroll in the IEHP Plan; and

WHEREAS, IEHP Health Plan desires to provide a health care delivery system that utilizes methods to promote the efficient delivery of health care, and develops and implements health education and health maintenance for its Members; and

WHEREAS, PROVIDER has the requisite facilities, equipment and personnel necessary to deliver Health Care Services, all of which are appropriately licensed in the State of California; and

WHEREAS, IEHP Health Plan and PROVIDER mutually desire to preserve and provide quality cost-effective Health Care Services, compliant with the terms and conditions specified herein and to the extent permitted by law, to serve the needs of IEHP Health Plan Members; and

WHEREAS, The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal.

WHEREAS, DHCS planned to establish a statewide Enhanced Care Management (ECM) benefit. The goal of an ECM benefit is to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries enrolled in a managed care health plan. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services. The proposed ECM benefit is replacing the current Health Homes Program.

WHEREAS, ECM was originally scheduled to begin in January 2021, but was delayed due to the impact of the COVID-19 public health emergency. As a result, ECM has a start date of January 1, 2022.

WHEREAS, IEHP Health Plan is participating in Enhanced Care Management (ECM); and

WHEREAS, PROVIDER wishes to participate as an ECM Provider for Enhanced Care Management, and PROVIDER is qualified to do so.

NOW, THEREFORE, in consideration of their mutual agreements and promises, the parties hereto agree as follows:

1. DEFINITIONS

The following terms whenever used in this Agreement shall have the definitions contained in this Section 1. Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement:

1.01 AGREEMENT – shall mean this Provider Agreement, dated as herein above stated, including all attachments, addendums and amendments hereto.

1.02 CAPITATION PAYMENTS – shall mean payments made to PROVIDER by IEHP Health Plan as a single, fixed, monthly amount. A fixed rate is paid per Member per month to cover a specified package of services, regardless of actual utilization as referenced in Attachment B, attached hereto.

1.03 FEE-FOR-SERVICE PAYMENTS – shall mean payments made to Provider by IEHP Health Plan on a Fee-For-Service basis for specific services performed in Attachment A, attached hereto. The specific payment rate is noted in the fee schedule in Attachment B, attached hereto.

1.04 COMMERCIAL PROGRAM – shall mean any product line in which the individuals eligible IEHP Health Plan are enrolled through Subscriber Agreement.

1.05 CO-PAYMENT – shall mean a nominal fee, approved by the applicable state and federal regulators that govern the IEHP Health Plan, that is charged to Members at the time of service for designated Health Care Services.

1.06 DHCS – is the Department of Health Care Services who finances and administers a number of California individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). The DHCS works closely with health care professionals, county governments and health plans to provide health care safety net for California's low-income and persons with disabilities.

1.07 DUAL ELIGIBLE BENEFICIARY – shall mean an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan.

1.08 EMERGENCY MEDICAL CONDITION – shall mean a medical condition that is

manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part.

1.09 EMERGENCY SERVICES – shall mean those health services needed to evaluate or stabilize an Emergency Medical Condition.

1.10 ENCOUNTER DATA – shall mean the data submitted by PROVIDER regarding all Capitated Services rendered to assigned Members during each month.

1.11 HEALTH CARE SERVICES – see attachment A and B.

1.12 HEALTHY KIDS PROGRAM – shall mean the program, jointly subsidized by the Prop 10 Commission, IEHP, and other interest groups that provides insurance coverage for children of families living in Riverside or San Bernardino County earning less than a designated Federal poverty Level and are not eligible for any insurance.

1.13 IEHP-DIRECT – shall mean the department within IEHP Health Plan that administers direct contracting.

1.14 IEHP PLAN – shall mean any plan operated by IEHP Health Plan covering the provision of Health Care Services to Members.

1.15 MEDI-CAL – shall mean the California name for Medicaid, the federal and state program of medical assistance for needy and low-income people.

1.16 MEDICALLY NECESSARY – shall mean reasonable and necessary services to protect life, to prevent significant illness or significant disability, to alleviate severe pain and to diagnose or treat disease, illness or injury.

1.17 MEDICARE – A benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by IEHP Health Plan as outlined in Attachment E. Medicare includes the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and DHCS.

1.18 MEMBER – shall mean any eligible beneficiary who has enrolled in IEHP Health Plan.

1.19 MRMIB – is the California Managed Risk Medical Insurance Board, the administrative agency of the California Government responsible for administering the Healthy Families Program.

1.20 OPEN ACCESS PROGRAM – shall mean the program whereby designated

Members are not formally assigned to a Primary Care Physician (PCP). This program allows for Members to be treated by any contracted PCP on a Fee For Service basis. PROVIDER shall treat any Member who is enrolled in the Open Access Program once eligibility is confirmed through IEHP Health Plan.

1.21 PARTICIPATING PROVIDER – shall mean any physician, licensed health care facility or other licensed health professional that is contracted with IEHP Health Plan to provide health care services to Members and identified in Attachment C, attached hereto and incorporated in full herein by reference.

1.22 PREPAID HEALTH PLAN – shall mean a Knox-Keene licensed health care plan holding a contract with the Department of Managed Health Care (DMHC) to provide services to beneficiaries.

1.23 PRIMARY CARE PHYSICIAN (PCP) – shall mean a physician who is responsible for supervising, coordinating and providing initial, primary and preventive care to Members, for initiating referrals, maintaining continuity of Member care, and providing health counseling and education. This means physicians who are practicing medicine in the areas of Family Practice, Pediatrics, Internal Medicine, Obstetrics-Gynecology, or General Practice.

1.24 PRIMARY CARE SERVICES – shall mean those covered services that Members are entitled to under the IEHP Health Plan, which PROVIDER is required to provide or to make available to Members. Primary Care Services shall include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses. Primary care is performed and managed by the Member's assigned physician, utilizing consultation or referral as appropriate.

1.25 PRIMARY HOSPITAL – shall mean an acute care facility licensed under the laws of the State of California that is accredited by an IEHP Health Plan approved agency and is contracted with IEHP Health Plan at which PROVIDER is a member in good standing of the medical staff and to which Member has been assigned.

1.26 PRIOR AUTHORIZATION – shall mean a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

1.27 PROVIDER-PREVENTABLE CONDITION (PPC) – means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR 447.26(b).

1.28 REFERRAL – shall mean the process where PROVIDER directs a Member to a participating provider to obtain Health Care Services.

1.29 STATE PROGRAM – shall mean Medi-Cal, Healthy Kids, and Open Access product lines administered through IEHP Health Plan.

1.30 SURCHARGES – shall mean an additional fee, excluding any applicable Co-

payment that is charged to a Member for covered services. Surcharges are prohibited under the IEHP Plan.

2. DUTIES OF PROVIDER

2.01 ACCESSIBILITY OF SERVICES – PROVIDER shall provide timely access to Health Care Services and provide for reasonable hours of operation in compliance with IEHP Health Plan established standards for access and availability, as these services are normally made available to the general public.

2.02 ADMINISTRATIVE GUIDELINES – PROVIDER agrees to perform his/her duties under this Agreement in a manner consistent with the administrative guidelines provided by IEHP Health Plan and comply with the policies and procedures outlined in the IEHP Provider Policy and Procedure Manual.

2.03 AVAILABILITY OF SERVICES – PROVIDER agrees to provide IEHP Health Plan with current information regarding Health Care Services available. PROVIDER shall notify and submit to IEHP Health Plan periodic reports that includes, but is not limited to, the identification of deletions and additions to Health Care Services provided by PROVIDER.

2.04 CHANGE IN PROVIDER INFORMATION – PROVIDER shall notify IEHP Health Plan in writing, ninety (90) days prior to any change in PROVIDER's office address, telephone number, office hours, tax identification number, or license status or number.

2.05 CITATIONS – PROVIDER shall notify IEHP Health Plan in writing within fifteen (15) days of each and every report of CMS, DHCS, The Joint Commission or any other accreditation agency, which contains any citation of PROVIDER for failure to meet any required standard; any legal or government action against any of its licenses, accreditations, or certifications; or any other situation that will materially impair the ability of PROVIDER to carry out the duties and obligations under this Agreement.

2.06 CONFORMANCE TO OTHER LAW – PROVIDER certifies compliance with the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et. Seq.), the Drug Free Workplace Act of 1990 (Gov. Code Section 8355), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the U.S Pro-Children Act of 1994 (20 USC 6081 et seq.). PROVIDER certifies awareness of Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor, the derivative Cal/OSHA Standard and laws and regulations relating thereto and shall comply therewith as to all relative elements under the Agreement.

2.07 COVERING PROVIDER – If applicable, if PROVIDER is unable to provide Health Care Services when needed, PROVIDER may secure the services of a qualified covering provider. PROVIDER shall notify IEHP Health Plan as soon as reasonably possible of his/her intent to secure such services.

PROVIDER may utilize only providers that have been credentialed or contracted by IEHP Health

Plan. PROVIDER shall ensure that the covering provider: 1) looks solely to PROVIDER for compensation, 2) shall accept IEHP Health Plan's UM/QM and peer review processes, 3) shall not bill Members for Health Care Services rendered under any circumstances, excluding that of Section 4.03 and 4) shall comply with the terms of this Agreement.

2.08 CREDENTIALING – PROVIDER shall meet IEHP Health Plan's credentialing requirements and maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities. In addition, PROVIDER shall maintain, at all times, active privileges at Primary Hospital, have written arrangements in place with a covering admitting physician approved by IEHP Health Plan, or rely on a contracted admitting physician provided by IEHP Health Plan. PROVIDER agrees that only those medical professionals who are credentialed by IEHP Health Plan shall treat Members. Hospital-based providers are not required to complete the IEHP Health Plan's credentialing requirements. PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities.

2.09 DATA REPORTING – PROVIDER shall submit to IEHP Health Plan, within thirty (30) days after each month of service and in a format acceptable to IEHP Health Plan, the Encounter Data as required by IEHP Health Plan, CMS, [MRMIB] and DHCS for the effective management of IEHP Health Plan's health care delivery system. PROVIDER shall ensure that Encounter Data submitted to IEHP Health Plan is complete and accurate. If Encounter Data received from PROVIDER is incomplete, inaccurate, and/or absent, IEHP Health Plan shall issue a maximum of two (2) thirty (30) day non-compliance warning notices to PROVIDER warning of low Encounter Data submissions falling below IEHP Health Plan's standard Encounter Data benchmark. If after receiving the second warning notice PROVIDER is unable or unwilling to demonstrate improvement in Encounter Data submission levels by the compliance date indicated therein, IEHP Health Plan shall convert PROVIDER's reimbursement from capitation to fee-for-service at IEHP Health Plan's prevailing Medi-Cal or Medicare rate, as applicable, to be effective at the expiration of the compliance period. IEHP shall confirm such change, in writing, via certified mail, of conversion to fee-for-service reimbursement due to PROVIDER's continued non-compliance.

2.10 FACILITY TRANSFERS – If applicable, PROVIDER agrees to notify IEHP Health Plan or designee, immediately and to assist in facilitating the transfer of Members requiring Health Care Services that are not offered or available at PROVIDER'S facilities. PROVIDER agrees to cooperate and comply with IEHP Health Plan standards with respect to required referral systems for excluded (carve out) services to ensure continuity of care between IEHP Health Plan and the local health departments or other agencies to which the Member is referred.

2.11 HOSPITAL ADMISSION – PROVIDER, or IEHP Health Plan designee, shall admit all Members with acute conditions to the Members' Primary Hospital only, unless an appropriate bed or service is unavailable. PROVIDER agrees to secure an authorization from IEHP Health Plan prior to admitting a Member for an elective service.

2.12 HOURS OF OPERATION AND AVAILABILITY – If applicable, PROVIDER

shall make arrangements to ensure the availability of physician services to Members twenty-four (24) hours per day, seven (7) days per week. PROVIDER agrees that scheduling of appointments shall be done in accordance with IEHP Health Plan standards and to maintain weekly appointment hours that are sufficient to serve Members. PROVIDER shall be available or have designated physician back-up available, telephonically to Members after regular business hours.

2.13 IDENTIFICATION OF OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS - On an annual basis PROVIDER shall identify the names of the following persons by listing them on Attachment D of this Agreement, attached hereto and incorporated by this reference, as required by DHCS and MRMIB:

A. PROVIDER officers and owners who own greater than 5% of the PROVIDER;
B. Stockholders owning greater than 5% of any stock issued by PROVIDER; and
C. Major creditors holding more than 5% of any debts owed by PROVIDER.

PROVIDER shall notify IEHP Health Plan in writing within thirty (30) days of any changes in the information provided in Attachment D.

2.14 INSURANCE – PROVIDER agrees, throughout the term of this Agreement, to maintain medical malpractice insurance with a reputable carrier in the minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate per year, plus extended reporting (tail coverage) endorsement, and to furnish IEHP Health Plan certificates evidencing such coverage.

2.15 INSURANCE – ANCILLARY PROVIDER – throughout the term of this Agreement PROVIDER agrees to maintain, at its sole cost and expense, professional general liability in the minimum amount of One Million Dollars ($1,000,000) combined single limited coverage; and One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate per year for professional liability for providing Health Care Services to Members on behalf of PROVIDER. PROVIDER employees may be covered by employer policies of insurance or by employer self-insurance programs. In the event PROVIDER procures a claims made policy as distinguished from an occurrence policy, PROVIDER shall procure and maintain prior to termination of such insurance, continuing "tail" coverage, unless successor policy coverage provides such "tail" protection. Evidence of insurance coverage for PROVIDER shall be provided to IEHP HEALTH PLAN each year. PROVIDER shall provide IEHP HEALTH PLAN with written notification thirty (30) days prior to any cancellation, reduction, or other material change in the amount or scope of any coverage required under this Section.

2.16 INSPECTION OF FACILITIES – Facilities used by PROVIDER to provide Health Care Services shall comply with provisions of Title 22, CCR, Section 53230 and Title 28, Section 1300.80. PROVIDER agrees to cooperate with inspections of PROVIDER facilities, as conducted by any state and federal regulatory agencies, or IEHP Health Plan staff, that are required to assure compliance with required facility standards.

2.17 LABORATORY SERVICES – PROVIDER shall utilize an IEHP Health Plan designated laboratory for all laboratory services as needed for Member care. PROVIDER shall get approval and an authorization number from IEHP Health Plan prior to utilizing another laboratory.

2.18 MEMBER GRIEVANCE RESOLUTION

2.18.01 PROVIDER shall notify IEHP Health Plan immediately, upon knowledge of a complaint by a Member. PROVIDER agrees to cooperate with IEHP Health Plan in resolving Member grievances and agrees to participate in the grievance review procedures of IEHP Health Plan. PROVIDER and PROVIDER's staff shall comply with all final determinations of IEHP Health Plan's grievance procedure, peer review and QM and UM Programs. At no time shall a Member's medical condition be permitted to deteriorate because of delay in provision of care that PROVIDER disputes. Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical disputes between Member and provider of service.

2.18.02 PROVIDER shall also report and forward copies of all Member grievances to IEHP Health Plan alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law. This includes, without limitation, grievances relating to discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the Americans with Disabilities Act.

2.19 NON-DISCRIMINATION

2.19.01 PROVIDER represents and assures that Health Care Services are provided to Members in the same manner and quality as such services are provided to PROVIDER's other patients. PROVIDER shall not refuse or fail to provide Health Care Services to any Member or otherwise impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of PROVIDER. PROVIDER shall not request, demand, require or seek directly or indirectly the transfer, discharge or removal of any Member for reasons of Member's need for or utilization of Health Care Services. PROVIDER shall not discriminate, exclude, or treat differently any Member on the basis of sex, race, ethnic group identification, color, ancestry, religion, creed, national origin, health status, physical disability (including HIV and AIDS), mental disability, medical condition, age, gender, gender identity, marital status, income level, sexual orientation, genetic information, source of payment, or identification with any other persons or groups defined in Penal Code Section 422.56. PROVIDER will provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act or any applicable state law. PROVIDER shall comply with Section 1557 of the Affordable Care Act of 2010 (the "ACA") (Title 42 of the United States Code ("USC"), Section 18116), the regulations promulgated thereto, and other applicable federal civil rights laws in providing services to Members, as may be amended from time to time and incorporated herein by this reference.

PROVIDER further agrees to include this non-discrimination clause in any and all subcontracts to perform services under this Agreement. Without limiting the generality of the foregoing, PROVIDER shall take reasonable and appropriate steps to:

a) Provide meaningful access to each Member with limited English proficiency (including, without limitation, offering a qualified interpreter) and ensure such language assistance services are accurate and timely, protect the privacy and independence of Members, and provided free of charge;

b) Ensure that communications with Members who have disabilities are effective and in accordance with the standards found at 28 CFR 35.160 through 35.164, including, without limitation, provision of sign language interpreters and appropriate auxiliary aids and services to Members with impaired sensory, manual, or speaking skills; and

c) Make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless PROVIDER can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity.

2.19.02 PROVIDER shall ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. PROVIDER shall comply with the applicable provisions of Title 2 CCR, Section 11105 *et seq*., including clause (b) specifically, as may be amended from time to time, and incorporated by reference herein.

2.20 NON-SOLICITATION – PROVIDER shall not solicit Members on behalf of any other IPA, medical group, and HMO or insurance company. Solicitation shall mean conduct by PROVIDER, office staff, agent, or employee of PROVIDER, which may be reasonably interpreted as designed to persuade Members to discontinue their membership with IEHP Health Plan.

2.21 OTHER CONTRACTUAL COMMITMENTS – PROVIDER represents and assures IEHP Health Plan that contractual commitments to other HMOs, insurance companies, medical groups and other related entities do not restrict or impair PROVIDER from performing its duties under this Agreement and do not constitute a conflict of interest with the provision of Primary Care Services for Members.

2.22 OTHER REPORTING – If applicable, PROVIDER agrees to submit all information or reports, in a timely manner, as may be required to enable IEHP Health Plan to fulfill its reporting and other obligations under the Agreement, the Knox-Keene Act and the IEHP Health Plan.

2.23 PHARMACEUTICAL SERVICES – PROVIDER shall provide pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with Title 22, CCR, Section 53854.

2.24 PRIOR AUTHORIZATION – As applicable, PROVIDER shall obtain advance authorization from IEHP Health Plan, or designee, prior to any non-emergent Health Care Services provided to a Member. In the case of an emergency, PROVIDER agrees to notify IEHP Health Plan, or designee, either orally or in writing, no later than the first working day following the date of service.

2.25 PROVIDER ADVERTISING – Prior to listing or otherwise referencing IEHP Health Plan in any promotional or advertising brochures, media announcements or other advertising or marketing material, PROVIDER shall first obtain the prior written consent of IEHP Health Plan.

2.26 QUALITY MANAGEMENT (QM) AND UTILIZATION MANAGEMENT (UM) – PROVIDER shall comply with IEHP Health Plan's QM and UM Programs and any amendments to these programs as may be established or adopted by IEHP Health Plan from time to time. If a potential quality of care issue is identified based on Member complaints, or other information, IEHP Health Plan shall alert PROVIDER to initiate appropriate action. PROVIDER further agrees to assist IEHP Health Plan in the implementation of a corrective action plan.

2.27 REFERRAL PROCESS – PROVIDER understands and agrees that all specialty consultation or care must be obtained utilizing the procedures designated by IEHP Health Plan. In addition PROVIDER shall not render Primary Care Services to unassigned Members nor provide Health Care Services that fall outside those listed in Attachment A, without prior authorization from IEHP Health Plan.
In the event that PROVIDER fails to comply with such procedures, IEHP Health Plan may, at its sole discretion, reimburse the provider of service and deduct such costs from any monies owed to PROVIDER.

2.28 SERVICES TO BE RENDERED – As applicable to Primary Care Providers, PROVIDER agrees to provide continuous and comprehensive Primary Care Services for all assigned Members with consideration of the physical, mental and psychosocial needs of the Members, including acute and chronic care. This includes coordinating specialty care and referrals, providing screening, counseling, preventive care services and periodic evaluation to ensure appropriate continuity of care, as outlined in Attachment A and E. As applicable to other Health Care Providers, PROVIDER shall provide to Members those Health Care Services that are Medically Necessary when such services are authorized by IEHP Health Plan, or designee, and in accordance with Attachment A and E of this Agreement. PROVIDER is responsible for coordinating the provision of Health Care Services with the Member's PCP, IPA, or IEHP Health Plan.

2.29 STANDARDS OF CARE – PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities.

All Health Care Services shall be provided by professional personnel and at physical facilities in accordance with all applicable federal and state laws, licensing requirements and professional standards, and in conformity with the professional and technical standards adopted by IEHP Health Plan. Health Care Services shall be rendered by qualified providers unhindered by fiscal and administrative management.

2.30 SKILLED NURSING FACILITY – Provider shall notify IEHP Health Plan within 24 hours or the next business day of all admissions to its facility. This requirement includes admissions of Medi-Medi members where IEHP Health Plan is the secondary payor.

3. DUTIES OF IEHP HEALTH PLAN

3.01 ADMINISTRATION – IEHP Health Plan shall perform all necessary administrative, accounting and reporting requirements and other functions to state and federal regulators consistent with the administration of IEHP Plan and this Agreement.

3.02 ADMINISTRATION OF PAYMENTS – IEHP Health Plan agrees to transmit Capitation Payments and other payments to PROVIDER in accordance with the terms and procedures set forth in this Agreement. All payments are subject to the availability of funds from payors to IEHP, including but not limited to, Federal congressional appropriation, State and/or other payor. The State of California operates on a fiscal year from July 1 through June 30. The DHCS' funding is based on the budget and appropriations, and subject to the availability of Federal congressional appropriation of funds.

3.03 AFTER-HOURS NURSE ADVICE LINE – IEHP Health Plan shall provide Members with access to after-hour medical advice and triage provided by licensed RNs, PAs and NPs. This service is provided Monday-Friday from 5:00pm - 8:00am and on weekends and holidays, through a toll-free telephone number.

3.04 AUTHORIZATIONS – IEHP Health Plan agrees to provide medical authorization access to PROVIDER for treatment and hospitalization of Members.

3.05 BENEFIT INFORMATION – IEHP Health Plan agrees to apprise all Members concerning the type, scope and duration of benefits and services to which such Members are entitled under the IEHP Plan. This includes, but is not limited to, written notification to Members of Health Care Services available and changes in the availability or location of Health Care Services being provided by PROVIDER, and issuance of an identification card to each Member upon enrollment.

3.06 CULTURAL AND LINGUISTIC SERVICES – IEHP Health Plan agrees to offer PROVIDER access to interpreter services for Members either through telephone language services or interpreters.

3.07 ELIGIBILITY INFORMATION – IEHP Health Plan shall maintain, update and distribute eligibility information to PROVIDER that contains those Members assigned to the PROVIDER within a specific month.

3.08 MARKETING ACTIVITIES – IEHP Health Plan agrees to provide marketing and public relations services, advertising and marketing to potential Members. IEHP Health Plan may use PROVIDER's name, office address, telephone number, and any other demographic information in any informational material distributed to Members and for other purposes related to the administration of the IEHP Health Plan.

3.09 MEDICAL MANAGEMENT – IEHP Health Plan shall provide appropriate services in support of PROVIDER for the medical care of Members, including but not limited to treatments and hospitalizations, case management and quality oversight. PROVIDER may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

3.10 MEMBER SERVICES – IEHP Health Plan shall provide customer service to Members, including, but not limited to, processing Member complaints and grievances, informing Members of IEHP Health Plan policies and procedures, providing Members with information about IEHP Health Plan and identifying contracted providers within IEHP Health Plan's network.

3.11 NOTIFICATION TO DHCS – IEHP Health Plan shall notify DHCS in the event of an amendment to or termination of this Agreement. Notice shall be given by properly addressed letter deposited in the U.S. Postal Service as first-class postage, prepaid registered mail.

3.12 PROVIDER ADVERTISING – IEHP Health Plan may use PROVIDER's name, office address, telephone number, and any other demographic information in any informational material distributed to Members and for other purposes related to the administration of the IEHP Plan.

3.13 PROVIDER EDUCATION AND TRAINING – IEHP Health Plan shall provide in-service training in the IEHP Provider Policy and Procedure Manual that contains IEHP Health Plan's policies and procedures.

IEHP Health Plan shall provide the necessary training on these policies and procedures when requested and in the development and initial implementation of procedures necessary to carry out the intent of this Agreement.

4. BILLING AND COMPENSATION

4.01 BILLING – In order to receive payment for Health Care Services rendered PROVIDER shall submit claims to IEHP Health Plan within one hundred and twenty (120) days from the date of service for authorized Health Care Services provided to Members. Capitated PROVIDER shall only submit claims to IEHP Health Plan for services not included in Attachment A.

The claim must be submitted on a CMS 1500 or UB-04 claim form and shall include all information necessary to verify and substantiate the provision of and charges for Health Care Services, including providing the authorization number, as applicable. PROVIDER shall not seek payment for claims submitted after one hundred and twenty (120) days from the date of service.

4.02 CAPITATION PAYMENTS – If applicable, IEHP Health Plan shall make monthly Capitation Payments to PROVIDER as outlined in Attachment B, and in association with Attachment B-1, for those Primary Care Services listed in Attachment A. Payments shall be post marked by the fifth (5th) day of each month following the month of service for all Members assigned to PROVIDER under the IEHP Direct PROVIDER number.

4.03 COLLECTION OF CHARGES FROM MEMBERS – PROVIDER agrees that the only charges for which a Member may be liable and be charged by PROVIDER shall be for applicable Co-payments, coinsurance and/or deductibles or for medical services not covered under the IEHP Plan. PROVIDER shall advise Member of their payment responsibility, if any, prior to rendering services that require Co-payments, coinsurance and/or deductibles. PROVIDER shall obtain a written waiver from Member prior to rendering non-covered medical services to Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP Health Plan has denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.04 COORDINATION OF BENEFITS – PROVIDER agrees to coordinate benefits with other programs or entitlement, excluding tort liability of a third party, and estates from deceased Members, and recognizes the other coverage as primary and IEHP Health Plan as the payor of last resort.

In the case in which IEHP Health Plan is other than primary, IEHP Health Plan shall pay the lesser of the amounts which when added to the amounts received by PROVIDER from other sources equals one hundred percent of the amount required under this Agreement as specified in Attachment B. If the amount paid by the primary payer is greater than the amount that would have been paid under this Agreement, IEHP Health Plan as secondary payer shall pay any co-pay, co-insurance, deductible or patient responsibility under the Member's coverage with the primary payor as reflected on an explanation of benefits or remittance advice from a primary payer. Unless Member has other health insurance coverage, PROVIDER accepts payment from IEHP Health Plan for Health Care Services as provided herein as full payment for such Health Care Services and shall at no time seek compensation from Members, excluding applicable Copayments for Medi-Cal, Healthy Kids Members or the State. In instances when Medi-Cal is secondary to Medicare, the contracted rate(s) herewithin shall not apply. Payment for services shall be made in accordance with CMS guidelines.

4.05 FULL COMPENSATION – PROVIDER shall accept the payments specified in Attachment B of this Agreement as payment in full for all Health Care Services provided to Members and for all administrative costs incurred for providing such services.

In the event IEHP Health Plan fails to make any payments to PROVIDER as provided herein, whether from IEHP Health Plan's insolvency or otherwise, Members shall not be liable for payment to PROVIDER, under any circumstances, for Health Care Services.

4.06 HOLD HARMLESS – In the event IEHP Health Plan fails to make any payments to PROVIDER as provided herein, whether from IEHP Health Plan's insolvency or otherwise, Members shall not be liable to PROVIDER, under any circumstances, for Health Care Services. PROVIDER further agrees to hold harmless the State of California in the event of non-payment by IEHP Health Plan.

4.07 POTENTIAL TORT LIABILITY – To the extent permitted by the Healthy Kids or Medicare programs, as applicable, in the event PROVIDER recovers any amount from a third party, PROVIDER shall notify IEHP Health Plan of any such recovery and shall provide IEHP Health Plan with an accounting of all such sums recovered.

In the event IEHP Health Plan has compensated PROVIDER for such Covered Services and PROVIDER has recovered sums from a third party, PROVIDER agrees to pay such recovered sums to IEHP Health Plan up to the amounts that IEHP Health Plan paid to PROVIDER, to the extent that IEHP Health Plan has not recovered such amounts from its own third party recovery efforts. PROVIDER shall pay these amounts to IEHP Health Plan within thirty (30) days of IEHP Health Plan informing PROVIDER of the amounts IEHP Health Plan recovered from its own third party recovery efforts, if any. This section does not obligate, nor does it prohibit, either IEHP Health Plan or PROVIDER to undertake such third party recovery efforts.

4.08 PROVIDER-PREVENTABLE CONDITION (PPC) – Contractor shall not pay any provider claims for a Provider-preventable Condition (PPC), in accordance with 42 CFR 438.3(g). Contractor shall report, and require any and all of its subcontracted providers to report, PPCs in the form and frequency required by APL 15-006, and any subsequent APLs on PPCs.

4.09 REIMBURSEMENT – IEHP Health Plan shall pay PROVIDER for authorized Health Care Services in accordance with California Health and Safety Code, § 1371, *et seq*., and Attachment B of this Agreement, within forty-five (45) working days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with IEHP Health Plan standards. IEHP Health Plan shall notify PROVIDER at least forty-five (45) days prior to any material modification to IEHP Health Plan's proprietary fee schedules, claims and dispute filing guidelines or other reimbursement guidelines. IEHP Health Plan shall not be obligated to pay PROVIDER on any claim not submitted within one hundred and twenty (120) days from the date of service. If for any reason it is determined that IEHP Health Plan overpaid PROVIDER, IEHP Health Plan may deduct monies in the amount equal to the overpayment from any future payments to PROVIDER after thirty (30) days written notice.

Provider is required to sign and return to IEHP the Electronic Authorization Registration form. By signing this form, Provider acknowledges that Provider agrees to receive payment electronically in the form of an electronic fund transfer and to access the Remittance Advice from the IEHP secure website.

Upon forty-five (45) days prior written notice to PROVIDER, IEHP Health Plan may change the rates or other compensation payable to PROVIDER at any time, or from time to time, during the term of the Agreement as determined by IEHP Health Plan to reflect implementation of State or federal laws and regulations, changes in the State budget or changes in DHCS or CMS policies, changes in covered Health Care Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to IEHP Health Plan, or any other change to the rates or level of funding paid to IEHP Health Plan. The amount of such adjustment shall reasonably be determined by IEHP Health Plan and may not be in direct proportion to or in the same amount as the adjustment to the rates or level of funding paid to IEHP Health Plan.

4.10 REIMBURSEMENT DISPUTES – In the event PROVIDER disagrees with any payment, denial, adjustment or contest made by IEHP Health Plan, PROVIDER has 365 calendar days to submit a written dispute to IEHP Health Plan. Said dispute shall include all information necessary to verify and substantiate the dispute. IEHP Health Plan shall handle all written disputes in accordance with Health and Safety Code, § 1371 et. seq. (AB1455).

4.11 SERVICE WAIVER – In the event Health Care Services are not covered under the IEHP Health Plan or are denied by IEHP Health Plan as not being Medically Necessary, PROVIDER shall not charge Members unless PROVIDER has obtained a written waiver from Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP HEALTH PLAN has denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.12 SURCHARGES PROHIBITED – Notwithstanding Section 4.03, PROVIDER shall in no event, including, without limitation, non-payment by IEHP Health Plan, insolvency of IEHP Health Plan, or breach of the Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive any form of payment from any Member, the State, or County, for Health Care Services provided pursuant to this Agreement. PROVIDER also agrees it shall not maintain any action at law or equity against a Member to collect sums owed by IEHP Health Plan to PROVIDER. Upon receipt, by IEHP Health Plan, of notice of any Surcharge being made by PROVIDER for Health Care Services, IEHP Health Plan shall take appropriate action consistent with the terms of this Agreement. PROVIDER's obligations regarding the collection of surcharges from Members shall survive the termination of this Agreement.

5. RECORDS AND CONFIDENTIALITY

5.01 ACCESS TO RECORDS – PROVIDER shall provide access at reasonable times upon demand by IEHP Health Plan, the U.S. Department of Health and Human Services, the Department of Corporations, DMHC, DHCS or any governmental regulatory agency responsible for the administration of the IEHP Health Plan, to inspect, exam or copy any books, papers and records, including but not limited to Member medical records, relating to Health Care Services provided pursuant to this Agreement. Such records shall be made available at all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California. PROVIDER shall allow the IEHP Health Plan to access and use PROVIDER's practitioner performance data.

5.02 CONFIDENTIALITY OF RECORDS – PROVIDER shall request from Member, or Member's legal representative, authorization for the release of the Member's medical records. PROVIDER shall safeguard the confidentiality of Member medical records and treatments in accordance with all state and federal laws, including, without limitation, Title 42, Code of Federal Regulations, Section 431.300 et seq., and Section 14100.2, California Welfare and Institutions Code, the Health Insurance Portability and Accountability Act (HIPAA) and regulations adopted thereunder.

5.03 RECORDS MAINTENANCE – PROVIDER shall prepare and maintain adequate records related to Health Care Services provided to each Member, in such form and containing such information as reasonably necessary for IEHP Health Plan to properly administer the IEHP Plan, consistent with state and federal law. PROVIDER shall maintain its books and records in accordance with general standards for books and record keeping. PROVIDER shall retain such records and encounter data for at least ten (10) years from the close of DHCS' fiscal year in which this Agreement is in effect. This obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

5.04 RECORDS RELATED TO RECOVERY FOR LITIGATION – Upon request by DHCS and IEHP Health Plan, PROVIDER shall timely gather, preserve and provide to IEHP Health Plan, in the form and manner specified by DHCS, any information specified by DHCS subject to any lawful privileges, in PROVIDER's possession, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify IEHP Health Plan of any subpoenas, documentation production requests, or requests for records, received by PROVIDER related to this Agreement.

6. DISPUTE RESOLUTION

6.01 DISPUTE RESOLUTION – For disputes unresolved by the IEHP Health Plan provider appeals process, IEHP Health Plan and PROVIDER agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, PROVIDER shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

6.02 JUDICIAL REFERENCE – At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter.

The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the San Bernardino Superior Court. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the County of San Bernardino, California, and that the hearing before the referee shall be concluded within nine (9) months of the filing and service of the complaint. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

6.03 LIMITATIONS – Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

6.04 VENUE – Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the counties of San Bernardino or Riverside, State of California.

7. TERM AND TERMINATION

7.01 TERM – The term of this Agreement shall become effective on _____ and shall remain in effect for an initial term of one year unless earlier terminated by either party as set forth below. Thereafter, this Agreement shall renew automatically, upon formal approval by the Inland Empire Health Plan Governing Board, on the same terms and subject to the same conditions.

7.02 DISSOLUTION OF IEHP HEALTH PLAN – This Agreement shall be terminated upon the dissolution of IEHP Health Plan by mutual action of the Riverside County and San Bernardino County Board of Supervisors. If IEHP Health Plan has incurred no obligations, either County Board of Supervisors may terminate the JPA and IEHP Health Plan by giving not less than sixty (60) days written notice thereof to the other party.

Also, either County Board of Supervisors may terminate the JPA by written mutual consent, by giving twelve (12) months' written notice thereof to the other party given that the JPA cannot be terminated until all forms of indebtedness incurred by IEHP Health Plan have been paid, or adequate provision for such payment shall have been made. Upon dissolution of IEHP Health Plan by Riverside County and San Bernardino County Board of Supervisors, this Agreement is rendered null and void.

The debts, liabilities, and/or obligations of IEHP Health Plan are those of IEHP Health Plan alone. Neither Riverside County nor San Bernardino County assumes any of the debts, liabilities and/or obligations of IEHP Health Plan.

7.03 TERMINATION WITHOUT CAUSE – Either party may terminate this Agreement without cause upon providing the other party with ninety (90) days prior written notice of termination. Termination shall take effect automatically upon expiration of the ninety (90) day notice period.

7.04 TERMINATION FOR CAUSE – This Agreement shall terminate immediately, upon IEHP Health Plan's written notice, in the event of the occurrence of any of the following:

7.04.01 FAILURE TO PROVIDE QUALITY SERVICES – PROVIDER's failure to maintain the standards as provided herein.

7.04.02 FAILURE TO RENDER SERVICES – PROVIDER's failure to provide Health Care Services to Members as provided herein.

7.04.03 BREACH OF MATERIAL TERM – PROVIDER's breach of any material term, covenant or condition of the Agreement.

7.04.04 LICENSING – Revocation, suspension, restriction or sanction of PROVIDER'S licenses, accreditation or certification required for the performance of the duties hereunder or otherwise excluded, ineligible or terminated from participation in Medicare or Medicaid (Medi-Cal). PROVIDER is considered sanctioned, excluded, ineligible, or terminated for purposes of this section if PROVIDER is named by the appropriate State or Federal departments or agencies on published exclusionary lists, including but not limited to the following: The Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE), General Services Administration (GSA) Excluded Parties Lists System (EPLS), California Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible List, State Exclusionary List, and State Disciplinary List (collectively, "Exclusionary Lists"). In the event PROVIDER or employed personnel appear on the Exclusionary Lists or is otherwise ineligible to participate in the Medi-Cal and Medicare programs, PROVIDER shall ensure that the PROVIDER or individual personnel shall not treat or otherwise participate in the care of IEHP members. In the event of appearing on the Exclusionary Lists, the PROVIDER must notify IEHP at compliance@iehp.org or 866-355-9038 as soon as reasonably possible but no later than five (5) business days of discovery of exclusionary status. The presentation of a claim for payment by a PROVIDER or its personnel who are ineligible for payment pursuant to this Section may be considered a breach of this Agreement. Any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

7.04.05 LOSS OF INSURANCE COVERAGE – Failure by PROVIDER to maintain adequate professional liability insurance coverage, as provided herein.

7.04.06 FRAUD – Upon IEHP Health Plan's determination that PROVIDER has engaged in a fraudulent activity against the Plan or its Members

7.05 NOTICE OF BANKRUPTCY – Notice shall be given within ten (10) working days to the other party of any filing for bankruptcy, insolvency or for reorganization, or the appointment of a receiver, trustee or conservator, or assignment to creditors.

In the event PROVIDER files for bankruptcy protection in any form, this Agreement may terminate immediately.

7.06 CONTINUING CARE RESPONSIBILITIES – In the event of termination of this Agreement, IEHP Health Plan shall be responsible to notify all Members under care prior to termination. PROVIDER shall continue to provide or arrange for Health Care Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP Health Plan to PROVIDER. If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP Health Plan notifies PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.07 CONTINUING CARE RESPONSIBILITIES – PRIMARY CARE PHYSICIAN – In the event of termination of this Agreement, PROVIDER shall continue to provide or arrange for Primary Care Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP Health Plan to PROVIDER. If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP Health Plan notifies PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.08 CONTINUING CARE RESPONSIBILTIES – SKILLED NURSING AND REHABILITATION FACILTIES – In the event of termination of this Agreement, PROVIDER shall continue to provide and be compensated for Health Care Services under the terms of this Agreement to Members who are admitted on the date of termination until the effective date of discharge or the safe transfer of such Members to another health care facility.

7.09 MEMBER RECORDS – Upon termination of this Agreement, PROVIDER agrees to assist IEHP Health Plan in the transfer of Member medical care by making available copies of medical records, patient files and other pertinent information necessary for efficient case management of Members.

7.10 NON-PAYMENT POLICY – Notwithstanding the above, or any other provisions to the contrary, PROVIDER agrees that in the event IEHP Health Plan ceases operations for any reason, including insolvency, PROVIDER shall continue to provide Health Care Services for those Members who are hospitalized on an inpatient basis. PROVIDER shall not bill, charge, collect or receive any form of payment from any such Member or have any recourse against Member for Health Care Services provided after IEHP Health Plan ceases operation. This continuation of Health Care Services obligation shall continue until Member is discharged from PROVIDER.

8. RELATIONSHIP OF PARTIES

8.01 CONFLICT OF INTEREST – The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

8.02 NON-LIABILITY OF COUNTIES – Neither Riverside County nor San Bernardino County assumes any responsibility for any of the obligations under this Agreement.

8.03 INDEMNIFICATION – PROVIDER shall indemnify and hold harmless IEHP Health Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PROVIDER's officers, directors, agents, employees, Providers, agents and shareholders acting alone or in collusion with others. PROVIDER also agrees to hold harmless both the State and Members in the event that IEHP Health Plan cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

8.04 INDEPENDENT PROVIDER – It is understood and agreed that PROVIDER is an independent contractor in the business of providing Health Care Services to Members and that no relationship of employer-employee exists between the parties hereto. Neither of the parties nor any of their respective officers, directors or employees shall act as, nor be construed to be, an agent, employee or representative of the other.

8.05 LIABILITY FOR OBLIGATIONS – Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless liability is found against either party based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law basis for liability. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any obligation for the payment of wages, salaries or other compensation (including all state, federal and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of such party's employees, agents and representatives.

8.06 PROVIDER PARTICIPATION – The execution of this Agreement shall qualify PROVIDER as a Participating Provider in the rendition of Health Care Services to Members pursuant to the terms of the IEHP Health Plan, as amended from time to time.

9. GENERAL PROVISIONS

9.01 AMENDMENT – This Agreement may be amended or modified only by mutual written consent of the parties. Amendments required due to legislative, regulatory or other legal authority do not require the prior approval of PROVIDER and shall be deemed effective immediately upon PROVIDER's receipt of notice.

9.02 ASSIGNMENT – PROVIDER shall not assign or delegate any duties, rights and obligations under this Agreement to any person or entity without first obtaining the written consent of IEHP Health Plan and DHCS. IEHP Health Plan and DHCS must approve all subcontracts between PROVIDER and other providers prior to use.

9.03 ATTORNEYS' FEES – If any action at law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, in addition to any other relief to which such party may be entitled.

9.04 CAPTIONS – Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

9.05 CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT – PROVIDER certifies that the individual signing herein has authority to execute this Agreement on behalf of PROVIDER, and may legally bind PROVIDER, and his/her contracted physicians as listed on Attachment C, to the terms and conditions of this Agreement, and any attachments hereto.

9.06 CONTRACT REQUIREMENTS – IEHP Health Plan is subject to the provisions of sections 1340 et. seq. of the Health and Safety Code, sections 1300.43 of Title 28 of the California Code of Regulations and sections 2698.100 et. seq, of Title 10 of the California Code of Regulations, as may be amended from time to time.
IEHP is subject to the requirements of California Health & Safety Code Chapter 2.2, Division 2 [Knox-Keene Act], and Subchapter 5.5, Chapter 3 [California Community Care Facilities Act], and of Title 28 of the California Code of Regulations and any provision required to be in the contract by either of these requirements shall bind IEHP whether or not provided in the contract.

9.07 CONFIDENTIALITY OF THIS AGREEMENT – To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms or reports without the approval of the other party, subject to the limitation of the Public Records Act and the Brown Act.

9.08 ENTIRE AGREEMENT – This Agreement, including all attachments and manuals, which are hereby incorporated in this Agreement, supersedes any and all other agreements, promises, negotiations or representations, either oral or written, between the parties with respect to the subject matter and period governed by this Agreement and no other agreement, statement or promise relating to this Agreement shall be binding or valid.

9.09 GOVERNING LAW – IEHP Health Plan, PROVIDER and this Agreement are subject, and must comply with, the applicable laws of the State of California and the United States of America including, but not limited to: the California Knox-Keene Act and the regulations promulgated thereunder by the California Department of Managed Health Care, the Health Maintenance Organization Act of 1973 and the regulations and CMS instructions promulgated thereunder by the United States Centers for Medicare and Medicaid Services (CMS), and the Waxman-Duffy Prepaid Health Plan Act and the regulations promulgated by DHCS, and the State Children's Health Insurance Program (found in Title 21 of the Social Security Act). Any provision required to be in this Agreement by any of the above Acts, CMS instructions and regulations shall bind IEHP Health Plan and PROVIDER, whether or not expressly provided in this Agreement.

9.10 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP PLAN and PROVIDER are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 (HITECH), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent hereto, for purposes of services rendered pursuant to the Agreement. Both parties agree to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA and HITECH. Both parties further agree that it shall be in compliance with the requirements of HIPAA, HITECH and the laws and regulations promulgated subsequent hereto.

9.11 INVALIDITY AND SEVERABILITY – In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

9.12 NOTICES – Any notices required to be given hereunder shall be in writing to either IEHP Health Plan or PROVIDER at the address listed below, or at such other addresses as either IEHP Health Plan or PROVIDER may hereafter designate to the other:

IEHP HEALTH PLAN:
Inland Empire Health Plan
P. O. Box 1800
Rancho Cucamonga, CA 91729-1800
(909) 890-2000
Attn: Director of Provider Contracting

PROVIDER:
The Illumination Foundation
1091 N. Batavia St.
Orange, CA 92867
(562) 713-2128
Attn: Office Manager

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

9.13 IEHP PROVIDER POLICY AND PROCEDURE MANUALS – IEHP Health Plan shall develop and provide to PROVIDER and PROVIDER shall comply with IEHP Policy and Procedure Manuals that shall set forth IEHP Health Plan's administrative requirements. IEHP Health Plan may modify the Manuals from time to time by written notice to the PROVIDER. The IEHP Provider Policy and Procedure Manuals are hereby incorporated in full by reference.

9.14 TERMS – Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement.

9.15 TIME OF THE ESSENCE – Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

9.16 WAIVERS – No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing, duly executed by the party waiving such obligations. All matters shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to other provisions of this Agreement unless so specified in writing.

9.17 COUNTERPARTS; SIGNATURES – this Agreement may be executed in separate counterparts, each of which shall be deemed an original, and all of which shall be deemed one and the same instrument. The parties' faxed signatures, signatures scanned into PDF format, and/or other such electronic transmission of signatures, shall be effective to bind them to this Agreement.

IN WITNESS WHEREOF, the parties hereto have signed this Enhancement Care Management Provider Agreement as set forth below.

THE ILLUMINATION FOUNDATION:

By: _____

_____
Print Name and Title

Date: _____

TIN: 71-1047686

INLAND EMPIRE HEALTH PLAN:

By: _____
Jarrod B. McNaughton, MBA, FACHE
Chief Executive Officer

Date: _____

By: _____
Chair, Governing Board

Date: _____

Attest: _____
Secretary, Governing Board

Date: _____

Approved as to Form:

By: _____
Anna W. Wang
Vice President, General Counsel

Date: _____

ATTACHMENT A

ECM POPULATIONS OF FOCUS

THE ILLUMINATION FOUNDATION

Provider shall indicate which of the following ECM Populations of Focus they will serve:

√	**ECM Populations of Focus**
	1. Enhanced Care Management (ECM) – Homeless families
	2. Enhanced Care Management (ECM) – Adult: Homeless without dependent children/youth
	3. Enhanced Care Management (ECM) – Adult: Avoidable hospital or ED utilization
	4. Enhanced Care Management (ECM) – Adult: Serious mental health and/or SUD needs
	5. Enhanced Care Management (ECM) – Adult: Justice involved
	6. Enhanced Care Management (ECM) – Adult: At risk for long-term care institutionalization
	7. Enhanced Care Management (ECM) – Adult: Nursing facility residents transitioning to the community
	8. Enhanced Care Management (ECM) – Adult: Intellectual or developmental disabilities
	9. Enhanced Care Management (ECM) – Adult: Pregnant and postpartum
	10. Enhanced Care Management (ECM) – Adult: Birth equity
	11. Enhanced Care Management (ECM) – Children/Youth: Homeless unaccompanied
	12. Enhanced Care Management (ECM) – Children/Youth: Avoidable hospital or ED utilization
	13. Enhanced Care Management (ECM) – Children/Youth: Serious mental health and/or SUD needs
	14. Enhanced Care Management (ECM) – Children/Youth: Justice involved
	15. Enhanced Care Management (ECM) – Children/Youth: Enrolled in CCS
	16. Enhanced Care Management (ECM) – Children/Youth: Involved in child welfare
	17. Enhanced Care Management (ECM) – Children/Youth: Intellectual or developmental disabilities
	18. Enhanced Care Management (ECM) – Children/Youth: Pregnant and postpartum
	19. Enhanced Care Management (ECM) – Children/Youth: Birth equity

ATTACHMENT B

ENHANCED CARE MANAGEMENT

THE ILLUMINATION FOUNDATION

I. ENHANCED CARE MANAGEMENT OVERVIEW

INTRODUCTION

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. One foundational component of CalAIM is Enhanced Care Management (ECM).[1]

Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of the highest-need Medi-Cal beneficiaries. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office, or at home. It serves to build on the Health Homes Program (HHP) and Whole Person Care (WPC) pilots and transitions those pilots to one larger benefit to provide a broader platform to build on positive outcomes from each program.

The Inland Empire Health Plan's (IEHP) ECM benefit is a clinical service delivery model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's health care team including the Primary Care Provider (PCP) as well as community-based service Providers. This integrated care team provides an intensive set of care management services for a subset of Medi-Cal Members. The ECM Provider focuses on whole-person, complex care management, which includes changing behaviors and patterns of health care among both Providers and Members with the goal of reducing avoidable, high-cost interventions and increasing the use of appropriate, timely interventions, along with improved self-management. IEHP's ECM service delivery model encompasses a person-centered, comprehensive approach to addressing the Member's goals for improvement and management of behavioral and physical health, acute care, and social needs.

DEFINITIONS

1 Department of Health Care Services (DHCS), California Advancing & Innovating Medi-Cal (CalAIM) Proposal, January 2021

1.01 ENHANCED CARE MANAGEMENT ("ECM") – shall mean a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of highest-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM is a Medi-Cal benefit.

1.02 ECM PROVIDER – shall mean a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

1.03 LEAD CARE MANAGER – shall mean a Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1.04 ADULTS and CHILDREN & YOUTH – in the Populations of Focus definitions, "Adult" is defined as an individual who is 21 years of age or older, and a "Child or Youth" is defined as an individual up to age 21, which means that Children and Youth definitions for ECM apply up to age 21.

1.04 ECM POPULATIONS OF FOCUS – to be eligible for ECM, Members must be enrolled in a Medi-Cal Managed Care Plan and meet at least one of the ECM Populations of Focus definitions described below:

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	**X**	
1b	Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	**X**	**X**
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers"	**X**	**X**
3	Individuals with Serious Mental Health and/or SUD Needs	**X**	**X**
4	Individuals Transitioning from Incarceration	**X**	**X**
5	Adults Living in the Community and At Risk for LTC Institutionalization	**X**	
6	Adult Nursing Facility Residents Transitioning to the Community	**X**	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		**X**
8	Children and Youth Involved in Child Welfare		**X**
9	Individuals with I/DD	**X**	**X**
10	Pregnant and Postpartum Individuals; Birth Equity Population of Focus	**X**	**X**

Detailed Population of Focus Definitions (Updated July 2023 per DHCS)

Each Population of Focus includes a detailed definition for the Population of Focus with eligibility criteria, examples of eligible Members, and operational guidance to support implementation. In the Populations of Focus definitions, "adult" is defined as an individual who is 21 years of age or older; and a "child or youth" is defined as an individual under 21. Consequently, the Children and Youth-specific definitions for ECM apply up to age 21, with limited exceptions as called out below. When a Member under 21 is served in ECM and does meet adult ECM criteria upon turning 21, the Member should not be disenrolled from ECM; rather, the ECM Provider and MCP should apply the MCP's usual, DHCS-approved "graduation" criteria to determine when the Member is ready to disenroll. Detailed Definitions of each Population of Focus can be found in the ECM Policy Guide posted on the DHCS website.

II. ENHANCED CARE MANAGEMENT COMPENSATION

PHASE ONE - RAMP-UP FUNDING

1. **IEHP Funding Obligation.**
    a. New Contracted ECM Provider
        i. Pursuant to the terms and conditions of this Agreement, IEHP will provide Ramp-up Funding to ECM PROVIDER to assist in expanding its participation in Enhanced Care Management. The total aggregate Ramp-up Funding per care team shall not exceed $390,000.00 and shall not exceed a total of six (6) Milestone payments within a nine (9) month period. Within the ramp-up period for newly contracted ECM Providers, ECM PROVIDER will not be paid capitation as per the terms outlined in Phase Two. ECM PROVIDER will transition to Capitation Payments as outlined in Phase Two after the ramp-up period has ended and final ramp-up payments have been made.

    b. Existing ECM Contracted Provider
        i. Pursuant to the terms and conditions of this Agreement, in addition to the Fees paid to PROVIDER as an EM Provider as outlined in Phase Two, IEHP will provide Ramp-up Funding to ECM PROVIDER to assist in expanding its participation in Enhanced Care Management. The total aggregate Ramp-up Funding per care team shall not exceed $100,000.00 and shall not exceed a total of two (2) payments per care team within a nine (9) month period.

2. **Use of Funds.** ECM PROVIDER shall utilize the funds to hire and develop PROVIDER as an ECM Provider to participate and/or expand in Enhanced Care Management.

3. **Ramp-up Funding Payments**.
    a. Payment Criteria.
        i. New Contracted ECM Provider

            1. For each monthly Milestone period completed, ECM PROVIDER is eligible to receive $65,000 for up to 6 months to support staffing the following ECM Care Team members listed below:

                a. Nurse (RN) Care Manager or Licensed Vocational Nurse Care Manger (LVN) with clinical oversight;
                b. Behavioral Health Care Manager;
                c. Care Coordinator; and
                d. Community Health Worker

            2. In the event ECM PROVIDER fails to meet any of the Milestone period goals, ECM PROVIDER shall have a thirty (30) day grace

period to submit its invoice to IEHP for approval. This approval is contingent upon ECM PROVIDER having met all goals in the successive month.

3. In no event shall ECM PROVIDER be compensated for more than a total of six (6) Milestone payments. Each payment is tied to the Milestone date as indicated in the MONTHLY MILESTONE TIMELINE.

ii. Existing ECM Contracted Provider

1. Overall ramp-up funding amount is equivalent to $100,000.00 per care team.
2. 50% ($50,000.00) allocated up front as payment 1 upon initiation and IEHP approval of additional care team request
3. The remaining 50% ($100,000.00) will be distributed upon proof of hire of the following ECM Care Team Members listed below:
    a. Nurse (RN) Care Manager or Licensed Vocational Nurse Care Manger (LVN) with clinical oversight;
    b. Behavioral Health Care Manager;
    c. Care Coordinator; and
    d. Community Health Worker
4. Provider will provide monthly updated on PROVIDER's progress toward achievement of hiring the care team members listed above
5. In no event shall Provider be compensated for more than a total of two (2) payments per additional care team.

b. For newly contracted ECM Providers, no later than five (5) business days following the end of each Milestone period provided in the MONTHLY MILESTONE TIMELINE below, ECM PROVIDER will submit a Milestone Progress Report and invoice IEHP in the form required by IEHP.

i. Upon completion of the deliverables for each Milestone period, ECM PROVIDER shall attach an invoice to the Milestone Progress Report requesting the appropriate payment amount pursuant to Paragraph 3(a). Invoice shall include, at minimum, the following details:

1. ECM Organization Name
2. Invoice Number
3. Date Submitted
4. Payment #
5. Employed Care Team Member Start Dates

ii. In the event the ECM PROVIDER fails to meet any of the Milestone period goals, ECM PROVIDER shall have a thirty (30) day grace period to submit

its invoice to IEHP for approval. This approval is contingent upon ECM PROVIDER having met all the goals in the successive month.

c. IEHP shall not be required to release any Ramp-Up Funding Payments submitted by ECM PROVIDER: (1) sixty (60) days after the Milestone period; or (2) after the expiration of the Ramp-Up Funding obligation.

d. IEHP retains the sole discretion to determine whether ECM PROVIDER has met each deliverable in the MONTHLY MILESTONE TIMELINE. IEHP will not unreasonably withhold approval of payment based on information provided by and available to ECM PROVIDER and delivered to IEHP for review.

4. **Termination of Ramp-up Funding.**

a. IEHP's funding obligation shall terminate nine (9) months from the Effective Date, provided that IEHP retains the sole discretion to terminate the Ramp-up Funding obligation at any time and for any reason.

b. If IEHP determines, in its sole discretion, that ECM PROVIDER failed to meet Milestone period goals for two (2) consecutive months, IEHP may immediately terminate its Ramp-Up Funding obligations.

c. In event IEHP terminated ECM PROVIDER Ramp-Up Funding for:

i. ECM PROVIDER failure to meet monthly Milestone goals for two (2) consecutive months, ECM PROVIDER shall be subject to a prorated recoupment of Ramp-Up Funding by IEHP to account for expenses incurred by IEHP prior to the early withdrawal.

II. ENHANCED CARE MANAGEMENT COMPENSATION

PHASE TWO - CAPITATION

On or before the fifth (5th) day of each month following the month of service, IEHP Health Plan shall pay ECM PROVIDER the following reimbursement rate for each Member assigned to the ECM PROVIDER who meets the eligibility criteria definition at the time of authorization or the engagement definition thereafter. Retroactive eligibility additions and deletions are limited to three-hundred sixty-five (365) days for all Members. Retroactive Medicare Status changes are limited to sixty (60) days.

STATE PROGRAMS (IEHP MEDI-CAL BENEFICIARIES THAT DO NOT HAVE MEDICARE COVERAGE OR HAVE MEDICARE PART A ONLY) AND **MEDI-MEDI (IEHP MEDI-CAL BENEFICIARIES WITH FULL FEE FOR SERVICE (FFS) MEDICARE COVERAGE OR MEDICARE PART B ONLY)**

FOR PRIMARY CARE BASED ECM PROVIDERS
IEHP shall reimburse ECM PROVIDER $400.00 per engaged member per month (PEMPM) for Adult Members who are authorized for ECM and who are engaged with the ECM PROVIDER as of the effective date of this Agreement. PEMPM for Members who are authorized for ECM and who are engaged with the ECM PROVIDER as of the effective date of this Agreement.

FOR BH/SMH/SUD BASED ECM PROVIDERS
IEHP shall reimburse ECM PROVIDER $475.00 per engaged member per month (PEMPM) for Adult Members who are authorized for ECM and who are engaged with the ECM PROVIDER as of the effective date of this Agreement.

FOR ALL ECM PROVIDERS
IEHP shall reimburse ECM PROVIDER $500.00 per engaged member per month (PEMPM) for Children/Youth Members who are authorized for ECM and who are engaged with the ECM Provider as of the effective date of this Agreement.

a) ECM Eligibility criteria definition:
   1. Member is an active Medi-Cal Member; and
   2. Member is eligible for ECM (meets eligibility criteria per the Populations of Focus criteria for ECM); and
   3. Member is assigned to the ECM Provider for primary care (Primary Care sites only); and

b) Engagement definition:
   In addition to the eligibility criteria above, Members must meet the following engagement definition:
   1. Member has received an ECM service where the first ECM service is received within 90 days of enrollment and all ongoing ECM services are received within at least 90 days of the last ECM service received; and
   2. IEHP has received an ECM service encounter (HCPCS G-code) for the Member following the timeline requirements as noted in b) 1.

ECM OVERLAPS / NON-DUPLICATION

PROVIDER will not be reimbursed for Members enrolled in the following programs as they are excluded from participation in ECM while enrolled in the other program:

- Exclusively Aligned Enrollment (EAE) D-SNPs [IEHP DualChoice (HMO D-SNP)]
- Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Family Mosaic Project
- Hospice
- 1915(c) Waivers
- Complex Care Management (CCM)
- California Community Transitions (CCT) Money Follows the Person (MFTP)

Payment Details

1. For ECM Providers primarily serving adults (less than 20% Children/Youth in enrolled caseload) payment will be provided for up to 250 IEHP enrolled Members who successfully meet the eligibility criteria and engagement definitions, as defined above. Payments are made on a per month per care team basis.

2. For ECM Providers primarily serving children (less than 20% Adults in enrolled caseload), payment will be provided for up to 150 IEHP enrolled Members who successfully meet the eligibility criteria and engagement definitions, as defined above. Payments are made on a per month per care team basis.

3. Evidence of ECM services rendered is documented through the use and successful submission of the following ECM code schema. All codes and definitions are subject to DHCS changes:

ECM Service	HCPCS Code	Modifier	Place of Service
In-Person: Provided by Clinical Staff	G9008	U1	As Appropriate
Phone/Telehealth: Provided by Clinical Staff	G9008	U1, GQ	"02" or "10"
In-Person: Provided by Non-Clinical Staff	G9012	U2	As Appropriate
Phone/Telehealth: Provided by Non-Clinical Staff	G9012	U2, GQ	"02" or "10"

Encounter Data – Providers contracted to provision ECM services shall send Encounters to IEHP on a CMS1500 claim form, or through the IEHP Provider Portal. Claims will be adjudicated as Encounters and Pay at $0. Claims submitted for services not listed above will be denied.

IEHP reimburses ECM PROVIDER on a per engaged member per month (PEMPM) rate for Members who meet the eligibility criteria for enrollment, as defined by DHCS, for ECM at the time of authorization and who are engaged with the ECM PROVIDER.

Place of service code definitions for reference can be found here:
Place of Service Code Set | CMS

II. ENHANCED CARE MANAGEMENT COMPENSATION

Outreach Fee-For-Service Payment

IEHP shall reimburse ECM PROVIDER $40.00 per outreach attempt for a maximum number of fifteen (15) attempts (successful or unsuccessful) per unique potentially eligible Member (adult or child/youth), per unique organization, per calendar year.

Outreach Definition: Outreach activities shall consist of the ECM Provider Care Team or specially trained ECM Outreach and Screening Team connecting with an individual Member for the purpose of enrolling the Member in the ECM benefit either in-person or telephonically/electronically.

"Telephonic/electronic" can include individualized text messaging or a secure individualized email to the Member; however, mass communications (e.g., mass mailings, distribution emails, and text messages) would not count as "outreach" and should not be included.

Outreach should also be documented in Care Director as an "outreach note" or other mutually agreed upon platform. Outreach documented outside of Care Director will be made available at the request of IEHP.

Outreach Data Reporting

At set intervals, at least monthly, the ECM Provider will provide IEHP their ECM Provider Initial Outreach Tracker File. Separate entries must be reported for each outreach attempt, including if there were multiple outreach attempts during the same day.

ECM Provider shall in good faith outreach to IEHP Members who are believed to be potentially ECM eligible. ECM Provider will not be reimbursed for Outreach claims for Members currently enrolled in ECM.

ECM Outreach and Engagement Service	HCPCS Code (CPT 1)	Modifier	Units of Service	Place of Service	Outreach Fee*
ECM Outreach in Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified	G9008	U8	1	As appropriate	$40.00
ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified	G9008	U8, GQ	1	"02" or "10"	$40.00

ECM Outreach in Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	G9012	U8	1	As appropriate	$40.00
ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	G9012	U8, GQ	1	“02” or “10”	$40.00

***Note: PROVIDER will be reimbursed $40.00 per unique Member per day regardless of unit(s) of service billed on claim line.**

PROVIDER will submit a claim on a CMS1500 claim form, or through the Provider Portal. PROVIDER shall not submit more than one (1) outreach unit per unique Member per day. Outreach claims paid by IEHP are not to exceed $600.00 per unique member per calendar year.

III. ENHANCED CARE MANAGEMENT - VALUED BASED PAYMENT (VBP) MEASURES

Section 1: ECM Benefit Overview

I. Introduction

The following information provides an overview of the Enhanced Care Management (ECM) Payment methodology for ECM PROVIDER and is designed as an easy reference. Although certain processes and outcomes are financially incentivized, the expectation is that ECM PROVIDER will comply with all the requirements of the ECM benefit as outlined in the scope of this agreement.

For more information about IEHP ECM payment methodology, email ECM@iehp.org.

II. Minimum Data Submission Requirements

1. Claims Data

   Claims data is important to ensuring payment for outreach attempts. Complete, timely, and accurate claims should be submitted through normal claims submission channels for all outreach attempts to potentially eligible ECM Members in accordance with, and in support of, the latest DHCS requirements for Outreach effort data collection. Please use the appropriate outreach codes listed above in the fulfillment of claims submission requirements.

2. Encounter Data

   Encounter data collection is required to fulfill DHCS mandates for ECM Provider Transmission File generation and also informs VBP performance and payment. Complete, timely, and accurate encounter data should be submitted through normal reporting channels and be structured in accordance with the latest DHCS guidance for all ECM services rendered to IEHP ECM enrolled Members. Please use the appropriate ECM encounter codes (HCPCS G-codes) listed in the table above to meet encounter reporting requirements. For more information regarding ECM encounter submission instructions, please refer to the ECM Encounter Submission Guide.

3. Care Director Data

   Care Director is the predominant and preferred platform that ECM Providers use to document ECM services (outreach, enrollment, assessment, care planning, coordination of care, clinical interventions, monitoring of outcome measures, and ongoing contacts).

Accurate documentation and transmission of care-related data is foundational to ensuring that patient meets their health outcome measures and goals, and measuring VBP performance and is therefore essential to success in the determining VBP level achievement for ECM. Any potential uses of Platforms outside of Care Director must be vetted and approved by IEHP in advance of any platform use other than Care Director for documenting ECM services in order to assure viable interoperability and data exchange of DHCS required information.

4. Member-Level Information Sharing Data

Member-level information sharing consists of three types of exchanges with a standardized set of "minimum necessary" data elements, standard file formats, transmission methods, and transmission frequencies. 1. MCP Member Information File 2. ECM Provider Return Transmission File 3. ECM Provider Initial Outreach Tracker File.

III. VBP Measurement Period Definition

VBP Measurement periods are defined as rolling quarters per Table 1 below.

Table 1: 2023-2024 ECM VBP Measurement Period Schedule

ECM VBP Measurement Period	Expected ECM VBP Payment Date
January, February, March 2023	On or around last business day of April 2023
February, March, April 2023	On or around last business day of May 2023
March, April, May 2023	On or around last business day of June 2023
April, May, June 2023	On or around last business day of July 2023
May, June, July 2023	On or around last business day of August 2023
June, July, August 2023	On or around last business day of September 2023
July, August, September 2023	On or around last business day of October 2023
August, September, October 2023	On or around last business day of November 2023
September, October, November 2023	On or around last business day of December 2023
October, November, December 2023	On or around last business day of January 2024
November 2023, December 2023, January 2024	On or around last business day of February 2024
December 2023, January 2024, February 2024	On or around last business day of March 2024
January, February, March 2024	On or around last business day of April 2024
February, March, April 2024	On or around last business day of May 2024
March, April, May 2024	On or around last business day of June 2024
April, May, June 2024	On or around last business day of July 2024
May, June, July 2024	On or around last business day of August 2024
June, July, August 2024	On or around last business day of September 2024
July, August, September 2024	On or around last business day of October 2024
August, September, October 2024	On or around last business day of November 2024
September, October, November 2024	On or around last business day of December 2024
October, November, December 2024	On or around last business day of January 2025

Section 2: Value-based Payment

I. VBP ECM Payment Measures

IEHP is aligning contracting with the intended goals of the ECM benefit to advance high value processes and improve health outcomes. VBP measures payments are currently only applicable for the adult populations. IEHP is focusing on the following measures:

- Care Planning
- Blood Pressure
- Depression
- Transition of Care

VBP metrics are the foundational components of ECM. Correspondingly, the care plan is at the heart of ECM service delivery because it memorializes patient-identified, whole-person health and wellness goals. The care plan guides the provision of services overtime and represents the ongoing conversation between the care team and Member in order to move them along the continuum towards improved health outcomes and self-management.

Hypertension is the most common diagnosis among all ECM enrollees and is an underlying factor of morbidity and mortality for these vulnerable populations. Blood pressure was selected as a VBP measure because even small improvements in blood pressure have a significant impact on reducing morbidity and mortality. Additionally, the ECM population overall has a disproportionate level of behavioral health diagnoses. Driving towards improvement in depression response measures across this population moves the needle in providing integrated and whole person care. Lastly, the transitions of care measure aims to reduce readmissions by providing timely post-discharge follow-up and ensuring the Member sees their PCP and/or Specialist to align with other IEHP measures.

II. Care Planning

Measure Description: The percentage of ECM enrolled Members who had a Care Plan initiated or updated during each month of the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not)

Measure Numerator:

1. Members in the denominator who had at least one intervention created / customized or updated *each month* of the measurement period.
    a. Created / customized:
        i. The intervention "date modified" does *not* equal the intervention "date created," **AND**

ii. The intervention name does *not* equal "patient stated intervention:" **AND**
iii. Associated with the intervention is one activity note with a contact date within the measurement period **AND**
iv. A note outcome of "Successful" or "COVID Vaccine Services Provided" **OR**

b. Updated:
i. Associated with the intervention is a subsequent activity note with a contact date within the measurement period **AND**
ii. A note outcome of "Successful" or "COVID Vaccine Services Provided."

III. Blood Pressure

Blood pressure is a standard reading in all medical office settings. The Blood Pressure measure will consider two components: documentation of blood pressure in Care Director or other IEHP approved platform and the actual controlling of blood pressure. Therefore, two measures will be described.

Measure 1 – Blood Pressure Documentation

Measure Description: The percentage of ECM enrolled Members who have at least one blood pressure documented in CD during the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not), **AND**
2. 18 years of age and older on the first date of the measurement period

Measure Numerator:

1. Members in the denominator who have at least one Physical Health Measures assessment with a status = complete, where the SBP and DBP fields are populated, with a contact date in the measurement period, **AND**
2. Where the SBP *and* DBP field values are within the valid ranges.
    a. SBP: > 40 and < 300 (greater than 40 and less than 300)
    b. DBP: > 40 and < 150 (greater than 40 and less than 150)

Measure 2 – Blood Pressure Control

Measure Description: The percentage of ECM enrolled Members who have a diagnosis of hypertension or who have documented elevated blood pressure in Care Director by the first day of the measurement period whose blood pressure (BP) was controlled (<140/90 mm Hg) by the end of the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not), **AND**
2. 18 years of age or older on the first date of the measurement period, **AND**
3. Where the SBP *and* DBP field values are within the valid ranges
    a. SBP: > 40 and < 300 (greater than 40 and less than 300)
    b. DBP: > 40 and < 150 (greater than 40 and less than 150), **AND**
4. Who meet at least one of the following criteria on the first day of the measurement period:
    a. Members who have a diagnosis of hypertension within the last two years **OR**

    b. Members who have at least two Physical Health Measures assessments with a status = complete, where the SBP was greater than or equal to 140 **OR** DBP was greater than or equal to 90 prior to the start of the measurement period

Measure Numerator:

1. Members in the denominator who have at least one Physical Health Measures assessment with a status = complete with a contact date in the measurement period where the SBP field is less than 140 but greater than 40 AND the DBP field is less than 90 but greater than 40.

IV. Depression

The Depression measure will consider two components: documentation of a PHQ-9 in Care Director and depression response for Members with elevated PHQ-9s. Therefore, two measures will be described.

Definition: For the purposes of the following measure, the term "enrollment" and "enrollment date" refer to the first enrollment date with the Healthcare Organization within the sequence during which they are continuously enrolled during the measurement period.

Measure 1 – Depression Documentation

Measure Description: The percentage of ECM enrolled Members who have a PHQ-9 documented within 90 days of enrollment.

Source Data: Care Director Data

Measure Denominator:

1. Members must be continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not) **AND**
2. Who achieved 90 days of enrollment during the measurement period, **AND**
3. 12 years of age or older on the first date of the measurement period.

Measure Numerator:

1. Members in the denominator who had a PHQ-9 assessment with a status = complete with a contact date within 90 days of their enrollment date

Measure 2 – Depression Response

Measure Description: The percent of ECM enrolled Members who, in response to a previously elevated PHQ-9, have a subsequent meaningful reduction in PHQ-9 documented during the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members must be continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (i.e., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not) **AND**
2. 12 years of age or older on the first date of the measurement period, **AND**
3. Who's last PHQ-9 prior to the start of measurement period was greater than 9

Measure Numerator:

1. Members in the denominator who have at least one PHQ-9 assessment with a status = complete and a contact date in the measurement period **AND**
2. Who's lowest PHQ-9 score within the measurement period is less than 10, **OR**
3. Who's lowest PHQ-9 score within the measurement period equals a 50% or greater reduction compared to the last PHQ-9 prior to the start to the measurement period

V. Transitions of Care

Measure Description:

The Transition of Care measure aims to reduce readmissions by conducting post-discharge assessment after an inpatient (IP) discharge in a timely manner. This measure is the percentage of Members with a TOC –Post-discharge Assessment completed within 14 days of IP discharge.

Source Data: Care Director

Measure Denominator:

1. Members must be continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (i.e., patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not) **AND**
2. Who have an IP discharge date within the last 14 calendar days of the previous measurement period **AND** prior to the last 14 calendar days of the current measurement period.

Measure Numerator:

1. Members who have a TOC-Post-discharge Assessment with a status = complete and a contact date equal to or less than 14 days after the IP discharge date.

Section 3: Level Determination for Measures

To qualify for measure performance at Level 1 for the Care Planning measure, 50% of enrolled Members must meet the Care Planning measure requirements. Increasing Care Planning measure performance qualifies ECM PROVIDER to reach Level 2 and 3 as demonstrated in Table 2.

To qualify for measure performance at Level 1 for the Blood Pressure measure, 80% of enrolled Members must have a blood pressure documented in Care Director. Once Level 1 is reached, analysis is conducted to determine if blood pressure is controlled at the performance level to qualify for either Level 2 or 3.

To qualify for measure performance at Level 1 for the Depression measure, 80% of patients must have a PHQ-9 completed within 90 days of enrollment. Once Level 1 is reached, analysis is conducted to determine if depression response is achieved at the performance level to qualify for either Level 2 or 3.

To qualify for measure performance at Level 1 for the Transition of Care measure, 50% of enrolled Members must meet the Transition of Care measure requirements. Increasing Transition of Care measure performance qualifies Providers to reach Level 2 and 3 as demonstrated in Table 2.

Table 2: Levels of Performance for VBP Measures

VBP Measure	Level 1	Level 2	Level 3
Care Planning (% initiated or updated)	50 – 64.99%	65 – 84.99%	85 – 100%
Blood Pressure (% documentation and control)	80% documentation + 50 – 64.99%	80% documentation + 65 – 84.99%	80% documentation + 85 – 100%
SMI (SBDBH, RVDBH & SUOS) Blood Pressure (% documentation and control)	50% documentation + 30-49.99%	50% documentation + 50 – 69.99%	50% documentation + 70 – 100%

Depression (% documentation or response)	80% documentation	80% documentation + 35 – 49.99%	80% documentation + 50 – 100%
Transitions of Care	50 – 64.99%	65 – 84.99%	85 – 100%

Section 4: Payment Methodology

Table 3 outlines the ECM VBP Payment structure. Table 4 outlines the ECM Payment rates across each payment methodology by Organization Type.

Table 3: VBP Payment Structure

VBP Measure	Level 1	Level 2	Level 3
Care Planning (% initiated or updated)	$5 PEMPM	$15 PEMPM	$25 PEMPM
Blood Pressure (% documentation and control)	$5 PEMPM	$15 PEMPM	$25 PEMPM
Depression (% documentation or response)	$5 PEMPM	$15 PEMPM	$25 PEMPM
Transitions of Care	$5 PEMPM	$15 PEMPM	$25 PEMPM
Total Maximum VBP Payment			$100 PEMPM

Table 4: ECM Rates per Methodology by Organization Type

	Cost Item	Rate
Primary Care ECM Provider	Maximum # Paid Outreach Attempts/Mbr/Provider/Yr	15
	Outreach - FFS	$40
	Enrollment/Engagement PEMPM - Adults	$400
	Enrollment/Engagement PEMPM – Children/Youth	$500
	VBP (potential) PEMPM	$100
Behavioral Health/SMI ECM Provider	Maximum # Paid Outreach Attempts/Mbr/Provider/Yr	15
	Outreach - FFS	$40
	Enrollment/Engagement PMPM - Adults	$475
	Enrollment/Engagement PMPM – Children/Youth	$500
	VBP (potential) PMPM	$100

ATTACHMENT C

PARTICIPATING PROVIDERS

THE ILLUMINATION FOUNDATION

The following list shall set forth the name, address, telephone number, and office hours of PROVIDER's facilities and the name, type and license of those providers who shall provide Health Care Services under this agreement. PROVIDER shall provide IEHP Health Plan written notification ninety (90) days prior to any changes in this Attachment C.

FACILITY NAME	ADDRESS	PHONE / FAX	GROUP NPI	OFFICE HOURS
The Illumination Foundation	2030 Iowa Ave., Riverside, CA 92507	(562) 800-7003 / (562) 999-3912 Fax	1013256213	9am – 5pm M – F

ATTACHMENT D

OFFICERS, OWNERS, STOCKHOLDERS AND CREDITORS

THE ILLUMINATION FOUNDATION

List, by category, all of the above:

Name	Title	*Ownership % (as applicable)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

* If corporation is publicly traded on a US stock market, indicate "Publicly Traded Corp."
Please indicate how your organization is legally organized (circle one): **501c Non-Profit Organization**

Corporation Partnership Sole Proprietorship

Other (please describe):

ATTACHMENT E

MEDICARE ADVANTAGE PROGRAM

THE ILLUMINATION FOUNDATION

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108- 173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between IEHP and PROVIDER not inconsistent herein shall remain in full force and effect. This Attachment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

I. DEFINITIONS

For purposes of this Attachment, the following definitions shall apply. All regulatory references in the brackets are to sections contained in 42 CFR Part 422, unless otherwise indicated.

1.1. **Centers for Medicare and Medicaid Services (CMS)** means the agency within the Department of Health and Human Services that administers the Medicare program.

1.2. **CMS Agreement** means the Medicare Advantage contract between CMS and the MAO.

1.3. **Completion of Audit** means the completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

1.4. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.5. **Dual Eligible Beneficiary** means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan.

1.6. **End Stage Renal Disease (ESRD)** means members who require kidney dialysis for the remainder of life.

1.7. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.

1.8. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

1.9. **Medicare Advantage (MA)** means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.10. **Medicare Advantage Organization (MA Organization or MAO)** means a public or private entity

organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

1.11. **Member or Enrollee** means a Medicare Advantage eligible individual who has enrolled in or elected coverage through a MAO.

1.12. **Provider** means (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.13. **Related Entity** means any entity that is related to the MA Organization by common ownership or control and (1) performs some of the MA Organization's management functions under contract or delegation; (2) furnishes services to Medicare Enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA Organization at a cost of more than $2,500 during a contract period.

II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

2.1. To give the Department of Health and Human Services (HHS), Department of Justice (DOJ), Department of Managed Health Care (DMHC), DHCS, CMS and the Comptroller General or their designees the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier, Downstream, and Related Entities to the CMS Agreement through ten (10) years from the final date of the Final Contract Period or from any Completion of Audit, whichever is later. [422.504(i)(2)(ii) and (iv)]

2.2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 2.1 of this Attachment directly from any First Tier, Downstream, or Related Entity. For records subject to review under Section 2.1, except in exceptional circumstances, CMS will provide notification to the MA Organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

2.3. To safeguard the privacy and confidentiality of any information that identifies a particular Member, and abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. [422.118(a)]

2.4. To maintain the records and information of Members in an accurate and timely manner. [422.118(c)]

2.5. To ensure that medical information pertaining to Members is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas. [422.118(b)]

2.6. To comply with MAO's standards for timeliness for appointments and waiting times for each type of service. [422.112(a)(6)(i)]

2.7. To ensure timely access by Members to the records and information that pertain to them. [422.118(d)]

III. ACCESS: BENEFITS AND COVERAGE

Provider agrees:

3.1. To not discriminate based on health status. [422.110(a)]

3.2. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for emergency and urgently needed services consistent with federal regulations, if such services are MAO's liability. [422.100(b)]

3.3. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for renal dialysis services for Members temporarily outside the service area consistent with federal regulations, if such services are MAO's liability. [422.100(b)(1)(iv)]
3.4. To direct access to mammography screening and influenza vaccinations. [422.100(g)(1)]
3.5. To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines. [422.100(g)(2)]
3.6. To direct access to in-network women's health provider for women for routine and preventative services. [422.112(a)(3)]
3.7. To have approved procedures to identify access and establish a treatment plan for Members with complex or serious medical conditions. [422.112(a)]
3.8. To provide access to benefits in a manner described by CMS. [422.112(a)(8)]
3.9. To maintain procedures to ensure that Members are informed of specific health care needs that require follow-up and receive, as deemed medically necessary by Provider, training in self-care and other measures that Members may take to promote their own health. [422.112(b)(5)]

IV. MEMBER PROTECTIONS

Provider agrees:

4.1. To work with the MAO regarding conducting a health assessment of all new Members within ninety (90) days of the effective date of enrollment. [422.112(b)(4)]
4.2. To provide all covered benefits in a manner consistent with professionally recognized standards of health care. [422.504(a)(3)(iii)]
4.3. To comply with all confidentiality and Member record accuracy requirements. [422.504(a)(13); 422.118)]
4.4. To document in a prominent place in the medical record whether or not an individual has executed an advance directive. [422.128(b)(1)(ii)(E)]
4.5. To hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or capitated provider organization. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided.
This provision does not prohibit collection of applicable coinsurance, deductibles, or copayments, as specified in the Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. [422.504(g)(1)(i); 422.504(i)(3)(i)]
4.6. That Members eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. MAO or Provider may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will accept the MAO payment as payment in full or bill the appropriate State source. [422.504(i)(3)(i) and 422.504(g)(1)(iii)]
4.7. If the CMS Agreement is terminated or is not renewed or the MAO becomes insolvent, to protect Members who are hospitalized from loss of health care benefits through the discharge date and through the period of time CMS premiums are paid. [422.504(g)(2) and (3)]
4.8. To provide for continuation of health care benefits for all Members for the duration of the contract period for which CMS premiums have been paid. [422.504(g)(2) and (3)]

4.9. To ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [422.112(a)(8)]

4.10. To address the special needs of Members who are members of specific ethnic and cultural populations such as, but not limited to, the Vietnamese and Latino populations. Provider shall in its policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive environment where difference are valued, respected and managed; (d) through cultural diversity training, foster in staff and/or providers' attitudes and interpersonal communication styles which respect Member's cultural backgrounds; and (e) referring members to culturally and linguistically appropriate community services program. In addition, Provider shall provide translation of written materials in the languages served. Written materials to be translated include, but are not limited to, signage, the member service guide, enrollee information, notices, marketing information and welcome packages. [422.112(a)(8)]

4.11. To educate Members regarding their health needs; share findings of the Member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms; recognize that the Member has the final say in the course of action to take among clinically acceptable choices.

4.12. To not encourage disenrollment of a Member because of the onslaught of ESRD. [422.110(b)]

V. DELEGATION

Provider agrees:

5.1. To perform and maintain services or activities under the Agreement, including delegated functions, consistent and compliant with MAO's contractual obligations under the CMS Agreement. [422.504(i)(3)(iii)] If any of the MAO's activities or responsibilities under the CMS Agreement are delegated to Provider, such delegated activities and reporting responsibilities shall be specified on a delegation agreement, which shall be an attachment to the Agreement.

5.2. That MAO may only delegate activities or functions to a Provider, related entity, contractor or subcontractor in a manner consistent with the requirements set forth in 42 CFR § 422.504(i)(4)(i). [422.504(i)(3)(ii)]

5.3. To comply with MAO's policies and procedures as set forth in the Medicare Advantage Participating Provider Operations Manual, including, without limitation, provisions that require a written arrangement to: (i) specify delegated activities and reporting responsibilities; (ii) provide for revocation of the delegated activities and reporting requirements or specify other remedies in instances where CMS or MAO determines that Provider and/or delegated parties have not performed satisfactorily; (iii) specify that the performance of Provider and/or delegated parties shall be monitored by MAO on an ongoing basis and formally reviewed by the MAO at least annually; (iv) specify that the credentials of medical professionals affiliated with Provider and/or delegated parties will be either reviewed by MAO or the credentialing process will be reviewed and approved by MAO and MAO shall audit the credentialing process on an ongoing basis; and (v) specify that Provider and/or delegated parties, in the performance of such delegated activities, shall comply with all applicable Medicare laws, regulations, and CMS instructions. [422.504(i)(4)]

5.4. That if MAO delegates selection of providers, contractors, or subcontractors to Provider or another organization, MAO retains the right to approve, suspend, or terminate any such arrangement. [422.504(i)(5)]

VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

6.1. To include, when applicable, specific payment and incentive arrangements in agreement with all Downstream Entities. [422.208]
6.2. That Members health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

MAO agrees:

6.3 To pay a contracted Provider under the terms of the contract between the MAO and the Provider. [422.520(b)]

6.4 To pay claims promptly according to CMS standards and comply with all payment provisions of state and federal law. CMS requires provider clean claims to be paid within thirty (30) days of receipt, interest on clean claims to be paid in accordance with §§ 1816 and 1842(c)(2)(B) of the Social Security Act if such claims are not paid within 30 days, and other claims from non-contracted providers to be paid or denied within 60 days of receipt. [422.520(a)]

VII. REPORTING AND DISCLOSURE

Provider agrees:

7.1. To submit to MAO all data, including medical records, necessary to characterize the content and purpose of each encounter with Member. [422.310(b)]
7.2. To submit and certify the accuracy, completeness and truthfulness of all encounter data. [422.504(a)(8); 422.504(l)]
7.3. To adhere to and comply with all reporting requirements as set forth in 42 C.F.R. 422.516 and the requirements in 42 C.F.R. 422.310. [422.504(a)(8)]
7.4. To submit, as required by CMS, a complete and accurate risk adjustment data, and a sample of the medical records for validation of risk adjustment data. [422.310(d)(3), (4); 422.310(e)]

VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT

Provider agrees:

8.1. To cooperate with an independent quality review and improvement organization's activities pertaining to provision of services for Members. [422.152(a)]
8.2. To comply with MAO's medical policy, Quality Assurance program, and Medical Management program. [422.152; 422.202(b); 422.504(a)(5)]

IX. COMPLIANCE

Provider agrees:

9.1. That the MAO or First Tier Entity must notify any Provider, in writing, of the reason(s) for denial, suspension or termination determinations that affect health care professionals, the right to appeal the action, and the process and timing for requesting a hearing. [422.202(d)(1)]

9.2. That MAO and First Tier Entity must provide at least 60 days written notice to each other before terminating the contract without cause. [422.202(d)(4)]
9.3. With respect to Downstream Entities, to provide both the First Tier Entity and the MAO at least 60 days written notice before terminating a contract without cause. [422.202(d)(4)]
9.4. To comply with HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164, and Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act and the anti-kickback statute. [422.504(h)]
9.5. To meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds.
9.6. To comply with (and require that all Downstream Entities comply with) all applicable MAO procedures and MAO's Medicare Advantage Participating Provider Operations Manual including, but not limited to, the accountability provisions. [422.504(i)(3)(ii)]
9.7. To comply with (and require that all Downstream Entities comply with) applicable state and Federal laws and regulations, including Medicare laws and regulations and CMS instructions. [422.504(i)(4)(v)]
9.8. To not employ or contract with (and require that all Downstream Entities not employ or contract with) individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. [422.752(a)(8)]
9.9. To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Members, including gathering and forwarding information on appeals to MAO, as necessary. [422.562(a)]
9.10. To adhere to Medicare's grievance and expedited grievance procedures for Members, including gathering and forwarding information to MAO, as necessary. [422.562(a); 422.564]
9.11. To adhere to all guidelines and requirements for marketing as set forth by CMS. This includes, but is not limited to, discouraging Providers from [42 CFR 422.2268; 423.2268]:
  9.11.1 Attempting to explain MAO membership and costs;
  9.11.2 Being the exclusive source of membership information;
  9.11.3 Acting as agents of the MAO;
  9.11.4 Acting outside their role as medical providers of care;
  9.11.5 Discriminating in favor of "healthy" patients.
9.12. Providers may do the following:
  9.12.1. Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;
  9.12.2. In compliance with Medicare marketing guidance and regulations, cooperatively advertise and market with MAO.

X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS

Provider agrees:

10.1. That all contracts must be signed and dated.
10.2. To serve Members during the term of this Agreement.
10.3. To comply with the regulatory requirements and MAO's guidelines promulgated by Medicare, which are more fully documented in MAO's policies, procedures, and manuals. [422.202(b)]
10.4. To comply with Medicare laws, regulations and CMS instructions which are more fully documented in MAO's policies, procedures and manuals. [422.504(i)(4)(v)]

10.5. That any services or other activities performed by Provider in accordance with a contract between MAO and Provider are consistent and comply with MAO's obligations under the CMS Agreement. [422.504(i)(3)(iii)]

XI. INTERPRETATION OF ATTACHMENT

Provider and MAO agree:

11.1. Except as provided in this Attachment, all other provisions of the Agreement between MAO and First Tier Entity not inconsistent herein shall remain in full force and effect.
11.2. This Attachment shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall terminate upon the termination of such Agreement.
11.3. For purposes of Medicare Members, the provisions of this Attachment and Federal Law shall prevail.

ATTACHMENT F

MEDI-CAL PROGRAM

THE ILLUMINATION FOUNDATION

This Attachment sets forth the Medi-Cal requirements pursuant to applicable laws, regulations, regulatory directives and the contract between IEHP HEALTH PLAN and the California Department of Health Care Services (the "Medi-Cal Agreement"). PROVIDER understands that the following requirements are applicable to PROVIDER as a subcontractor of IEHP HEALTH PLAN. In the event of any conflict between the terms and conditions of the Agreement, including those by amendment or attachment, and those contained in this Attachment, the terms and conditions of this Attachment shall control.

1. **Specification of Services**. PROVIDER shall provide the services specified in Attachment A.

2. **Legal and Regulatory Requirements**. PROVIDER agrees to comply with all applicable state and federal Medicaid laws and regulations, including contractual requirements set forth under the Medi-Cal Agreement and the applicable requirements of the Medi-Cal Managed Care Program. PROVIDER further understands and agrees that this Agreement is governed by and construed in accordance with all laws and applicable regulations governing the Medi-Cal Agreement between IEHP HEALTH PLAN and DHCS.

3. **Approval by DHCS**. PROVIDER understands that the Agreement is effective upon written approval by DHCS, or by operation of law where DHCS has acknowledged receipt and has failed to approve or disapprove the Agreement within 60 days of receipt. Amendments shall be submitted to DHCS for prior approval, at least 30 days before the effective date of any proposed changes governing compensation, services, or terms. Proposed changes, which are neither approved nor disapproved by DHCS, shall become effective by operation of law 30 days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

4. **Term of Agreement**. The term of the Agreement shall be as set forth in Section 7. TERM AND TERMINATION of the underlying Agreement, with termination provisions as further described in Section 7.01 TERM.

5. **Emergency Services**. In the event that PROVIDER is delegated risk for non-contracting emergency services, PROVIDER shall provide the services in compliance with applicable State and Federal law as well as applicable sections of the Medi-Cal Agreement (including but not limited to, 22 CCR § 53855 and Exhibit A, Attachment 8, Provision 13 of the Medi-Cal Agreement).

6. **Reports**. PROVIDER agrees to submit any reports required by IEHP HEALTH PLAN, in a form acceptable to IEHP HEALTH PLAN.

7. **Monitoring Rights**. PROVIDER shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS.

8. **Audit and Inspection**. PROVIDER agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services

furnished under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20 of the Medi-Cal Agreement:

a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees.

b) At all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California.

c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

d) For a term of at least 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

e) Including all Encounter Data, as applicable, for a period of at least 10 years.

f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit PROVIDER at any time.

g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate PROVIDER from participation in the Medi-Cal program; seek recovery of payments made to PROVIDER; impose other sanctions provided under the State Plan, and direct IEHP HEALTH PLAN to terminate the Agreement due to fraud.

9. **Compensation**. The method and amount of compensation to be received by PROVIDER is set forth in Attachment B.

10. **PROVIDER Subcontracts**. PROVIDER agrees to maintain and make available to DHCS, upon request, copies of all subcontracts and to ensure that all subcontracts are in writing and require that the subcontractor:

a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the Agreement, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees.

b) Retain all records and documents for a minimum of 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

11. **Transfer of Care**. In the event the Medi-Cal Agreement between IEHP HEALTH PLAN and DHCS is terminated, PROVIDER shall assist IEHP HEALTH PLAN in the orderly transfer of Members and medical care, as required by the Medi-Cal Agreement; including but not limited to, making available

to DHCS copies of medical records, patient files, and any other pertinent information, necessary for efficient case management of Members. PROVIDER further agrees to assist IEHP HEALTH PLAN in the orderly transfer of care in the event the contract between PROVIDER and a subcontractor is terminated.

12. **Notice to DHCS**. PROVIDER agrees to notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the U.S. Postal Service as first-class registered mail, postage attached. The parties agree to comply with timeframes for notification as required by DHCS, and other applicable requirements, even if such requirements may delay amendment or termination of the Agreement.

13. **Assignment and Delegation**. PROVIDER agrees that assignment or delegation of this Agreement is void unless prior written approval is obtained from DHCS in those instances where prior approval by DHCS is required.

14. **Hold Harmless**. PROVIDER agrees to hold harmless both the State and Members in the event IEHP HEALTH PLAN cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. PROVIDER shall further ensure that any subcontracts contain this requirement.

15. **Records Related to Litigation**. PROVIDER agrees to timely gather, preserve, and provide to IEHP HEALTH PLAN and/or DHCS, any records in PROVIDER's possession, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in PROVIDER's possession relating to threatened or pending litigation by or against DHCS. PROVIDER agrees to use all reasonable efforts to immediately notify IEHP HEALTH PLAN and DHCS of any subpoenas, document production requests, or requests for records, received by PROVIDER related to this Agreement. PROVIDER shall further ensure that any subcontracts contain this requirement.

16. **Interpreter Services**. PROVIDER agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. **Provider Grievances**. PROVIDER understands that it has a right to submit a grievance to IEHP HEALTH PLAN, which includes any complaint, dispute, request for consideration, or appeal, in accordance with IEHP HEALTH PLAN's process to resolve provider grievances.

18. **Quality Improvement System**. PROVIDER agrees to participate and cooperate in IEHP HEALTH PLAN's Quality Improvement System. If IEHP HEALTH PLAN has delegated Quality Improvement activities to PROVIDER, the Agreement shall include those provisions required under the Medi-Cal Agreement (Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities). The Agreement shall include, at minimum:

    a. Quality improvement responsibilities, and specific delegated functions and activities of the IEHP HEALTH PLAN and PROVIDER.

    b. IEHP HEALTH PLAN's oversight, monitoring, and evaluation processes and PROVIDER's agreement to such processes.
    c. IEHP HEALTH PLAN's reporting requirements and approval processes, and PROVIDER's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

d. IEHP HEALTH PLAN's actions/remedies if PROVIDER's obligations are not met.

19. **Revocation of Delegated Activities**. PROVIDER agrees to allow revocation of delegated activities or obligations (as applicable), or specify other remedies in instances where DHCS or IEHP HEALTH PLAN determine that the PROVIDER has not performed satisfactorily.

20. **Data Sharing for Coordination of Care**. If PROVIDER is responsible for Member care coordination, IEHP HEALTH PLAN agrees to share with PROVIDER any utilization data that DHCS has provided to IEHP HEALTH PLAN, and PROVIDER agrees to receive the utilization data provided and use it as PROVIDER is able for the purpose of Member care coordination.

21. **Changes to DHCS Contract**. IEHP HEALTH PLAN agrees to inform PROVIDER of prospective requirements added by DHCS to the Medi-Cal Agreement before the requirement would be effective, and PROVIDER agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

22. **Provider Data**. If applicable, PROVIDER shall submit to IEHP HEALTH PLAN complete, accurate, reasonable, and timely provider data needed (and requested) by IEHP HEALTH PLAN in order to meet its provider data reporting requirements to DHCS. Such provider data may include, but not be limited to, claims and payment data, health care services delivery Encounter Data, and network information as may be required by the Medi-Cal Agreement (Exhibit A, Attachment 3, Provision 1; APL 16-019).

23. **Encounter Data**. If applicable, PROVIDER shall submit to IEHP HEALTH PLAN complete, accurate, reasonable, and timely Encounter Data needed by IEHP HEALTH PLAN in order for IEHP HEALTH PLAN to meet its encounter data reporting requirements to DHCS.

24. **Prohibition of Balance Billing.** PROVIDER shall not collect reimbursement or balance bill a Medi-Cal member for the provision of covered services.

25. **Provider Training**. IEHP HEALTH PLAN shall provide, and PROVIDER shall participate in, cultural competency, sensitivity, and diversity training.

26. **Policies and Procedures**. PROVIDER shall implement and maintain policies and procedures that are designed to detect and prevent fraud, waste, and abuse.

27. **Protected Health Information (PHI)**. As a condition of obtaining access to PHI of IEHP HEALTH PLAN relating to Medi-Cal Members, PROVIDER acknowledges receipt of a copy of Exhibit G of the Medi-Cal Agreement, and agrees to the restrictions and conditions therein with respect to such PHI.

ATTACHMENT G

DMHC REQUIREMENTS

THE ILLUMINATION FOUNDATION

PROVIDER understands that IEHP HEALTH PLAN is subject to requirements applicable to health plans set forth under the Knox-Keene Act and related regulations of the California Code of Regulations ("CCR") promulgated by the Department of Managed Health Care ("DMHC"). The following provisions are required by state and federal statutes and regulations applicable to health plans. As a subcontractor of IEHP HEALTH PLAN, PROVIDER is subject to the requirements below. In the event of any conflict between the terms and conditions of the Agreement, including those by amendment or attachment, and those contained in this Attachment, the terms and conditions of this Attachment shall control.

DMHC Provisions

1) In the event that IEHP HEALTH PLAN fails to pay PROVIDER for covered health care services, the Member or subscriber shall not be liable to PROVIDER for any sums owed by IEHP HEALTH PLAN. PROVIDER shall not collect or attempt to collect from a Member or subscriber any sums owed to PROVIDER by the IEHP HEALTH PLAN. PROVIDER, or agent, trustee or assignee thereof, may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the PROVIDER by IEHP HEALTH PLAN. (Health and Safety Code Section 1379)

2) To the extent that any of IEHP HEALTH PLAN's quality of care review functions or systems are administered by PROVIDER, PROVIDER shall deliver to IEHP HEALTH PLAN any information requested in order to monitor or require compliance with IEHP HEALTH PLAN's quality of care review system. (28 CCR § 1300.51, J-5)

3) PROVIDER's primary care physicians are responsible for coordinating the provision of health care services to Members who select PROVIDER's providers for primary care physician services. (28 CCR § 1300.67.1(a))

4) PROVIDER shall maintain Member medical records in a readily available manner that permits sharing within IEHP HEALTH PLAN of all pertinent information relating to the health care of Members. (28 CCR § 1300.67.1(c))

5) PROVIDER shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (28 CCR § 1300.67.2(b))

6) To the extent PROVIDER has any role in rendering emergency health care services, PROVIDER shall make such emergency health care services available and accessible twenty-four (24) hours a day, seven days a week. (28 CCR § 1300.67.2(c))

7) PROVIDER shall participate in IEHP HEALTH PLAN's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. PROVIDER shall timely notify IEHP HEALTH PLAN of

any changes to address or inability to maintain IEHP HEALTH PLAN's access standards. (28 CCR § 1300.67.2(f))

8) IEHP HEALTH PLAN is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the regulations promulgated hereunder (Chapter 2 of Division 1 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulations that are required to be in this Agreement shall bind the IEHP HEALTH PLAN and PROVIDER (as applicable) whether or not expressly set forth in this Agreement. (28 CCR § 1300.67.4(a)(9))

9) Upon the termination of this Agreement, IEHP HEALTH PLAN shall be liable for covered health care services rendered by PROVIDER (other than for copayments) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of PROVIDER at the time of termination of the Agreement until the services being rendered to the subscriber or Member by PROVIDER are completed, unless the IEHP HEALTH PLAN makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code Section 1373.96) (28 CCR § 1300.67.4(a)(10))

10) Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code Section 1373.65(f).

11) The written contract between IEHP HEALTH PLAN and PROVIDER shall be prepared or arranged in a manner which permits confidential treatment by the Director of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provisions of the Agreement. (28 CCR § 1300.67.8(a))

12) PROVIDER shall maintain all records and provide all information to the IEHP HEALTH PLAN or the DMHC as may be necessary for compliance by the IEHP HEALTH PLAN with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. (Health and Safety Code Section 1381) (28 CCR § 1300.67.8(b))

13) PROVIDER shall afford IEHP HEALTH PLAN and the DMHC access at reasonable times upon demand to the books, records and papers of PROVIDER relating to health services provided to Members and subscribers, to the cost thereof, to payments received by PROVIDER from Members and subscribers of the IEHP HEALTH PLAN (or from others on their behalf), and, unless PROVIDER is compensated on a fee-for-services basis, to the financial condition of PROVIDER. PROVIDER shall promptly deliver to IEHP HEALTH PLAN, any financial information requested by IEHP HEALTH PLAN for the purpose of determining PROVIDER's ability to bear capitation or other applicable forms of risk sharing compensation. (28 CCR § 1300.67.8(c))

14) PROVIDER shall not and is hereby prohibited from demanding surcharges from Members for covered health care services. Should IEHP HEALTH PLAN receive notice of any such surcharges by PROVIDER, IEHP HEALTH PLAN may take any action it deems appropriate including but

not limited to demanding repayment by PROVIDER to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost against any amounts otherwise owing to PROVIDER. (28 CCR § 1300.67.8(d))

15) Upon IEHP HEALTH PLAN's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code Section 1385)

16) To the extent that any of IEHP HEALTH PLAN's quality assurance functions are delegated to PROVIDER, PROVIDER shall promptly deliver to IEHP HEALTH PLAN all information requested for the purpose of monitoring and evaluating PROVIDER's performance of those quality assurance functions. (28 CCR § 1300.70)

17) PROVIDER may utilize IEHP HEALTH PLAN's Provider Dispute Resolution process by phoning or writing the Claims Department (P.O. Box 4319, Rancho Cucamonga, CA 91729-4319, Attention IEHP Claims Resolution Unit; Telephone # (909) 890-2054 or (866) 223-4347). Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (28 CCR § 1300.71.38)

18) For any material revision to the Agreement or to the sub-delegation of duties by the parties, the parties shall receive prior authorization from the DMHC. (28 CCR § 1300.52.4)

19) A description of the grievance procedure shall be readily available at each PROVIDER facility. PROVIDER shall provide grievance forms and assist Members in filing grievances. PROVIDER shall cooperate with IEHP HEALTH PLAN in responding to Member grievances and requests for independent medical reviews. (28 CCR § 1300.68(b))

20) Any pursuit and recovery of a third party lien shall comply with all applicable laws and regulations, including without limitation, California Civil Code Section 3040. PROVIDER shall cooperate with IEHP HEALTH PLAN in identifying such third party liability claims and providing any required information.

21) PROVIDER shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04, as applicable.

22) PROVIDER is entitled to all protections afforded under the Health Care Providers' Bill of Rights. (Health & Safety Code Section 1375.7)

A Public Entity
Inland Empire Health Plan

January 21, 2022

VIA ELECTRONIC MAIL
pbhalla@ifhomeless.org

The Illumination Foundation
1091 N. Batavia St.
Orange, CA 92867

Attn: Office Manager

Enclosed please find the fully executed 2nd Amendment to the Ancillary Provider Agreement between The Illumination Foundation and the Inland Empire Health Plan.

If you have any questions regarding this Amendment, please do not hesitate to contact me directly at (909) 890-2712.

Sincerely,

Daniel Vargas
Manager, Provider Contracting

SECOND AMENDMENT

ANCILLARY PROVIDER AGREEMENT

BETWEEN

INLAND EMPIRE HEALTH PLAN AND IEHP HEALTH ACCESS

AND

THE ILLUMINATION FOUNDATION

WHEREAS, the Inland Empire Health Plan ("IEHP"), IEHP Health Access ("Health Access") (known collectively as "IEHP Health Plan"), and The Illumination Foundation ("PROVIDER") agree to further amend the Ancillary Provider Agreement, as amended, between them dated June 1, 2019 (the "Agreement");

NOW THEREFORE, the parties agree as follows:

A. The language of ATTACHMENT A, HEALTH CARE SERVICES is hereby deleted in its entirety and replaced as attached hereto (See amended ATTACHMENT A, SCOPE OF HEALTH CARE SERVICES).

B. The language of ATTACHMENT B, COMPENSATION is hereby deleted in its entirety and replaced as attached hereto (See amended ATTACHMENT B, COMPENSATION).

C. The new ATTACHMENT A-1, SCOPE OF HEALTH CARE SERVICES is hereby added to the agreement as attached hereto (ATTACHMENT A-1, SCOPE OF HEALTHCARE SERVICES).

D. The new ATTACHMENT A-2, SCOPE OF HEALTH CARE SERVICES is hereby added to the agreement as attached hereto (ATTACHMENT A-2, SCOPE OF HEALTHCARE SERVICES).

E. The new ATTACHMENT A-3, SCOPE OF HEALTH CARE SERVICES is hereby added to the agreement as attached hereto (ATTACHMENT A-3, SCOPE OF HEALTHCARE SERVICES).

F. The new ATTACHMENT A-4, SCOPE OF HEALTH CARE SERVICES is hereby added to the agreement as attached hereto (ATTACHMENT A-4, SCOPE OF HEALTHCARE SERVICES).

G. The new ATTACHMENT B-1, COMPENSATION is hereby added to the agreement as attached hereto (ATTACHMENT B-1, COMPENSATION).

H. The new ATTACHMENT B-2, COMPENSATION is hereby added to the agreement as attached hereto (ATTACHMENT B-2, COMPENSATION).

I. The new ATTACHMENT B-3, COMPENSATION is hereby added to the agreement as attached hereto (ATTACHMENT B-3, COMPENSATION).

J. The new ATTACHMENT B-4, COMPENSATION is hereby added to the agreement as attached hereto (ATTACHMENT B-4, COMPENSATION).

K. Notwithstanding the date of execution, unless otherwise referenced, this Second Amendment shall be effective January 1, 2022.

L. All other terms and conditions of the Agreement, as amended, are to remain in full force and effect.

M. PROVIDER certifies that the individual signing herein has authority to execute this Amendment on behalf of PROVIDER and may legally bind PROVIDER to the term and conditions of this Amendment, and any attachments hereto.

(THE BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK)

IN WITNESS WHEREOF, the parties hereto have signed this Second Amendment as set forth below.

THE ILLUMINATION FOUNDATION:

By: Pooja Bhalla

Pooja Bhalla, Executive Director of Healthcare Services
Print Name and Title

Date: 12/10/21

TIN: 71-1047686

INLAND EMPIRE HEALTH PLAN
AND
IEHP HEALTH ACCESS:

By: DocuSigned by: EB1F4AD25DD84F8...
Jarrod B. McNaughton, MBA, FACHE
Chief Executive Officer

Date: 1/11/2022

By: DocuSigned by: EB1F4AD25DD84F8...
Chair, Governing Board

Date: 1/11/2022

Attest: DocuSigned by: EB1F4AD25DD84F8...
Secretary, Governing Board

Date: 1/11/2022

Approved as Form:

By: DocuSigned by: 4E9523BFACFF4CD...
Anna W. Wang
General Counsel

Date: 1/11/2022

ATTACHMENT A

SCOPE OF HEALTH CARE SERVICES

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

PROVIDER agrees to provide recuperative care services to Members at program location or at local motels or at other appropriately licensed facilities as mutually agreed by PROVIDER and IEHP and as listed on Attachment C of this agreement.

PROVIDER's responsibilities under this Agreement are summarized as follows:

1. **Recovery Care Coordination and Facilitation** - PROVIDER shall coordinate and facilitate Member's recovery care after hospital discharge. It is understood that PROVIDER does not provide direct medical services nor have employees or associated volunteers acting in a professional medical capacity. PROVIDER shall accept or deny the Member within 2 business hours of receiving the completed referral application from IEHP. PROVIDER agrees to exit each Member from the program as soon as he/she is determined to no longer require the program's recuperative care services. The actual length of stay shall not exceed 90 days.

2. **Case Management** - PROVIDER shall case manage each Member to prepare the Member for permanent supportive housing as appropriate. In collaboration with IEHP-contracted Community Supports Housing Tenancy and Sustaining Services providers, PROVIDER shall determine Member's eligibility for social services and temporary/permanent housing programs. Case management services shall include assisting Member in replacing missing or necessary documents, such as birth certificate, photo ID, immigration papers, and Social Security cards. Members shall also receive:
    - Assistance with applying for income-related benefits, such as General Relief, food stamps, SSDI, SSI, Medicare, Medi-Cal, unemployment benefits, etc.
    - Referrals to primary medical care, mental health services, and other community services as needed.
    - Assistance with monitoring any Member legal issues and making appropriate referrals while addressing any barriers to accessing and maintaining housing and services (e.g., credit history, criminal records, pending warrants, etc.).

    Upon exit from the program, PROVIDER shall make all reasonable efforts to connect each Member to an alternative facility, shelter, or permanent housing.

3. **Transportation** - PROVIDER shall provide and/or arrange for the transportation of Members to and from any follow up appointments scheduled during the Members' approved length of stay with PROVIDER. The initial transportation from the discharging hospital to the program will be provided by the hospital.

ATTACHMENT A
(Continued)
SCOPE OF HEALTH CARE SERVICES

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

4. **Responsible Party** – PROVIDER agrees that it is administratively and financially responsible for items 1 through 3 above.

5. **Safe and Quality Accommodations –** PROVIDER agrees to:
    - Provide Members with a clean and safe place to sleep, daily meals, hygiene supplies, and access to laundry.
    - Ensure a bed is available to each Member admitted 24 hours a day.
    - Confirm that on-site showering and laundering facilities are available to IEHP Members.
    - Ensure that clean linens are provided upon admission.
    - Confirm that facility provides access to secured storage for personal belongings and medications.
    - Guarantee and ensure that food services meet applicable public health guidelines for food handling.
    - Provide at least three meals a day to IEHP Members.
    - Ensure that meals accommodate medical diet restrictions.
    - Ensure that facility maintains 24-hour staff presence. On-site staff is trained at a minimum to provide first aid and basic life support services.
    - Ensure that facility has a full time, but not 24 hours a day, licensed clinical staff to perform assessments, supervision, and medication reconciliation. Clinical staff must consist of a Registered Nurse, Nurse Practitioner or higher degree.
    - Provide 24-hour on call medical support when clinical staff is not on site.
    - Maintain written policies and procedures for responding to life threatening emergencies.
    - Comply with all local fire safety standards governing its facility.
    - Maintain a written Code of Resident Conduct or Behavioral Agreement that describes program policies including potential causes for early discharge.
    - Maintain policies and ensure staff trainings related to:
        - The handling of alcohol, illegal drugs and unauthorized prescriptions drugs found on site.
        - The handling of weapons brought into the facility, including strategies to maximize Member and staff safety and appropriate staff response to violence
    - Establish a process to notify IEHP about a Member that is being considered for possible discharge due to behavior issues prior to discharging.

ATTACHMENT A
(Continued)
SCOPE OF HEALTH CARE SERVICES

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

6. **Quality Environmental Services** - PROVIDER agrees to:
    - Maintain written policy and procedure for safe storage, disposal and handling of biomedical and pharmaceutical waste, including expired or unused medications and needles.
    - Maintain written protocol for managing exposure to bodily fluids and other biohazards.
    - Provide safe storage/handling and security of IEHP Members' medications.
    - Maintain written protocols in-place to promote infection control and the management of communicable diseases (i.e.: scabies, lice etc.).
    - Ensure that facility and equipment are cleaned and disinfected to control illness or infection.

7. **Transitions of Care** - PROVIDER agrees to:
    - Confirm that facility maintains clear policies and procedures for the screening and management of referrals into the program including the following criteria:
        - Written admission criteria
        - Review for clinical appropriateness
        - Point of contact or phone number for referrals
        - Ability to admit 24 hours a day 7 days a week
        - Clinical Summary
        - Referral decision time and communication back
        - HIPAA compliant communication
    - Ensure that the program maintains standards of admitting practices by the following measures:
        - Each Member admitted to program has a designated case manager or provider of record.
        - The facility performs medication reconciliation within 12 hours of admission.
        - The facility screens for and honors existing advanced directives.
        - The facility identifies the IEHP Member's current Primary Care Provider (PCP) and notifies them about the IEHP Member's transition into the program.
    - The facility works collaboratively with IEHP's housing team and other Community Supports Providers (as applicable) during the transition. This includes telephonic case management, attending on-site interdisciplinary care team meetings and providing reports/files as needed for oversight.

ATTACHMENT A
(Continued)
SCOPE OF HEALTH CARE SERVICES

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

8. **Post-Acute Care** - PROVIDER agrees to:
    - Ensure that the medical record is maintained for each IEHP Member and its content, maintenance and confidentiality meet the requirements set forth in federal and state laws and regulations.
    - Confirm that appropriate clinical staff conduct a baseline assessment of each Member to determine factors that will influence care, treatment, and services. This assessment includes:
        - Current diagnosis, pertinent history, medication history (including allergies), current medication and treatments.
        - Physical and mental health status (PHQ 9 assessment).
        - Behavioral health needs, including substance abuse.
        - Pain Status, as needed.
        - Fall Risk.
        - Immunization Status (at a minimum influenza and COVID).
    - Ensure that an individualized care plan is developed for each IEHP Member specifying treatments, desired outcomes and/or goals. PROVIDER must share plan with IEHP Housing team within 48 hours of admission.
    - Confirm that each IEHP Member receives at least one wellness check every 24 hours by staff and that any changes in the IEHP Member's condition or concerns are communicated to the designated clinical provider.
    - Ensure that all IEHP Members that have transitioned into recuperative care will be presented at the IEHP interdisciplinary care team meeting by the recuperative staff.

9. **Care Coordination and Wraparound Services** - PROVIDER agrees to:
    - Ensure that the facility will support the IEHP Member in developing self-management goals.
    - Assist in navigating the health system and building a relationship with the IEHP Member's PCP.
    - Coordinate and provide transportation to and from medical and behavioral health appointments.
    - Ensure communication occurs between the recuperative care staff and outside providers to follow up on any changes in the Member care plan.
    - Make referrals to behavioral health services (substance use, mental health services as needed).
    - Facilitate access to housing, including supportive housing services when appropriate.
    - Identify and refer to community resources as needed.
    - Submit applications for SSI/SSDI and other benefit programs as needed.
    - Collaborate with other IEHP-contracted Community Supports providers as appropriate.

- Participate in interdisciplinary care team (ICT) conferences with IEHP, Community Supports Housing Transition Navigation Services providers, county partners, and any other party identified as being integral to Member's success in remaining housed and their overall well-being.
- Collaborate with IEHP to ensure Member access to Community Supports services via a "closed-loop" referral system.
- Notify appropriate IEHP staff when a significant change in condition occurs that would negatively impact Member's ability to find or maintain housing.

10. **Coordinating Discharges** - PROVIDER agrees to:
    - Maintain written discharge policy. The policy will specify the personnel authorized to make discharge decisions.
    - Ensure that IEHP Member is informed of the discharge policy and procedure.
    - Contact IEHP in case of an authorization expiration and have a conference call to verify the authorization expiration before determining further action.
    - Ensure that IEHP Members are given a minimum of 24 hours' notice prior to being discharged from the program (exceptions for some administrative discharges).
    - Provide a discharge summary available to the IEHP Member with the following discharge instructions:
        - Written medication list.
        - List of follow-up appointments and contact information.
        - Instructions for accessing relevant community resources.
    - Provide a summary of the discharging IEHP Members at the IEHP ICT meeting.
    - Ensure that the care plan is updated with the discharge plan and any recommendations from the ICT will be shared with IEHP and the IEHP Member's PCP upon Member's discharge.

11. **Quality and Reporting** - PROVIDER agrees to:
    - Provide access to IEHP staff to conduct on-site audits and file reviews.
    - Maintain a quality improvement plan in place that will audit staff and IEHP Member files to ensure that the appropriate standards are maintained.
    - Provide regular reports to IEHP on outcomes of interest and key performance indicators.
    - Ensure that the program has a policy for managing and reporting incidents such as falls, physical altercations, theft, etc.
    - Fulfill duties as a mandated reporter of suspected child, elder, or dependent adult abuse.

ATTACHMENT A
(Continued)
SCOPE OF HEALTH CARE SERVICES

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

- Require that staff employed by the PROVIDER have written job descriptions and meet the qualifications required by such job descriptions.
- Ensure that licensing and credentials are initially verified and reviewed, at minimum, on an annual basis.
- Provider ongoing training to Community Supports Recuperative Care (Medical Respite) staff to ensure services are appropriate and to promote continuous quality improvement.
- Adhere to the DHCS CalAIM Community Supports guidelines for Recuperative Care (Medical Respite), limiting each Member's length of stay to no more than 90 days.
- Comply and deliver services in accordance with contract deliverables and objectives.

12. **Billing and Employee requirements** - PROVIDER agrees to:
    - Provide IEHP a Daily Census that will include, but not limited to: IEHP Member name, Authorization Number, IEHP ID Number, Status (Admit, Pending), Admit Date, Exit Date, Length of Stay, Housing Interview (Yes, No), Prior Facility, Departure Notes, and Other Notes as applicable.
    - Ensure that at least one (1) RN or higher medical services provider to provide evaluations and reporting as required by IEHP.
    - Capture encounter data in accordance with the Inbound 837 Implementation File and Companion Guide.
    - Include their encounter data using the applicable CPT in their Inbound 837.
    - Communicate with IEHP regularly to update status on Members quarterly and biannually to update HEDIS reporting measures required by housing and any other important reporting requirements deemed necessary by IEHP for the health and welfare of their Members under PROVIDER care.
    - Maintenance of program and Member records and legally permissible data systems as required.
    - Submit reports and claims as requested and in a timely manner and provide all required supporting documentation.

ATTACHMENT A-1

SCOPE OF HEALTH CARE SERVICES

HOUSING TENANCY AND SUSTAINING SERVICES

THE ILLUMINATION FOUNDATION

PROVIDER agrees to provide housing tenancy and sustaining services as outlined below:

1. PROVIDER will provide the services for IEHP Members who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services; and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

2. PROVIDER shall:

    - Provide ongoing outreach to and engagement of the client population including field and community-based locations, health and behavioral health facilities, interim and bridge housing settings, criminal justice and custody facilities, and other locations as needed to engage the target population.

    - Assist Members with rental application including paperwork required by Housing Authorities and the Section 8 program.

    - Assist Members with mental health and life skills services and referrals.

    - Establish a case management plan based on written authorization from IEHP, including but not limited to establishing future goals, improvement of behaviors associated with substance use, reduction in frequency and quantity of the use of alcohol and other substances, coping with mental and behavioral health disorders, coping with chronic medical conditions, accessing medical care, and improvement of interpersonal relationships.

    - Help Members access public benefits and educational opportunities as appropriate.

    - Assist Members with budgeting and money management.

    - Assist Members with substance use disorder services and referrals with a focus on harm reduction.

    - Provide referrals to primary medical care, mental health services, and other community services as needed.

ATTACHMENT A-1
(Continued)
SCOPE OF HEALTH CARE SERVICES

HOUSING TENANCY AND SUSTAINING SERVICES

THE ILLUMINATION FOUNDATION

- Assist Members in obtaining clothing and food.
- Provide group programming ranging from life-skills groups to community activities.
- Provide eviction prevention counseling and advocacy.
- Assist with educational, vocational, and employment services as appropriate for each Member.
- Assist Members with inter-partner violence and safety planning services and referrals.
- Provide transportation assistance to Members.
- Assist Members with medication regimen.
- As needed, collaborate with county entities or other IEHP-contracted Community Supports Housing Transition Navigation Services providers to help Member locate affordable permanent housing, establish and maintain relationships with landlords/agencies willing to provide affordable permanent housing to IEHP Members, and assist with negotiating rental agreements.
- Assist with identification of federal and regional public funding sources (e.g., housing vouchers) that might be available to a Member to cover housing costs.
- Administer move-in assistance funds to assist Members with timely security deposits, household goods and furnishings, utility deposits, etc.
- Assist with temporary or interim housing until Member moves into an available permanent supportive housing unit.
- Assist with monitoring any Member legal issues and making appropriate referrals while addressing any barriers to accessing and maintaining housing and services (e.g., credit history, criminal records, pending warrants, etc.).

ATTACHMENT A-1
(Continued)
SCOPE OF HEALTH CARE SERVICES

HOUSING TENANCY AND SUSTAINING SERVICES

THE ILLUMINATION FOUNDATION

- Collaborate with county entities or other IEHP-contracted Community Supports Housing Transition Navigation Services providers and property owners to ensure Members provide authorization to receive the support needed to remain housed and stable, including attending and/or convening periodic meetings with partners to problem solve around Member, building, and community issues.

- Work closely with IEHP-contracted Community Supports Housing Transition Navigation Services providers to help ensure Member's housing sustainability.

- Collaborate with other IEHP-contracted Community Supports providers as appropriate.

- Provide ongoing training to Community Supports Housing Tenancy and Sustaining Services staff to ensure services are appropriate and to promote continuous quality improvement.

- Provide regular reports on metrics to IEHP, meeting the following specifications:

    - Weekly reports describing the current total Member census being served by the PROVIDER; census reports should be provided at the Member level and will include Member's phase of housing placement transition (e.g., assessment, enrollment pre-transition, transition into community- based housing, case closure planning, etc.).

    - Quarterly reports will be provided summarizing (in aggregate) the efficiency of PROVIDER's services. The efficiency of service measures will describe- in aggregate- average participant wait times for:
        - Referral to assessment by PROVIDER,
        - Assessment to enrollment,
        - Enrollment to pre-transition,
        - Pre-transition into transition into community-based housing,
        - From transition into community-based housing to PROVIDER, and
        - Case closure.

- For those Members who have been transitioned into community-based housing, quarterly reports will be provided summarizing (in aggregate) the average duration of participant retention in community-based housing.

ATTACHMENT A-1
(Continued)
SCOPE OF HEALTH CARE SERVICES

HOUSING TENANCY AND SUSTAINING SERVICES

THE ILLUMINATION FOUNDATION

- Participate in interdisciplinary care team (ICT) conferences with IEHP, Community Supports Housing Transition Navigation Services providers, county partners, and any other party identified as being integral to Member's success in remaining housed and their overall well-being.

- Fulfill duties as a mandated reporter of suspected child, elder, or dependent adult abuse.

- Collaborate with IEHP to ensure Member access to Community Supports services via a "closed-loop" referral system.

- Maintain program and Member records and legally permissible data systems as required.

- Submit reports and claims as requested and in a timely manner and provide all required supporting documentation.

- Notify appropriate IEHP staff when a significant change in condition occurs that would negatively impact Member's ability to find or maintain housing.

- Comply and deliver services in accordance with contract deliverables and objectives.

- Provide regular reports to IEHP on outcomes of interest and key performance indicators.

ATTACHMENT A-2

SCOPE OF HEALTH CARE SERVICES

HOUSING TRANSITION NAVIGATION SERVICES

THE ILLUMINATION FOUNDATION

PROVIDER will provide the following services:

- Unit identification
- Secure housing and establishing site control
- Provide owner/participant liaison services
- Manage unit repairs and modifications
- Provide unit habitability and tenant wellness checks
- Provide housing retention services
- Community-based organizations will collaborate with Riverside and San Bernardino Counties to leverage available housing vouchers or other housing program funding.
- Work closely with IEHP-contracted Community Supports Housing Tenancy and Sustaining Services providers to help ensure Member's housing stability.
- Once Member has "graduated" from Housing Tenancy and Sustaining services, collaborate with IEHP Housing Team as needed to address any issues that may jeopardize Member's housing.
- Collaborate with other IEHP-contracted Community Supports providers as appropriate.
- Participate in interdisciplinary care team (ICT) conferences with IEHP, Community Supports Housing Tenancy and Sustaining Services providers, county partners, and any other party identified as being integral to Member's success in remaining housed and their overall well-being.
- Collaborate with IEHP to ensure Member access to Community Supports services via a "closed-loop" referral system.
- Maintenance of program and Member records and legally permissible data systems as required.
- Notify appropriate IEHP staff when a significant change in condition occurs that would negatively impact Member's ability to find or maintain housing.
- Comply and deliver services in accordance with contract deliverables and objectives.

Quality and Reporting - PROVIDER agrees to:

- Provide access to IEHP Team Members to conduct on-site audits and file reviews.
- Maintain a quality improvement plan in place that will audit staff and IEHP Member files to ensure that the appropriate standards are maintained.
- Ensure that the program has a policy for managing and reporting incidents such as falls, physical altercations, theft, etc.
- Provide regular reports to IEHP on outcomes of interest and key performance indicators.
- Submit reports and claims as requested and in a timely manner and provide all required supporting documentation.
- Fulfill duties as a mandated reporter of suspected child, elder, or dependent adult abuse.

ATTACHMENT A-2

SCOPE OF HEALTH CARE SERVICES

HOUSING TRANSITION NAVIGATION SERVICES

THE ILLUMINATION FOUNDATION

- Require that staff employed by the PROVIDER have written job descriptions and meet the qualifications required by such job descriptions.
- Ensure that licensing and credentials are initially verified and reviewed, at minimum, on an annual basis.
- Provision of ongoing training to Community Supports Recuperative Care (Medical Respite) staff to ensure services are appropriate and to promote continuous quality improvement.

ATTACHMENT A-3

SCOPE OF HEALTH CARE SERVICES

HOUSING DEPOSITS

THE ILLUMINATION FOUNDATION

PROVIDER will provide the following services:

A. Assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:
    1. Security deposits required to obtain a lease on an apartment or home.
    2. Set-up fees/deposits for utilities or service access and utility arrearages.
    3. First month's coverage of utilities, including but not limited to, telephone, gas, electricity, heating, and water.
    4. First months and last month's rent as required by landlord for occupancy.
    5. Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
    6. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve the Member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Work closely with IEHP-contracted Community Supports Housing Tenancy and Sustaining Services providers to help ensure Member's housing stability.

C. Collaborate with other IEHP-contracted Community Supports providers as appropriate.

D. Participate in interdisciplinary care team (ICT) conferences with IEHP, Community Supports Housing Tenancy and Sustaining Services providers, county partners, and any other party identified as being integral to Member's success in remaining housed and their overall well-being.

E. Collaborate with IEHP to ensure Member access to Community Supports services via a "closed-loop" referral system.

F. Maintenance of program and Member records and legally permissible data systems as required.

G. Submit reports and claims as requested and in a timely manner and provide all required supporting documentation.

ATTACHMENT A-3
(Continued)
SCOPE OF HEALTH CARE SERVICES

HOUSING DEPOSITS

THE ILLUMINATION FOUNDATION

Quality and Reporting - PROVIDER agrees to:

- Provide access to IEHP staff to conduct on-site audits and file reviews.
- Maintain a quality improvement plan in place that will audit staff and IEHP Member files to ensure that the appropriate standards are maintained.
- Ensure that the program has a policy for managing and reporting incidents such as falls, physical altercations, theft, etc.
- Provide regular reports to IEHP on outcomes of interest and key performance indicators.
- Fulfill duties as a mandated reporter of suspected child, elder, or dependent adult abuse.
- Require that staff employed by the PROVIDER have written job descriptions and meet the qualifications required by such job descriptions.
- Ensure that licensing and credentials are initially verified and reviewed, at minimum, on an annual basis.
- Provision of ongoing training to Community Supports staff to ensure services are appropriate and to promote continuous quality improvement.
- Notify appropriate IEHP staff when a significant change in condition occurs that would negatively impact Member's ability to find or maintain housing.
- Adhere to the DHCS CalAIM Community Supports guidelines for Housing Deposits, ensuring that each Member authorized for a housing deposit receives it only once during the Member's lifetime.
- Comply and deliver services in accordance with contract deliverables and objectives.

ATTACHMENT A-4

SCOPE OF HEALTH CARE SERVICES

SHORT-TERM POST-HOSPITALIZATION HOUSING

THE ILLUMINATION FOUNDATION

PROVIDER agrees to provide Short-Term Post-Hospitalization Housing services that utilize best practices (e.g., Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care) for Members who are experiencing homelessness and have complex health, disability, and/or behavioral health conditions.

PROVIDER's responsibilities under this Agreement are summarized as follows:

A. Provide Members who do not have a residence and who have high medical and/or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.

B. Provide Members with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.

C. Adhere to the DHCS CalAIM Community Supports guidelines for Short-Term Post-Hospitalization Housing and assist IEHP to ensure that Members meet homelessness criteria as defined one of the following: HUD criteria; Welfare & Institutions (W&I) code; or the HUD definition of at risk for homelessness.

D. Assist Members under age 18 with obtaining Short-Term Post-Hospitalization Housing services if the Member qualifies as homeless under the Runaway and Homeless Youth Act or meets criteria for homelessness under the McKinney-Vento Homeless Assistance Act.

E. Adhere to the DHCS CalAIM Community Supports guidelines for Short-Term Post-Hospitalization Housing, limiting services to each Member to once in a lifetime, and not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on Member needs).

F. Adhere to the DHCS CalAIM Community Supports guidelines for Short-Term Post-Hospitalization Housing, stating that this service is only available if the Member is unable to meet such an expense.

ATTACHMENT A-4
(Continued)
SCOPE OF HEALTH CARE SERVICES

SHORT-TERM POST-HOSPITALIZATION HOUSING

THE ILLUMINATION FOUNDATION

G. PROVIDER will coordinate and facilitate Member's recovery care after hospital discharge. It is understood that PROVIDER does not provide direct medical services nor have employees or associated volunteers acting in a professional medical capacity. PROVIDER agrees to exit each Member from services as soon as he/she is determined to no longer require Short-Term Post-Hospitalization Housing services or has been receiving services for a maximum duration of 6 months.

H. PROVIDER will assess each Member to determine if Member is a candidate for permanent supportive housing as appropriate. In collaboration with IEHP-contracted Community Supports Housing providers, PROVIDER will determine Member's eligibility for social services and temporary/permanent housing programs and refer Member for services as appropriate.

I. Upon exit from the program, if not transitioned to permanent supportive housing, PROVIDER shall make all reasonable efforts to connect each Member to an alternative facility, shelter, or permanent housing.

J. If indicated, assist Member in navigating the health system and building a relationship with the Member's PCP.

K. As needed, assist Member in accessing transportation to and from medical and behavioral health appointments.

L. Collaborate with other IEHP-contracted Community Supports providers as appropriate.

M. Participate in interdisciplinary care team (ICT) conferences with IEHP, other Community Supports services providers, county partners, and any other party identified as being integral to Member's success in remaining housed and their overall well-being.

N. Once services are authorized, collaborate with IEHP to ensure Member's access to Community Supports services via a "closed-loop" referral system, which will include follow up with the Member to ensure that services were received.

Coordinating Discharges - PROVIDER agrees to:

- Maintain written discharge policy. The policy will specify the personnel authorized to make discharge decisions.
- Ensure that IEHP Member is informed of the discharge policy and procedure.

ATTACHMENT A-4
(Continued)
SCOPE OF HEALTH CARE SERVICES

SHORT-TERM POST-HOSPITALIZATION HOUSING

THE ILLUMINATION FOUNDATION

- Contact IEHP in case of an authorization expiration and have a conference call to verify the authorization expiration before determining further action.
- Ensure that IEHP Members are given a minimum of 24 hours' notice prior to being discharged from the program (exceptions for some administrative discharges).
- Provide a discharge summary available to the IEHP Member with the following discharge instructions:
    - Written medication list
    - List of follow-up appointments and contact information
    - Instructions for accessing relevant community resources

Quality and Reporting - PROVIDER agrees to:

- Provide access to IEHP staff to conduct on-site audits and file reviews.
- Maintain a quality improvement plan in place that will audit staff and IEHP Member files to ensure that the appropriate standards are maintained.
- Provide regular reports to IEHP on outcomes of interest and key performance indicators.
- Ensure that the program has a policy for managing and reporting incidents such as falls, physical altercations, theft, etc.
- Fulfill duties as a mandated reporter of suspected child, elder, or dependent adult abuse.
- Require that staff employed by the PROVIDER have written job descriptions and meet the qualifications required by such job descriptions.
- If applicable, ensure that licensing and credentials are initially verified and reviewed, at minimum, on an annual basis.
- Provision of ongoing training to Community Supports Short-Term Post-Hospitalization Housing staff to ensure services are appropriate and to promote continuous quality improvement.
- Comply and deliver services in accordance with contract deliverables and objectives.

Billing and Employee requirements - PROVIDER agrees to:

- Provide IEHP a Daily Census that will include, but not limited to: IEHP Member name, Authorization Number, IEHP ID Number, Status (Admit, Pending), Admit Date, Exit Date, Length of Stay, Housing Interview (Yes, No), Prior Facility, Departure Notes, and Other Notes as applicable.
- Ensure that at least one (1) RN or higher medical services provider to provide evaluations and reporting as required by IEHP, these requirements include, but are not limited to measures in Exhibit 1.
- Capture encounter data in accordance with the Inbound 837 Implementation File and Companion Guide.

ATTACHMENT A-4
(Continued)
SCOPE OF HEALTH CARE SERVICES

SHORT-TERM POST-HOSPITALIZATION HOUSING

THE ILLUMINATION FOUNDATION

- Include their encounter data using the applicable CPT codes including, but not limited to, the CPT codes referenced in Exhibit 1, in their Inbound 837.
- Communicate with IEHP regularly to update status on Members quarterly and biannually to update HEDIS reporting measures required by housing and any other important reporting requirements deemed necessary by IEHP for the health and welfare of their Members under PROVIDER care.
- Maintenance of program and Member records and legally permissible data systems as required.
- Submit reports and claims as requested and in a timely manner and provide all required supporting documentation.

ATTACHMENT B

COMPENSATION

RECUPERATIVE CARE (MEDICAL RESPITE)

THE ILLUMINATION FOUNDATION

When IEHP Health Plan is the payor for authorized Health Care Services, reimbursement for authorized Health Care Services rendered shall be according to the following fee schedules:

A. STATE PROGRAMS:

REV Code	HCPCS Code	Modifier	Description	Reimbursement
560	T2033	U6	Residential care, not otherwise specified (NOS), waiver; per diem	$226 Per Diem

Claims for recuperative care services must be billed on a UB-04 claim using Bill Type 891-899 and Place of Service 16.

PROVIDER will charge for the day of admission regardless of actual admission time and will not charge for day of exit regardless of time.

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

ATTACHMENT B-1

COMPENSATION

HOUSING TENANCY SERVICES & SUSTAINING SERVICES

THE ILLUMINATION FOUNDATION

When IEHP Health Plan is the payor for authorized Health Care Services, reimbursement for authorized Health Care Services rendered shall be according to the following fee schedules:

A. STATE PROGRAMS:

HCPCS Code	Modifier	Description	*Reimbursement	Frequency
T2040	U6	Financial management, self-directed; per 15 minutes	$525.00 Per Member Per Month	Payable only once per calendar month, per Member
T2041	U6	Support brokerage, self-directed; per 15 minutes	$525.00 Per Member Per Month	Payable only once per calendar month, per Member

***Only one (1) of the above noted services is payable per calendar month, per Member. Reimbursement shall not exceed $525.00 per calendar month, per Member.**

Claims for housing tenancy services & sustaining services must be billed on a CMS 1500 claim form.

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

ATTACHMENT B-2

COMPENSATION

HOUSING TRANSITION NAVIGATION SERVICES

THE ILLUMINATION FOUNDATION

When IEHP Health Plan is the payor for authorized Health Care Services, reimbursement for authorized Health Care Services rendered shall be according to the following fee schedules:

A. STATE PROGRAMS:

HCPCS Code	Modifier	Description	*Reimbursement	Frequency
H0043	U6	Supported housing, per diem	$535.00 Per Member Per Month	Payable only once per calendar month, per Member
H2016	U6	Comprehensive community support services, per diem	$535.00 Per Member Per Month	Payable only once per calendar month, per Member

Only one (1) of the above noted services is payable per calendar month, per Member. Reimbursement shall not exceed $535.00 per calendar month, per Member.

Claims for housing transition navigation services must be billed on a CMS 1500 claim form.

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

ATTACHMENT B-3

COMPENSATION

HOUSING DEPOSITS

THE ILLUMINATION FOUNDATION

When IEHP Health Plan is the payor for authorized Health Care Services, reimbursement for authorized Health Care Services rendered shall be according to the following fee schedules:

A. STATE PROGRAMS:

HCPCS Code	Modifier	Description	*Reimbursement
H0044	U2	Supported housing, per month.	100% of billed charges

Total Member lifetime benefit maximum shall not exceed $5,000. Deposit amount must be included on the claim.

Claims for housing deposits services must be billed on a CMS 1500 claim form.

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

ATTACHMENT B-4

COMPENSATION

SHORT TERM POST HOSPITALIZATION

THE ILLUMINATION FOUNDATION

When IEHP Health Plan is the payor for authorized Health Care Services, reimbursement for authorized Health Care Services rendered shall be according to the following fee schedules:

A. STATE PROGRAMS:

HCPCS Code	Modifier	Description	Reimbursement
H0044	U3	Supported housing, per month	$119 Per Diem

Claims for short term post hospitalization services must be billed on a CMS 1500 claim form.

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

CALAIM CONTRACT

Group Services Agreement

The Illumination Foundation ("Group") and **Molina Healthcare of California** ("Health Plan") enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Group and Health Plan each are referred to as a "Party" and collectively as the "Parties."

RECITALS

A. WHEREAS, Health Plan is a licensed and approved, or is seeking licensure and approval to offer health care products and services in new counties in which it is not yet licensed to operate, by required governmental agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services;

B. WHEREAS, Group is an integrated entity that is approved to contract on behalf of individuals and entities to provide health care and related services in accordance with applicable laws and desires to provide services to eligible recipients; and

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products covered under this Agreement.

D. NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

ARTICLE ONE - DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.

a. **Advance Directive** means a Member's written instruction, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.

c. **Agreement** means this Group Services Agreement between Group and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Appeals and Grievance Programs** mean the policies and procedures established by Health Plan to timely identify, process, and resolve Member and Provider appeals, grievances, complaints, disputes, or inquiries.

e. **Assigned Member** Compensation Terms, who is enrolled in a Product and who has been assigned/attributed to Group as noted in Attachment B, Compensation Terms. Assigned Members are a subset of Members.

f. **California Department of Health Care Services** ("DHCS") means the department within the State of California which administers medical assistance programs.

g. **Capitation Payment** means the payment made to Group under this Agreement for Capitated Services provided.

h. **Capitated Services** mean the Covered Services for which Group has agreed to assume financial responsibility and which are identified under the "Group" heading of the applicable Product's Division of Financial Responsibility Attachment, attached to this Agreement as Attachment G. Capitated Services are a subset of Covered Services.

1. **Centers for Medicare and Medicaid Services** ("CMS") means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

J. **Claim** means a bill for a Non-Capitated Service provided by Group or, if applicable, a Provider.

k. **Clean Claim** means a Claim for a Non-Capitated Service submitted on an appropriate industry standard form, which has no defect, impropriety, lack of required substantiating documentation necessary to adjudicate the Claim, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.

l. **Contract Period** means a twelve-month (12) month calendar period beginning on January first (1st) and ending of December thirty-first (31st) of each calendar year.

m. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to a Member that are Medically Necessary and are benefits of the Member's Product.

n. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

o. **Date(s) of Service** means the date(s) on which Group or, if applicable, a Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

p. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products, below the level of the arrangement between Health Plan (or applicant) and Group. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

q. **Emergency Medical Condition** means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

r. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize an Emergency Medical Condition.

s. **Encounter Data** means the information that describes health care interactions between Members and providers relating to the receipt of any item or service by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

t. **Government Contract** means the contract between Health Plan and a governmental agency for a Product.

u. **Government Program Requirements** mean the requirements of governmental agencies for a Product, which includes, but are not limited to, the requirements set forth in the Government Contract.

v. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, and established by Section 100500 et seq. of the California Government Code, including all implementing statutes and regulations.

w. **Health Plan** means Molina Healthcare of California.

x. **Law** means, without limitation, federal, state/commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.

y. **Medicaid** means the joint federal-state or federal-commonwealth program provided for under Title XIX of the Social Security Act, as amended.

z. **Medically Necessary or Medical Necessity** means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, and at least as likely to produce equivalent results.

aa. **Medicare Advantage** ("MA") means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVTTT of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

bb. **Medicare-Medicaid Program** ("MMP") means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.

cc. **Medicare Program Revenue** means the Part A and Part B Monthly CMS Payment that Health Plan receives from CMS for Medicare Program Members assigned to Provider

dd. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

ee. **Molina Marketplace** means the products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

ff. **Non-Capitated Services** mean those Covered Services which are not Capitated Services and are being reimbursed on a fee-for-service basis and for which a fee-for-service reimbursement rate is included in Attachment B, Compensation Terms, for the Product. Non-Capitated Services are a subset of Covered Services.

gg. **Organizational Providers** mean the facilities who have an ownership interest in, control interest in, or other contractual relationship with the Group and who provide health care and related services to Members. The facilities may include, but are not limited to, hospitals and ambulatory surgery centers.

hh. **Overpayment** means a payment Group or a Provider receives, which after applicable reconciliation, Group or a Provider is not entitled to receive or retain pursuant to Laws, Government Program Requirements, or this Agreement.

11. **Participating Primary Care Provider** ("PCP") means a Practitioner Provider who is a primary care provider under an applicable Product.

JJ. **Participating Provider** means an individual or entity that is contracted with Health Plan to provide services to Members, and, as applicable, credentialed by Health Plan or Health Plan's designee.

kk. **Per Member Per Month** ("PMPM") means payment amounts on an individual Assigned Member per month basis.

11. **Practitioner Providers** mean all persons who have an employment relationship with, an ownership or control interest in, or other contractual relationship with Group and who provide health care and related services to Members. These persons may include, but are not limited to, physicians, physician assistants, and nurse practitioners.

mm. **Products** mean the health insurance programs, identified on Attachment A, Products, in which Group agrees to participate and which will include any successors to the health insurance programs.

nn. **Provider** means each Practitioner Provider and Organizational Provider that Group has the authority and authorization to bind to this Agreement and who may provide Covered Services and bill under the entities identified in Attachment H, Provider Identification Sheet, and who are permitted to provide health care and related services subject to the terms of this Agreement. Group will ensure, as applicable, that each Practitioner Provider and Organizational Provider providing Covered Services complies with the applicable terms of the Agreement. Each entity or person shall be considered an "Individual Provider."

oo. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Group and Provider are required to follow.

pp. **Quality Improvement Program** ("QI Program") means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

qq. **Responsible Entity** means an entity, including, but not limited to, a capitated independent practice association or any entities that are capitated by Health Plan, which is financially responsible for certain Covered Services.

rr. **State Children's Health Insurance Program** ("SCHIP" or "CHIP") means the program established pursuant to Title XXI of the Social Security Act, as amended.

ss. **Subcontractor** means an individual or organization, including Downstream Entity, with which Group contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

tt. **Utilization Review and Management Program** ("UM Program") means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Group agrees to provide services within the scope of Group's business and in accordance with the terms and conditions of this Agreement. Group further agrees to ensure Providers will provide or arrange for the provision of health care and related services in accordance with the terms and conditions of this Agreement. Group will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, and Laws and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Group and its Providers' facilities, equipment, personnel, technology (hardware and software), and administrative services will be at a level and quality necessary to perform its respective duties under this Agreement and to comply with Laws and Government Program Requirements. Group will further ensure that its personnel comply with the applicable terms of this Agreement.

c. **Prior Authorization.** For a Covered Service that requires a prior authorization, Providers are required to obtain prior authorization from Health Plan for such Covered Service. Providers do not have to obtain prior authorizations before providing Emergency Services.

   a) ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to the Plan for authorization of ECM.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when a Provider obtains prior authorization, a Group and its Providers will only utilize Participating Providers to provide Covered Services. Each Provider will notify Health Plan so that Health Plan can determine the appropriate provider to perform services if a Participating Provider is not available.

e. **Staffing.** ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Contract and any other related DHCS guidance.

f. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Providers will follow Health Plan's Drug Formulary/Prescription Drug List and prior authorization and prescription policies. Group acknowledges the authority of pharmacies to substitute generics or low-cost alternative prescriptions for prescribed medications.

g. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Group will ensure Providers are free to communicate all treatment options to Members regardless of limitations on Covered Services.

h. **Member Eligibility Verification.** Providers will verify a Member's eligibility before providing a Covered Service unless the situation involves the provision of an Emergency Service and will confirm eligibility in a manner that is consistent with Law and Government Program Requirements on redeterminations of eligibility.

1. **Availability of Services.** Providers will meet applicable standards for timely access to care and services in accordance with Laws and Government Program Requirements. Providers will ensure the availability of Covered Services twenty-four (24) hours a day, seven (7) days a week, for those Covered Services that are required to be made available twenty-four (24) hours a day, seven (7) days a week.

J. **Hospital Admission.** Providers will immediately notify Health Plan of a Member hospital admission, including any inpatient admission, and when a Member is seen in the emergency department.

k. **Privileges.** Specialist and primary care Practitioner Providers will have staff/admitting privileges with at least one (1) Health Plan contracted hospital as necessary to provide Covered Services. Practitioner Providers will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against a

Practitioner Provider which could result in the suspension, reduction, or modification of the Practitioner Provider's hospital privileges if permitted by Law. If a specialist or primary care Practitioner Provider does not have privileges with at least one (1) Health Plan contracted hospital, the Provider must provide an acceptable arrangement to Health Plan that ensures Members' continuity of care.

l. **Access.** Organizational Providers will agree to use best efforts to arrange privileges or other appropriate access to inpatient/outpatient facilities for Participating Providers, including hospitalist providers, who are qualified medical or osteopathic physicians and Health Plan's case management staff, provided the individuals meet the credentialing requirements and privileges standards established by the facility.

m. **Medical and Allied Health Care Professionals.**

1. Medical and allied health care professionals who provide health care and related services in an Organizational Provider's inpatient/outpatient facility shall do so in accordance with applicable Laws and Government Program Requirements. Organizational Providers will ensure that medical and allied health care professionals providing health care and related services within its inpatient/outpatient facilities are, as applicable, licensed, certified, credentialed, re-credentialed, and privileged within the scope of the individual's specialty. Additionally, Organizational Providers will require notice from a medical or allied health care professional when, as applicable: (i) a required license is limited, suspended, or revoked or a disciplinary proceeding is commenced against the individual by a governmental or accrediting agency; (ii) there is a lapse in required insurance coverage; or (iii) the individual is excluded/precluded or terminated from participation in a state/commonwealth or federal health care program.

11. If an Organizational Provider identifies a deficiency in the delivery of health care services by a medical or allied health care professional, the Organizational Provider will take appropriate corrective action. Corrective action may include the termination, suspension, reduction, or modification of privileges. Organizational Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be implemented against a medical or allied health care professional that results in the tennination, suspension, reduction, or modification of privileges, if permitted by Law.

2.2 **Rights of Members.** Group and its Providers will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Neither Group, including its Providers, nor Health Plan will use the other's name, including, but not limited to, trademarks, service marks, domain names, or logos ("Marks") without the prior written approval of the other Party. This Agreement does not grant either Party a license or sublicense to the other Party's Marks. However, Group may refer to Health Plan in its listings of participating health plans. Additionally, Health Plan may use Group and each Provider's name and related information: (i) in Health Plan's filings and publications to identify Group and its Providers as a Participating Provider; (ii) in communications to identify Group and its Providers to Members; and (iii) as may be required to comply with the Laws and Government Program Requirements. Group agrees that marketing materials related to this Agreement created by either Group or its Providers require Health Plan's review and prior written approval unless otherwise noted in the Agreement.

2.4 **Non-Discrimination.** Group agrees not to discriminate in performing its duties under this Agreement and will ensure its Providers do not discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, creed, ancestry, language, age, sex, marital status, sexual orientation, gender identity, health status, physical, sensory or mental handicap, disability, socioeconomic status, identification with any other persons or groups defined in Penal Code 422.56, participation in publicly financed programs of health care services or any other basis prohibited by Law. Providers will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Records.** Group will maintain complete and correct books and records relating to services provided under this Agreement for tax, accounting, and operation purposes. Each Provider will maintain medical and billing records ("Records") for each Member to whom the Provider provides health care and related services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies

and procedures. Providers will retain such Records for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Group agrees it and its Providers will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Group and its Providers will not disclose or use a Member's name, address, social security number, identity, other personal information, treatment modality, or Record without obtaining appropriate authorization. This section does not affect or limit the Group or a Provider's obligation to make available the Record, Encounter Data, and information concerning a Member's care to Health Plan, a governmental agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Group will promptly deliver or ensure its Providers promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third-party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Group or, if applicable, its Providers are responsible for the fees associated with producing the above items. Group and its Providers will further give direct access to the items as requested by Health Plan or as required by a governmental agency. This section will survive any termination.

d. **Member Access to Member Record.** Group and its Providers will give each Member access to the Member's Record and other applicable information in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.6 **Program Participation.**

a. **Participation in Appeals and Grievance Programs.** Providers will participate in and comply with Health Plan's Appeals and Grievance Programs.

b. **Participation in Quality Improvement Program.** Providers will participate in and comply with Health Plan's QI Program. Providers will cooperate in conducting peer reviews and audits of care and services provided.

c. **Participation in Utilization Review and Management Program.** Providers will participate in and comply with Health Plan's UM Program. Providers will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Providers will participate in and comply with Health Plan's credentialing and re-credentialing program. Each Provider requiring credentialing must be credentialed by Health Plan or Health Plan's designee before providing Covered Services and must remain credentialed throughout the term of the Agreement to continue to provide Covered Services. Each Provider will promptly notify Health Plan of any change in the information submitted or relied upon by Provider to achieve or maintain its credentialed status.

    a) ECM Provider shall be Medicaid- enrolled where a State-level enrollment pathway exists, as is required by Federal Law.

e. **Health Education/Training.** Providers will participate in and comply with Health Plan's provider education and training program, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

f. **ECM Training.** ECM Provider shall participate in all ECM training and technical assistance provided by the Plan, including in-person sessions, webinars, and/or calls as necessary.

g. **Program Corporation.** Unless specifically delegated to Group in writing, Group will ensure compliance with and will participate and comply with Sections 2.6 a. through e.

2.7 **Provider Manual.** Group and its Providers will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be updated by Health Plan as provided by Law. Group acknowledges the Provider Manual is available at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials, in a manner consistent with Law, in an electronic format, which includes, but is not limited to, posting on Health Plan's web-portal; physical copies are available upon request. Supplemental Materials become binding upon the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Providers will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's web-portal.

2.10 **Information Reporting and Changes.** Group will deliver to Health Plan a complete and accurate list of its Providers including, as applicable, each Individual Provider, together with the specific infonnation required for administration of this Agreement. This information includes, but is not limited to, the information required by Health Plan to produce provider directories and any subsequent changes to that information. Group will be required to deliver any changes as to who is included under this Agreement within five (5) days. Each Provider, including, as applicable, each Individual Provider, will only be part of this Agreement after the Provider has received written approval from Health Plan, which includes, but is not limited to, confirmation that credentialing is complete if required. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another manner or different timeframe, Group will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Requirements.** Group warrants and represents that it has, and its Providers have, the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide Covered Services in accordance with Laws and Government Program Requirements. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Group or a Provider will deliver evidence of any approvals to Health Plan upon request. Group agrees and will ensure its Providers maintain such approvals in good standing, free of disciplinary action, and in unrestricted status. Group and its Providers will promptly notify Health Plan of changes in its status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Group and its Providers. Group and its Providers shall comply with all requirements of 28 CCR 1300.49 et seq., as applicable.

b. **Unrestricted Status.** Group represents to its best knowledge, information, and belief, neither it, nor any of its Providers, including, as applicable, Individual Providers, employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors or any persons or entities with an ownership or control interest in Provider as defined and set forth in 42 CFR 455.101 and 455.104 (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state, commonwealth or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Group will check or will ensure its Providers check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government and every state, commonwealth, and the District of Columbia's Medicaid exclusion lists (including criminal background and registry checks) to determine whether any Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Group will notify or will ensure its Providers notify Health Plan immediately in writing if it is determined that any Personnel are suspended or excluded from any Federal Health Care Program. Group agrees that it is subject to 2 CFR Part 376 and will require its Providers as well as its respective Personnel agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Group or a Provider's non-compliance with this provision or any payments were made to Group or a Provider while under non-compliance with this provision, Health Plan will issue a letter requesting payment of the amount. If the Group does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any amounts due. If required,

such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

c. **Legal Actions.** Group and its Providers will give prompt written notice to Health Plan of: (i) a legal claim asserted against it by a Member and information about its resolution; (ii) a criminal investigation or charge, information, or indictment filed and information about its resolution; and (iii) a legal claim that may jeopardize financial soundness and information about its resolution. This section will survive any termination.

d. **Liability Insurance.** Group will maintain and, as applicable, will ensure that its Providers maintain the following insurance, and additional insurance coverage consistent with industry standards and as required by Laws and Government Program Requirements.

i. General Liability, including, but not limited to, liability resulting from bodily injury inclusive of mental anguish, death of persons and damage to and destruction of property arising out of or based upon any act or omission of Provider or its respective officers, directors, employees, or agents, with one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate, bodily injury and property damage combined single limit of coverage. Health Plan is to be named as an additional insured and insurance shall evidence primary and non-contributory coverage. Subrogation rights against Health Plan are to be waived;

ii. Medical professional liability with limits of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for a policy year. Notwithstanding the preceding sentence, hospitals will maintain medical professional liability with limits of at least ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) in the aggregate for a policy year. If the coverage is claims made or occurrence reported, Provider must purchase "Extended Reporting Period" coverage (i.e., tail coverage) for a period of not less than three (3) years upon termination of the Provider's present or subsequent policy unless such policy covers prior acts for at least three (3) years. Subrogation rights against Health Plan will be waived.

iii. Umbrella Liability with limits of five million dollars ($5,000,000). Notwithstanding the preceding sentence, hospitals will maintain limits of ten million dollars ($10,000,000).

All the insurance policies referenced will be with admitted insurers having an A.M. Best rating of A-VII or better. Such insurance will be secured and maintained at the Group and, if applicable, the Provider's own expense. Group will furnish Health Plan with certificates of insurance completed by its respective insurance carriers: (i) certifying that minimum insurance coverage as required above is in effect; and (ii) stating that Health Plan is an additional insured for the pertinent policy. Health Plan shall be given not less than thirty (30) days written notice prior to any cancellation or material change to any policy. Group will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. This rights and duties of this section survive any termination as it relates to those Covered Services which were provided prior to the effective date of the termination.

2.12 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Group and its Providers will comply with the Laws that are applicable to this Agreement. Group acknowledges, and Group will ensure its Providers acknowledge, that Health Plan has entered into Government Contracts for each Product and that Group and its Providers will comply with the applicable Government Program Requirements for each Product. Upon written request, Health Plan will give Group a copy of each Government Contract under which Group is participating, redacted to remove financial and other private and trade secret information.

b. **Fraud and Abuse Reporting.** Group and its Providers will comply with Laws and Government Program Requirements relating to fraud, waste, and abuse. Group and its Providers will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Group or a Provider discovers an occurrence of fraud, waste, or abuse, it will notify Health Plan within two (2) business days. Group and its Providers will fully cooperate in investigations conducted by Health Plan or by a governmental agency. If Health Plan, DHCS, CMS, or the United States Department of Health and Human Services ("HHS") Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS

Inspector General may inspect, evaluate or audit the Group or Provider at any time, and Group and its Providers will fully cooperate with and provide records for any such audit. This section will survive any termination.

c. **Advance Directive.** Providers will comply with Laws and Government Program Requirements related to Advance Directives.

d. **Ownership Disclosure Information.** If applicable, Group and each Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Group, a Provider, or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the tenn of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Group, a Provider or disclosing entity also has an ownership or control interest.

2.13 **Reciprocity Agreements.** Group and its Providers will cooperate and ensure reciprocity of health care and related service to Non-Assigned Members. Group and its Providers will cooperate and ensure reciprocity of health care and related service to Affiliates' enrollees. For Affiliates' enrollees, Group or, if applicable, its Providers will be compensated for Clean Claims that are determined to be payable at the applicable rate set forth in this Agreement unless otherwise required by Law and Government Program Requirement. Group and its Providers will follow the hold hannless provisions of this Agreement for Affiliates' enrollees.

2.14 **Abuse, Neglect, and Exploitation.** Providers will comply with the Laws and Government Program Requirements relating to the reporting of abuse, neglect, and exploitation.

2.15 **Transfer of Members.** Neither Group nor its Providers will unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.16 **Condition Change.** Providers will promptly notify Health Plan's Care Management Team upon becoming aware of a significant change in a Member's health or functional status or death.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Health Plan Compliance.** Health Plan will comply with all Laws and Government Program Requirements that are applicable to this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of a Provider.

3.3 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames required by Laws and Government Program Requirements after receiving all necessary information from the Provider.

3.4 **Medical Necessity Determination.** Health Plan's determination regarding Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern.

3.5 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.6 **Provider Services.** Health Plan will make available a Provider Services Department that, among other Health Plan duties, is available to assist Group and its Providers with questions about this Agreement.

3.7 **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Group and Providers' compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan to address the deficiency. Group and its Providers are required to accept and implement such corrective action plan. Group and its Providers are not entitled to a corrective action plan prior to any termination.

3.8 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Group or to a Provider if Health Plan determines that Group or a Provider poses a threat to Members' health and safety or during a termination notice period in accordance with Laws and Government Program Requirements. Each Provider will ensure copies of the Member's medical records are delivered to the new provider within ten (10) business days ofreceipt of the Health Plan's or the Member's request to transfer the records. Subject to the foregoing, if a Provider requests reassignment of a Member, Health Plan will consider reassignment in accordance with Laws and Government Program Requirements or, if there are no applicable Laws or Government Program Requirements, upon good cause shown by the Provider.

3.9 **Quality Bonus Payment Program.** Health Plan may offer Group or its Providers the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). The QBPP will promote quality of care if offered. Group and its Providers must register with Health Plan's web portal to be eligible for any QBPP. Payments under the QBPP will be based on the terms of the QBPP as set forth in the Provider Manual, in a Supplemental Material, or in an amendment to this Agreement. QBPP payments are not guaranteed payments and are paid separately from the compensation due pursuant to the terms of this Agreement.

ARTICLE FOUR- COMPENSATION

4.1 **Compensation.** Health Plan will pay Group in accordance with Attachment B, Compensation Terms.

4.2 **Member Hold Harmless.** Group agrees and will ensure its Providers agree that in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Group or a Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This does not prohibit a Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services in accordance with Laws and Government Program Requirements. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.3 **Financially Responsible Entity Payments.** If a Provider provides Covered Services that are the responsibility of a Responsible Entity, the Group or, if applicable, Provider, will look solely to the Responsible Entity for payment for the Covered Services.

ARTICLE FIVE - TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year ("Initial Term") and will renew for successive one (1) year terms unless terminated by either Party in accordance with this Agreement.

5.2 **Termination without Cause.** After the expiration of the Initial Term, this Agreement or an individual Product under this Agreement may be terminated without cause by either Party by giving at least ninety (90) days' written notice prior to the end of the Contract Period. The termination will become effective at the end of the last day of the Contract Period.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement or an individual Product under this Agreement upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement or an individual Product under this Agreement, without providing the other Party the opportunity to cure a material breach, should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement or an individual Product under this Agreement may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Group's license or any other approval needed to provide Covered Services is limited, suspended, or revoked or a disciplinary proceeding is commenced against Group by a governmental or accrediting agency or an indictment is issued against Group;

b. Either Party fails to maintain adequate levels of insurance;

c. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Group or Health Plan is appointed by appropriate authority;

d. If Group is capitated or participating in another risk-sharing compensation methodology and Health Plan determines Group is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

e. Health Plan reasonably determines that Group's facility, equipment, or Personnel are insufficient to provide Covered Services;

f. Either Party is excluded/precluded from participation in a state, commonwealth, or federal health care program;

g. Group is terminated as a provider by a state, commonwealth, or federal health care program;

h. Either Party engages in fraud, waste, or abuse or permits fraud, waste, or abuse by another in connection with the Party's obligations under this Agreement;

1. Health Plan reasonably determines that Covered Services are not being properly provided or arranged for by Group and such failure poses a threat to Members' health and safety;

J. Group violates any Law;

k. Group fails to satisfy the terms of a corrective action plan, or if Group is unable to maintain its compliance with Health Plan's Delegation Services Addendum requirements as outlined in Attachment L, Delegated Services Addendum, and Attachment L-1, Delegated Services Addendum, Credentialing Requirements, including, but not limited to, maintaining required credentialing delegation status;

l. Health Plan ceases to offer a Product and any run-out period required by a Law or Government Program Requirements has expired; or

m. Termination is required by a governmental agency.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable notice to Members who are currently receiving care and the Parties will ensure the continuity of care in accordance with Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

5.7 **Provider Termination.** Health Plan may restrict, suspend, or terminate a Provider or an Individual Provider, under the same terms and conditions as Health Plan may terminate Group as stated in the Agreement in accordance with applicable Law, this includes, but is not limited to, the reasons noted in Sections 5.2, 5.3, and 5.4. Group will immediately restrict, suspend, or terminate a Provider or, if applicable, an Individual Provider from participating under this Agreement for a failure to meet the terms of this Agreement or upon a Health Plan or a governmental authority's request.

ARTICLE SIX - GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the

indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement. This Section will survive the tennination of this Agreement.

6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement. Nothing contained in this Agreement will cause either Party to be liable or responsible for any debt, liability, or obligation of the other Party or any third-party unless the debt, liability, or obligation is expressly assumed and evidenced in writing.

6.3 **Governing Law.** The laws of the State of California will govern this Agreement to the extent such laws are not preempted by federal laws.

6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Provider Manual, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction or any governmental agency with oversight authority for this Agreement to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated because of such decision.

6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members or to assign a minimum number of Members to Group or its Providers.

6.8 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Group's consent. Such regulatory amendment will be binding upon Group.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, any amendment of a material term to this Agreement must be in writing and executed by the Parties.

6.9 **Delegation or Subcontract.** Upon the Effective Date, Group will submit to Health Plan a list identifying each of Group's Subcontractors and a description of the services the Subcontractor provides. After the Effective Date, Group will promptly submit to Health Plan updates to the list. Group will ensure that each Subcontractor complies with the applicable terms of this Agreement. Group's contract with a Subcontractor will be in writing and will bind Subcontractor to the applicable terms required for compliance with this Agreement. Health Plan has the right to request Group limit the use of a Subcontractor that does not meet the applicable terms of the Agreement and Group agrees to take reasonable action to comply with the request.

6.10 **Assignment.** Group may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

6.11 **Arbitration.**

a. **Arbitration Requirements.** Any dispute, claim, or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation, or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate (hereafter "Dispute"), shall be determined by arbitration, subject to the terms of this section. The arbitration shall take place in Los Angeles County, California before one (1) arbitrator. The arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in health care. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. This section shall not preclude the Parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Matters that primarily involve a Provider's professional competence or conduct (i.e., malpractice, professional negligence, or wrongful death) are not eligible for arbitration. Group will ensure that its Provider rely on Group to initiate Arbitration.

b. **Meet and Confer.** Prior to the initiation of arbitration, the Parties shall attempt to resolve any Dispute arising out of or relating to this Agreement via a good faith "Meet and Confer." To initiate a Meet and Confer, a Party shall deliver to the other Party a written notice of the Dispute that includes a demand to Meet and Confer. The notice shall include: (i) a statement of the Party's position and a summary of arguments supporting that position; and (ii) the name and contact information of the executive who will participate in the Meet and Confer. The Meet and Confer shall be held within forty-five (45) days of the delivery of the notice, at a mutually acceptable time and place, between appropriate representatives of the Parties, including a person authorized to settle the Dispute (the "First Meeting"). The Parties may agree to further discussions after the First Meeting. At no time prior to the First Meeting shall either Party initiate an arbitration or litigation related to this Agreement, except to pursue a provisional remedy that is authorized by law or by JAMS Rules or by agreement of the Parties. This limitation is inapplicable to a Party if the other party refuses to comply with the requirements of this subsection.

c. **Rules for Arbitration.** The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court oflaw, nor will the arbitrator have the authority to award punitive, exemplary, or treble damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties adopt and agree to implement the JAMS Optional Arbitration Appeal Procedure that is in place at the time of the arbitration with respect to any final award in an arbitration arising out of or related to this Agreement.

The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute. The award may be vacated, modified or corrected pursuant to the Federal Arbitration Act, 9 USC§§ 9-11. Grounds for vacating an award include: (i) where the award was procured by corruption, fraud, or undue means; (ii) where the arbitrators were guilty of misconduct or exceeded their powers; (iii) evident material miscalculation; (iv) evident material mistake in the description of any person, thing, or property referred to in the award; and (v) imperfections in a matter of form not affecting the merits.

Each Party shall bear its own costs and expenses of arbitration, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration.

Arbitration must be initiated within one (1) year of the earlier of the date the Dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise the Dispute will be deemed waived and the complaining Party shall be barred from initiating arbitration or other proceedings. The Parties expressly agree that the deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email. Notwithstanding the preceding sentence, if facsimile or email is used to deliver any notice of termination of the Agreement, a copy of the notice of termination must also be delivered in: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; or (iii) by overnight courier that guarantees next day delivery.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

6.15 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party if it is determined that: (i) the Party used the efforts a reasonable person would during the force majeure event to perform its duties under this Agreement; (ii) the Party's inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event; and (iii) the Party's inability to perform its duties during the force majeure event is not due to its failure to develop and maintain a Business Continuity Plan to respond to the force majeure event.

6.16 **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Group or Providers, including, but not limited to, Member lists, QI Program, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Neither Group nor a Provider will disclose or release information to a third party without the written consent of Health Plan. However, each Party may share information with its subsidiaries and affiliates and its respective personnel and designees as necessary to fulfill the terms of this Agreement. Nothing in the Agreement will preclude either Party from disclosing infonnation as required for compliance with a Law or Government Program Requirement or as required to comply with a governmental authority request provided that the information is only disclosed in a manner and to the extent required for compliance and in accordance with applicable Law. Group and its Providers will either return confidential information or destroy confidential information and provide confirmation of the destruction to Health Plan upon request if the Agreement terminates. This section will survive any termination.

6.17 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Group or a Provider's non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan will issue a letter requesting payment of the amount. If the Group does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any amounts due. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

6.18 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.

6.19 **Offshore Resources.** Neither Group nor its Subcontractors will perform any work related to the administration of the Agreement outside the United States of America without the prior written consent of Health Plan.

6.20 **Business Continuity Plan.** Group and, as applicable, its Providers maintain a comprehensive Business Continuity Plan ("BCP"). The BCP will address, at a minimum: (i) processes and resources needed to ensure continuity and re-establishment of health care services; (ii) how Group/Provider will interact with its business continuity suppliers, if any; (iii) alternate service/business locations; (iv) notification and escalation procedures; and (v) resilience of critical third-party service providers, if any. In the event a business disruption materially impacts Group or a Provider's provision of service under this Agreement, Group or the Provider will notify Health Plan of the disruption and the steps being implemented under the BCP within twelve (12) hours of the incident. The inclusion of a Disaster Recovery Plan ("DRP") will address the loss of access to a technology platform beyond twelve (12) hours. The DRP will further address, at a minimum, the data backup scheme including, but not limited to, Recovery Point Objective ("RPO"), Recovery Time Objective ("RTO"), and a summary description of fail-over and restoration procedures at the alternate service/business location. The DRP's RPO and RTO will have to align with Group and the Provider's provision of service under this Agreement. Group or a Provider will submit a copy of the BCP and DRP within thirty (30) days upon the request of the Health Plan; unless a shorter timeframe is required for compliance with a Law and Government Program Requirement. Group and its Providers will test the adequacy of its BCP-DRP at least annually and upon request (Health Plan will give no less than thirty (30) days advance notice); Health Plan may participate in such test. Group and its Providers will deliver the most recent BCP-DRP test results to Health Plan within thirty (30) days of a Health Plan request. In the event of a failed test, Provider or, if applicable, Group and Health Plan will jointly agree to a CAP. Group and its Providers will cooperate in audits of the BCP-DRP conducted by Health Plan or its designees.

6.21 **Business Associate.** Notwithstanding the Entire Agreement section of the Agreement, the Parties acknowledge and agree that for purposes of this Agreement, Group is a business associate of Health Plan, and this Agreement is subject to the requirements of Health Plan's Business Associate Agreement ("BAA") executed separately from this Agreement.

6.22 **Liaisons.** Each Party will appoint a liaison who will be the person authorized to act on behalf of such Party for all purposes in the implementation of this Agreement. However, the liaison will not be authorized to waive any provision or to enter into any amendment or revision of this Agreement without the express approval of the legally responsible individual or governing body/entity of such Party.

6.23 **Joint Operations Meetings.** The Parties will meet regularly to discuss items that include, but are not limited to, network provider adequacy, performance of duties, and process improvements.

6.24 **Data Usage.** The provisions of this section will apply only to the extent that Group or a Provider, now or in the future, acts as a "Service Provider" under the California Consumer Privacy Act ("CCPA"), Cal. Civ. Code § 1798.100, et seq., § 1798.140(v), and regulations promulgated thereunder. Group warrants and represents that all Personal Information shall not be: (i) retained, used, or disclosed by Group for any purpose other than for the specific purpose of performing the services specified in the Agreement; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Group shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Agreement or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140 (t)(l). "Personal Information" has the same meaning as set forth in Cal. Civ. Code § 1798.140 (o).

6.25 **Elective Cesarean Section.** The provisions of this Section apply only to an Organizational Provider that is a hospital, such Organization Provider will agree to participate in the California Maternal Quality Care Collaborative to support the reduction of Cesarean Section ("C-Section") births. Such Organization Provider will agree to use best efforts to reduce C-sections to at or below the requirement established by state and government agencies. At the signing of this Agreement, the standard is to be at or below the national C-Section average of 23.9%.

MOLINA HEALTHCARE OF CALIFORNIA

GROUP SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Group acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that it will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Group Signature and Information.

Group's Legal Name ("Group")-Matching the applicable tax form (i.e. W-9, Line 1): **The Illumination Foundation**	
Authorized Representative's Signature: Pooja Bhalla	Authorized Representative's Name - Printed: Pooja Bhalla
Authorized Representative's Title: Executive Director of Healthcare Services	Authorized Representative's Signature Date: 11/15/2021
Telephone Number: (949)273-0555	Fax Number - Official Correspondence: (888)517-7123
Mailing Address - Official Correspondence: 1091 N. Batavia St. Orange, CA 92867	Payment Address - If different than Mailing Address:
IRS 1099 Address - If different than Mailing Address:	Tax ID Number - As listed on corresponding tax form: **71-1047686**
NPI - That corresponds to the above Tax ID Number: 1073863056	Email Address - Official Correspondence: Info@ifhomeless.org

Health Plan Signature and Information.

Molina Healthcare of California ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name - Printed: Abbie A. Totten
Authorized Representative's Title: MHC Plan President	Authorized Representative's Countersignature Date: 12/17/2021
Mailing Address - Official Correspondence: 200 Oceangate LB CA 90802	Email Address - Official Correspondence: MAC_Contract_Terms@MolinaHealthCare.com
Effective Date of the Agreement ("Effective Date"): **01/01/2022**	

ATTACHMENT A

Products

Provider's participation in the Medicaid Product listed below is contingent upon Health Plan executing a Government Contract with the appropriate governmental agency. Provider agrees to participate in the Medicaid Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement. For all other Products, Provider's participation in each Product listed below is contingent upon the Product being offered by the appropriate governmental agency and upon Health Plan executing a Government Contract with the appropriate governmental agency. Subject to applicable Laws and Government Program Requirements, Provider agrees to participate in each Product on the date it becomes operational for Health Plan under its Government Contract under the terms of this Agreement.

1.1 **Medicaid** - including, but not limited to, Medi-Cal Geographic Managed Care, Medi-Cal Two Plan, and any other Medicaid programs Health Plan offers in the future.

1.2 **Medicare-Medicaid Program** - including, but not limited to, Cal MediConnect.

ATTACHMENT B

Compensation Terms

MCP agrees to reimburse ECM Providers for Enhanced Care Management Services at the rates outlined below.

I. Enhanced Care Management Rates:

1.1. Rates: Rate shall commence after Molina receives a qualified HCPCS code (applicable "G" code) from the ECM Provider. Molina agrees to compensate ECM 95% of DHCS premium rate in effect for the applicable coverage month for the Enhanced Care Management Program. Compensation is contingent upon submission of at least one HCPCS code (applicable "G" code) with a valid modifier each month, **in** accordance with the guidelines specified below.

At least one (1) HCPCS code submission with a valid modifier is required for each ECM Member at minimum every ninety days. If more than one **(1)** HCPCS code submission is submitted for each ECM Member at minimum every ninety days, only one encounter/ encounter code per ECM Member will be accepted per month for payment. The payment ECM Provider shall receive for the one encounter/encounter code that is accepted is 95% of the DHCS premium rate **in** effect for the applicable coverage month for the ECM Services. The ECM Provider is responsible for reporting all encounters data back to the Health Plan. The ECM Provider will provide outreach engagement to the ECM members.

1.2. **Codes: HCPCS and Modifiers.** DHCS selected HCPCS code (applicable "G" code) for. The definition of "G" code is as follows: Comprehensive assessment of and care planning for patients requiring chronic care management services.

HCPCS code along with seven (3) different modifiers are listed in the table below for the ECM services. This coding scheme uses **HIP**AA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other ECM services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The ECM coding scheme is as follows:

ECM Service	HCPCS Code	Modifier
ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	Applicable "G" code	Ul
ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	Applicable "G" code	Ul,GQ
ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	Applicable "G" code	U2
ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	Applicable "G" code	U2,GQ

II. Community Supports Rates

MCP agrees to reimburse Community Supports Providers for services at the rates outlined below. Payment for Covered Services. Covered Services shall be paid under the State of California Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

2.1 **Rates:**

Housing Transition Navigation Services:

H0043	Supported Housing	$350.00 Monthly Case Rate Per Member

Housing Deposits:

H0044	Supported Housing, per month	Cost not to exceed member lifetime $5,000.00

Housing Tenancy and Sustaining Services:

T2041	Support brokerage, self-directed (15 minutes	$430.00 Monthly Case Rate Per Member

Recuperative Care:

T2033	Residential Care	$220.00 Per Diem

2.2 **Codes: HCPCS and Modifiers** Community Support Provider must submit the correct HCPCS codes and modifier combined as defined by DHCS. All telehealth services must be provided in accordance with DHCS policy.

ATTACHMENT C

Laws and Government Program Requirements

Medicaid

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicaid Product. Provider must remain in compliance with this attachment and ensure its individual providers comply with this attachment.

1.1 **Definitions.**

a. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; or (iii) serious dysfunctions of any bodily organ or part.

b. **Emergency Services** mean inpatient and outpatient services furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize a Member's Emergency Medical Condition.

c. **Medically Necessary or Medical Necessity** means reasonable and necessary health care services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For Health Plan's Medi-Cal Members who are under the age of twenty-one (21), Medical Necessity shall also include the standards set forth in Title 22 of the California Code of Regulations ("CCR") Sections 51340 and 51340.1.

i. For Members receiving Managed Long-Term Services and Supports ("MLTSS"), Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services, of the State Contract.

ii. When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of twenty-one (21), "Medical Necessity" is expanded to include the standards set forth in 42 USC § 1396d(R), and Welfare and Institutions Code Section 14132(v).

1.2 All services to be provided by Provider are set forth in this Agreement.

1.3 This Agreement shall be governed by and construed in accordance with all laws, regulations, and contractual obligations governing the contract between Health Plan and Department of Health Care Services ("DHCS"). Provider will comply with all applicable requirements of DHCS, Medi-Cal Managed Care Program, and all applicable requirements specified in the contract between Health Plan and DHSC and any subsequent amendments, federal and state laws and regulations, and Medi-Cal Managed Care Division ("MMCD") Policy Letters. (MCP Contract, Exhibit A, Attachment 6, Provisions 14.B.2 and 14.B.21; Title 22, CCR,§§ 53250(c)(2) and 53867). Accordingly, this Agreement will comply with 42 CFR 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, Section 1300 et seq.; Welfare and Institutions Code Section 14200 et seq.; Title 22 CCR§§ 53900 and 53800 et seq.; and other applicable Federal and State laws and regulations.

1.4 Except as otherwise provided in the contract between Health Plan and DHCS, this Agreement shall become

effective for non -federally qualified health maintenance organizations ("HMO") upon approval by DHCS in writing or by operation oflaw where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within sixty (60) days of receipt. Except as otherwise provided in the contract between Health Plan and DHCS, for federally qualified HMOs this Agreement shall be exempt from prior approval by DHCS and submitted to DHCS upon request. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later.

l. 5 The term of the Agreement, including the beginning and end dates, methods of extension, renegotiation, and termination, are set forth in the Agreement.

1.6 If responsibility for coverage and payment of emergency services has been delegated to Provider, Provider must cover and pay for emergency services regardless of whether the Provider that furnishes the services has an agreement with Provider.

a. **Emergency Services.**

1. Provider may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a) of the definition of emergency medical condition. Further, Provider may not deny payment for treatment obtained when a representative of Health Plan instructs the Member to seek Emergency Services.

11. Provider may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying Provider, the Member's primary care provider, Health Plan, or DHCS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to provide stabilization.

b. **Non-Contracting Provider Emergency Services Payment.**

1. Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Health Plan, or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Health Plan. Emergency Services shall not be subject to Prior Authorization by Health Plan.

11. At a minimum, Provider must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

m. For all non-contracting providers, reimbursement by Provider or its subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5 Claims Processing, above, and 42 USC§ 1396u-2(b)(2)(D), and California Welfare and Institutions Code Section 14091.3.

1v. Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and 22 CCR§ 53620 et. seq., except Section 53698. Provider agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a decision that Health Plan is liable for payment of a

claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and 22 CCR §53702.

1.7 Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan.

1.8 Provider will comply with all monitoring provisions of the contract between Health Plan and DHSC and any monitoring requests of DHCS.

1.9 Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Agreement, available for the purpose of an audit inspection, evaluation, examination or copying, this further includes, but is not limited to, the Access Requirements and State's Right to Monitor, as set forth in the contact between Health Plan and DHCS, Exhibit E, Attachment 2, Provision 20, Inspection Rights. Inspection rights: (i) by DHCS, CMS, Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General of the United States, the Department of Justice ("DOJ") bureau of Medi-Cal Fraud , and Department of Managed Health Care ("DMHC") and other authorized State agencies, their duly authorized representatives or their designees, including DHCS' External Quality Review Organization contractor; (ii) at all reasonable times at the Provider's place of business or at such other mutually agreeable location in California; (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping; (iv) for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later; (v) including all Encounter Data for a period of at least ten (10) years; (vi) ifDHCS, CMS, or the DHHS Inspector General determines there is reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time; (vii) upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and direct Health Plan to terminate this Agreement due to fraud.

1.10 Full disclosure of the method and amount of compensation or other consideration to be received by the Provider is set forth in the Agreement.

1.11 Provider agrees to maintain and make available to DHCS, upon request, copies of all its sub-subcontracts and Provider will ensure that all of its sub-subcontracts are in writing and Provider agrees to:

a. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the contract between Health Plan and DHCS, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees; and

b. Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

1.12 If any inspection or evaluation is made of the premises of Provider, Provider shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

1.13 Provider agrees to assist Health Plan in the transfer of care in the event Health Plan's contract with DHCS terminates pursuant to Exhibit E, Attachment 2, Provision 14, of Health Plan's contract with DHCS.

1.14 Provider agrees to assist Health Plan in the transfer of care in the event a sub-subcontract terminates for any reason.

1.15 Provider agrees to notify DHCS in the event this Agreement is amended or terminated. For the purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

1.16 Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS.

1.17 Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan

cannot or will not pay for services performed by Provider pursuant to this Agreement.

1.18 Provider will make no claim for recovery in circumstances involving casualty insurance, tort liability, or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award.

1.19 Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS.

1.20 Provider agrees to arrange for the provision of interpreter services for Members at all of Provider's sites.

1.21 Provider has the right to submit a grievance. Health Plan's process to resolve Provider grievances are set forth in this Agreement and the Provider Manual.

1.22 Provider agrees to participate and cooperate in Health Plan's quality improvement activities.

1.23 If Provider is specifically delegated by Health Plan, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Agreement. If Health Plan delegates quality improvement activities, the parties agree that the attachment or addendum will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of Health Plan and Provider; (ii) Health Plan's oversight, monitoring, and evaluation processes and Provider's agreement to such processes; (iii) Health Plan's reporting requirements and approval processes, including, Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) Health Plan's actions/remedies if Provider's obligations are not met.

1.24 Provider agrees to the revocation of delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or Health Plan determine that Provider has not performed satisfactorily.

1.25 To the extent that the Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use it as the Provider is able for the purpose of Member care coordination.

1.26 Health Plan will inform Provider of prospective requirements added by DHCS to Health Plan's contract with DHCS before the requirement becomes effective. Provider agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

1.27 Providers will submit to Health Plan complete, accurate, reasonable, and timely provider data needed by Health Plan in order for Health Plan to meet its provider data reporting requirements to DHCS.

1.28 Provider will submit to Health Plan complete, accurate, reasonable, and timely Encounter Data needed by Health Plan in order for Health Plan to meet its Encounter Data reporting requirements to DHCS. All Encounter Data shall be submitted to Health Plan no later than twelve (12) months from the date of service.

1.29 Provider will not balance bill a Medi-Cal Member.

1.30 Health Plan shall provide cultural competency, sensitivity, or diversity training to staff, Provider, and subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

1.31 Provider may utilize Health Plan's Provider Dispute Resolution Process by writing the Provider Dispute Resolution Department, P.O. Box 22722, Long Beach, CA 90801 or calling: (855) 322-4075. The Provider Dispute Resolution

Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code§ 809.1, et. seq. Please see the Provider Manual for current information regarding the dispute resolution process, including additional ways to submit disputes.

1.32 Provider will comply with language assistance standards and regulations developed by the DMHC pursuant to Health and Safety Code §1367.04.

1.33 Provider is entitled to all protections afforded them under the Health Care Providers' Bill of Rights as set forth in Health and Safety Code §1375.7.

1.34 Notwithstanding any other term of the Agreement, this Agreement and all information received in accordance with the contract between Health Plan and DHCS will be public record on file with DHCS, except as specially exempted by Law. DHCS ensures the confidentiality of infonnation and contractual provisions filed with DHCS to the extent the information and provisions are specially exempted by Law. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (Welfare and Institutions Code§ 14452(a))

1.35 Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (22 CCR§ 53251(c) and (e))

1.36 **Non-Discrimination Clause.**

a. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC§ 4212). Such notices shall state Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC§ 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment

Opportunity,' and as supplemented by regulation at 41 CFR § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders

f. In the event of Provider's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

1.37 Pursuant to Health and Safety Code Section 1261, if Provider is licensed pursuant to Health and Safety Code Section 1250, Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

1.38 Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the DHCS.

1.39 Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, California Code of Regulations, Division 1, Chapter 9, commencing with Section 37000. Provider shall document and appropriately follow up on blood lead screening test results.

Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

1.40 Provider shall provide Health Plan with the Disclosure Statement set forth in Title 22, California Code of Regulations Section 51000.35 prior to commencing services under this Agreement.

1.41 Provider will not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Agreement from a Medi-Cal Member or person acting on behalf of the Member. Collection of a claim may be made under those circumstances described in 22 CCR§§ 53220, 53222, and 53886.

1.42 Health Plan will not take punitive action against Provider if Provider requests an expedited resolution or supports a Member's appeal. Health Plan will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the Member need in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

1.43 If Provider is required to file monthly Financial Statements with DMHC to monitor Provider's financial viability, Provider shall file an exact copy of the monthly Financial Statements with DHCS. Provider shall submit monthly financial statements to the DHCS upon request, if deemed necessary, to monitor Provider's financial viability. Information submitted shall be based on current operations. Provider shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

1.44 Provider shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Provider as a result of services performed under this Agreement, except for

statistical information not identifying any such person. Provider shall not use such identifying information for any purpose other than carrying out the Provider's obligations under this Agreement. Provider shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person. Provider shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by Health Plan, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

1.45 Provider agrees that if any performance under this Agreement that includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a ("CLIA") and the regulations thereto.

ATTACHMENT D

Medicare-Medicaid Program

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

1.1 **Definitions.**

a. **First Tier, Downstream and Related Entity** ("FDR") means an individual or entity that enters into a written arrangement that is acceptable to CMS and California Department of Health Care Services ("DHCS") with Health Plan, to provide administrative or health care services to the Health Plan under Health Plan's contract with CMS and DHCS. For the avoidance of doubt, a Provider is considered an FDR.

1.2 **Operation of the MMP Product.** Any FDR performing any function on Health Plan's behalf related to the operation of the MMP Product will comply with 42 CFR §§ 422.504; 423.505; and 438.3(k).

1.3 **Right to Audit.** The United States Department of Health and Human Services ("HHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the FDR and HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

1.4 **Availability of Records.** FDR, as required by CMS and DHCS and other regulatory agencies, must make its records available to CMS and DHCS and its agents, designees, or any other authorized representatives of the State of California or the United States Government, or their designees, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours.

1.5 **Hold Harmless.** Members will not be held liable for payment of any fees that are the obligation of Health Plan.

1.6 **Accountability.** Any services or other activity performed by an FDR will be performed in accordance with the Health Plan's contractual obligations to CMS and DHCS; including the requirements at 42 CFR § 438.414 in relation to the grievance system.

1.7 **Termination for Cause.** If the Agreement is terminated for cause, Health Plan will provide a written statement to Provider of the reason or reasons for termination with cause.

1.8 **Claims Payment.**

a. Health Plan will pay Provider for Clean Claims for Covered Services that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement and such payments will be made no later than within ninety (90) days of the date of Health Plan's receipt of the Clean Claim.

b. Health Plan will not pay Provider for a provider preventable condition. As a condition of payment, Provider will comply with reporting requirements on provider preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by Health Plan or DHCS. Provider shall comply with such reporting requirements to the extent that Provider directly furnishes services.

1.9 **Compliance with Laws.** Provider will comply with all federal and State laws, regulations and CMS instructions, including, without limitation, federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 et. seq.), and the anti-kickback statute (Section 1128(B)(b) of the Social Security Act), and HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164.

1.10 **Exclusions.**

a. Providers must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified, or registered. Provider must have good standing in the Medicare and Medi-Cal programs and, as applicable, a valid NPI number. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot provide service under this Agreement.

b. Health Plan may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

1. Furnished by Provider during any period when any individual or entity is excluded from participation under title V, XVIII, XIX, or XX, pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, and regulations at 42 CFR Part 1001 et seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR §§ 101.1801 and 1001.1901.

11. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

111. Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

1v. Furnished by an individual or entity that is included on the preclusion list, as defined in 42 CFR § 422.222.

1.11 **Provider Participation.**

a. Provider shall work in collaboration with Health Plan to actively improve the quality of care provided to Members, consistent with the quality improvement strategic work plan and all other requirements of Health Plan's contract with CMS and DHCS.

b. Provider will comply with federal requirements for disclosure of ownership and control, business transitions, and information for persons convicted of crimes against federal health care programs, including Medicare, Medicaid, or CHIP and shall provide to Health Plan all state and federally required disclosures in accordance with 42 CFR § 455, 42 CFR § 1002.3, and as specified by DHCS and CMS.

c. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable Medi-Cal fee-for-service, the provider only serves Medi-Cal enrollees. Member will be offered appointments for Covered Services within the time period appropriate for their condition.

d. Provider will not hold any Member liable for: (i) the debts of Health Plan in the event of Health Plan's insolvency; (ii) Covered Services provided to Members in the event that Health Plan fails to receive payment from CMS or DHCS for such Covered Services; (iii) Covered Services provided to Members in the event that CMS, DHCS, or Health Plan fails to pay Provider; and (iii) payments in excess of the amount that would be owed by the Member if Health Plan had directly provided services.

e. Provider will be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, or other unique needs of any minority, including Member who are homeless, disabled (both congenital and acquired disabilities) and other special populations served. This includes have the capacity to communicate with members in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

f. Each physician providing Covered Services to Member must have a unique identifier in accordance with the system established under 42 USC§ 1320d-2(b).

1.12 **Incentive Plans.** Health Plan and FDR must comply with all applicable requirements governing physician incentive plans, including, but not limited to, such requirements appearing at 42 CFR Parts 417,422,434, 438.3(i), and 1003.

1.13 **Reporting.** FDR must provide the infonnation indicated below.

a. All information CMS and DHCS require under the MMP Product related to the performance of Health Plan's responsibilities, including non-medical information for the purposes of research and evaluation;

b. Any information CMS and DHCS require to comply with applicable Law and regulations; and

c. Any information CMS or DHCS require for external rapid cycle evaluation including, but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Member satisfaction, Member complaints and appeals, and enrollment/disenrollment rates.

1.14 **Delegation.**

a. If FDR is specifically delegated an activity by Health Plan, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Agreement.

b. Health Plan will remain fully responsible for functions delegated and for ensuring adherence to the contact between Health Plan and DHCS. Therefore, Health Plan will continually asses FDR's ability to perform delegated activities and Health Plan may impose correction action as necessary.

c. Health Plan may revoke delegated activities and reporting requirements or specify other remedies in instances where CMS, DHCS, or the Health Plan determine that such parties have not performed satisfactorily.

1.15 **Corrective Action.** Health Plan monitors Provider's performance under this Agreement on an ongoing basis and Health Plan may impose corrective action as necessary.

1.16 **Medical Providers.** If FDR is a medical provider, the following provisions will apply.

a. Health Plan will pay provider under the terms of this Agreement.

b. FDR agrees that services must be provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

c. FDR will abide by all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information.

d. FDR will ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

e. FDR must maintain Member records and information in an accurate and timely manner.

f. FDR must ensure timely access by Members to the records and information that pertains to them.

g. FDR must ensure Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members.

h. FDR must comply with the Federal Emergency Medical Treatment and Labor Act ("EMTALA") and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

1. Health Plan is prohibited from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such Provider has in good faith: (i) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms, or requirements of the Health Plan's health benefit plans as they relate to the needs of such Provider's patients; or (ii) communicated with one or more his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Health Plan for services provided to the patient.

J. Health Plan may not take punitive action against a Provider who requested an expedited resolution or supports a Member's appeal.

k. FDR, including, but not limited to, PCPs, may not close or otherwise limit its acceptance of Members as patients unless the same limitations apply to all commercially insured individuals.

l. Provider is not required to indemnify Health Plan for any expenses and liabilities, including without limitation, judgments, settlements, attorney's fees, court costs and any associated charges, incurred in connection with any claim or action brought against Health Plan based on Health Plan's management decisions, utilization review provisions or other policies, guidelines, or actions. For the avoidance of doubt, nothing in this section creates any conflict with the Section 5.1, Indemnification, in the Agreement.

m. FDR will assist Health Plan in the transfer of care in the event this Agreement terminates for any reason.

n. FDR will assist Health Plan in the transfer of care in the event of a sub-subcontract termination for any reason.

o. If this Agreement is amended or terminated, notice will be given to DHCS. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

p. Assignment of delegation of the Agreement will be void unless prior written approval is obtained from DHCS.

q. FDR will timely gather, preserve, and provide to DHCS, any record in the FDR's possession.

r. FDR will provide interpreter services for Members at all provider sites.

s. FDR has the right to submit grievances as set forth in Health Plan's Provider Manual.

t. FDR will participate and cooperate in Health Plan's QI Program.

u. If FDR is delegated QI activities, the agreement shall include provisions as specified by DHCS.

1.17 **Laboratory Providers.** If Provider has a laboratory testing site, Provider must have either a Clinical Laboratory Improvement Amendment ("CLIA") certificate or waiver of a certificate of registration along with a CLIA identification number.

1.18 **Federal Funds.** Provider acknowledges that payments Provider receives from Health Plan are, in whole or part, from federal funds. Therefore, Provider and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; and Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84.

ATTACHMENT E

Provider Identification Sheet

When Provider includes multiple entities that may bill Health Plan with different Tax Identification Numbers ("TIN"), Provider must supply each Legal Name and TIN. Each Legal Name and TIN must exactly match the corresponding tax fonn (i.e. W-9) that Provider supplies to Health Plan.

Legal Name - Matching the applicable tax form (i.e. W-9, Line 1)
Tax ID Number -As listed on corresponding tax form
NPI - That corresponds to the Tax ID Number
IRS 1099 Address - If different than Mailing Address

Legal Name - Matching the applicable tax form (i.e. W-9, Line 1)
Tax ID Number - As listed on corresponding tax form
NPI - That corresponds to the Tax ID Number
IRS 1099 Address - If different than Mailing Address

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Legal Name - Matching the applicable tax form (i.e. W-9, Line 1)
Tax ID Number -As listed on corresponding tax form
NPI - That corresponds to the Tax ID Number
IRS 1099 Address - If different than Mailing Address

Use of continuation pages is acceptable to collect additional information

ATTACHMENT F

MEDI-CAL / DUALS PROGRAM
PROVIDER STANDARD TERMS AND CONDITIONS

MEDI-CAL/ DUALS CALAIM ENHANCED CARE MANAGEMENT PROGRAM

Provider shall provide CALAIM Enhanced Care Management (ECM) Services to eligible Health Plan Beneficiaries identified for participation in the ECM benefit. In the event there is a conflict between the terms of this Attachment and other provisions in the Agreement, this Attachment will control for ECM Services. For purposes of this attachment, Provider will be referred to as a Enhanced Care Management Entity (ECM).

DEFINTIONS

1.1 Beneficiary means a person who is eligible to receive ECM Services.

1.2 **Enhanced Care Management Entity (ECM)** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs to high-cost and /or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. ECM is a Medi-Cal benefit.

1.3 **ECM Provider:** a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Pocus forECM.

1.4 Lead Care Manager: (ECM Lead Care Manager) a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Molina Healthcare, as described in the DHCS-Molina Healthcare ECM and Community Supports Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any In Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1.5 **Model of Care (MOC)** means the ECM and Community Supports Model of Care (MOC) is Molina Healthcare's framework for providing ECM and Community Supports, including it Policies and procedures for Partnering with ECM and Community Supports Provider.

I. MEMBER ASSIGNMENT TO AN ECM PROVIDER

1.1 Molina Healthcare shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten (10) business days after ECM authorization.

1.2 ECM Provider Shall immediately accept all Members assigned by Molina Healthcare for ECM, with the exception that ECM Provider shall be permitted to decline a Member assignment if ECM Provider Shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity

1. ECM Provider shall immediately alert Molina Healthcare if it does not have the capacity to accept a member assignment.

1.3 Upon initiation of ECM, ECM Provider shall ensure each Member assigned has a Lead Care Manger who interacts directly with the Member and/or their 2 family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any In Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

1.4 ECM Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested. ECM Provider shall notify Molina Healthcare if the Member wishes to change ECM Providers. Molina Healthcare must implement any requested ECM Provider change within thirty days.

II. ECM Provider Requirement

1.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;

1.2 ECM Provider shall have experience and expertise with the services it proposes to the provide;

1.3 ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS-Molina Healthcare ECM and Community Supports Contract and associated guidance;

1.4 ECM Provider shall have capable and engaged organizational leadership;

1.5 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;

1.6 ECM Provider shall have the capacity to communicate to Members in culturally and linguistically appropriate and accessible ways;

1.7 ECM Provider shall have agreements and processes in place to engage and cooperate with area hospitals, Primary Care Providers, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Members; and

1.8 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

1.9 ECM Provider Shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal Members enrolled in managed care. ECM Provider ensure the approach is person-centered, goal oriented, and culturally relevant.

1.10 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care.

1.11 Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.

1.12 Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

1.13 Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

1.14 Enhanced Coordination of Care, which shall include, but is not limited to:

a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;

b. Maintaining regular contact with all Providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;

e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
f. Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

1.15 Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

a. Working with Members to identify and build on successes and potential family and/or support networks;
b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of 6 supporting Members' ability to successfully monitor and manage their health; and
c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

1.16 Comprehensive Transitional Care, which shall include, but is not limited to:
a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
b. For Members who are experiencing, or who are likely to experience a care transition:
i. Developing and regularly updating a transition of care plan for the Member;
ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
iv. Coordinating medication review/reconciliation; and
v. Providing adherence support and referral to appropriate services.

CALAIM CONTRACT

ECM PROVIDER OUTREACH AND MEMBER ENGAGEMENT

1.1 ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with Molina Healthcare's Policies and Procedures.

1.2 ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need forECM.

1.3 ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.

1.4 ECM Provider shall use the following modalities, as appropriate, if in-person modalities are unsuccessful or to reflect a Member's stated contract preferences:

Mail
Email
Texts
Telephone calls
Other

1.5 ECM Provider shall comply with non-discrimination requirement set forth in State and Federal law.

DELIVERY OF (ECM) ENHANCED CARE MANAGEMENT

1.1 ECM Provider shall obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between Molina Healthcare and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

1.2 Member authorization for £CM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.

1.3 When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to the Molina Healthcare.

1.4 ECM Provider shall notify the Molina Healthcare to discontinue ECM under the following circumstances:

The Member has met their care plan goals for ECM;
The Member is ready to transition to a lower level of care;
The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
ECM Provider has not had any contact with the Member despite multiple attempts.

1.5 When ECM is discontinued, or will be discontinued for the Member, Molina Healthcare is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

ECM Requirements and Core Service Components of ECM

1.1 ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-Molina Healthcare ECM Community Supports Contract.

1.2 ECM Provider shall:

Ensure each Member receiving ECM has a Lead Care Manager;
Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
Alert Molina Healthcare to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and

Follow Molina Healthcare instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

1.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care.

1.4 ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with Molina Healthcare's Policies and Procedures, as follows:

Outreach and Engagement of Molina Members into ECM

Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:

Engaging with each Member authorized to receive ECM primarily through in-person contact;

Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.

Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and

Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight

1.5 Enhanced Coordination of Care, which shall include, but is not limited to:

Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;

Maintaining regular contact with all Providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;

Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;

Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;

Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and

Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

1.6 Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

Working with Members to identify and build on successes and potential family and/or support networks;

Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and

Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

1.7 Comprehensive Transitional Care, which shall include, but is not limited to:

Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;

For Members who are experiencing, or who are likely to experience a care transition:

Developing and regularly updating a transition of care plan for the Member;

Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

Coordinating medication review/reconciliation; and

Providing adherence support and referral to appropriate services.

1.8 Member and Family Supports, which shall include, but are not limited to:

Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and Molina Healthcare, as applicable;

Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;

Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;

Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and

Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

1.9 Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:

Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by Molina Healthcare as Community Supports; and

Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

Data Sharing to Support ECM

a. Molina Healthcare will provide to ECM Provider the following data at the time of assignment and periodically thereafter:

i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

ii. Encounter and/or claims data; iii. Physical, behavioral, administrative and SDOH data (e.g., HMIS data) for all assigned Members; and

iv. Reports of performance on quality measures and/or metrics, as requested.

Claims Submission and Reporting

a. ECM Provider shall submit claims for the provision of ECM-related services to Molina Healthcare using the national standard specifications and code sets to be defined by DHCS.

b. In the event ECM Provider is unable to submit claims to Molina Healthcare for ECM-related services using the national standard specifications and code sets, ECM Provider shall submit to Molina Healthcare the minimum data elements identified by the Molina Healthcare that allow Molina Healthcare to convert ECM Provider's data into the national standard specifications and code sets for submission to DHCS.

Quality and Oversight

a. ECM Provider acknowledges Molina Healthcare will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions.

b. ECM Provider shall respond to all Molina Healthcare requests for information and documentation to permit ongoing monitoring of ECM.

Payment

a. Molina Healthcare shall pay contracted ECM Providers for the provision of ECM.

b. Molina Healthcare payment to ECM Providers shall meet the following requirements:

i. ECM Provider is paid when ECM is initiated for any given Member;

ii. Payment to ECM Provider, made when ECM is initiated, includes compensation for outreach efforts that occurred prior to the initiation of services; and

iii. ECM Provider has financial incentives to engage hard-to-reach populations.

c. Molina Healthcare is encouraged to tie ECM Provider payments to achieving outcomes related to high-quality care and improved health status.

d. Molina Healthcare shall pay 90% of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Molina Healthcare receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment

ATTACHMENT G

MEDI-CAL / DUALS PROGRAM

PROVIDER STANDARD TERMS AND CONDITIONS

MEDI-CAL/ DUALS CALAIM COMMUNITY SUPPORTS PROGRAM

In Community Supports are medical appropriated and cost-effective alternatives to services covered under the State Plan. The Community Supports option within CAlAIM builds upon work done in WPC Pilots to address social needs, with Community Supports to be provided as a substitute for, or to avoid, higher-cost covered services such as hospital or nursing facility admissions, discharge delays, and emergency department (ED) use as determined appropriate for the member's needs.

DEFINTIONS:

1.1 **Beneficiary** means a person who is eligible to receive Community Supports Services.

1.2 **Community Supports:** Pursuant to 42 CPR 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost effective alternatives to services or settings under the State Plan. Community Supports are optional for both the Molina Healthcare and the Member and must be approved by DHCS. DHCS already has pre-approved the list of Community Supports included in Section 2: DHCS-Approved Community Supports. services [See Community Supports Section 2: DHCS Pre-Approved Community Supports].

1.3 **Community Supports Provider:** a contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and/or training providing one or more of the Community Supports approved by DHCS.

I. **Overview:**

1.1 The Community Supports Provider may elect to offer the following DHCS-authorized Community Supports to Members (check as applicable):

Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Short-term Post-Hospitalization Housing
Recuperative Care (Medical Respite)
Respite Services
Day Habilitation Programs
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
Community Transition Services/Nursing Facility Transition to a Home
Personal Care and Homemaker Services
Environmental Accessibility Adaptations (Home Modifications)
Meals/Medically Tailored Meals
Sobering Center
Asthma Remediation

CALAIM CONTRACT

II. Community Supports Provider Requirements

1.1 Community Supports Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004

a) If APL 19-004 does not apply to an Community Supports Provider, the Community Supports S Provider will comply with the Molina Healthcare's process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be an Community Supports Provider.

b) Experience and training in the elected Community Supports. The Community Supports Provider shall have experience and/or training in the provision of the Community Supports being offered. The Community Supports Provider shall have the capacity to provide the Community Supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by the Molina Healthcare.

1.2 If the Community Supports Provider subcontracts with other entities to administer its functions of Community Supports, the Community Supports Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.

III. Delivery of Community Supports

1.1 Community Supports Provider shall deliver contracted Community Supports services in accordance with DHCS service definitions and requirements

1.2 Community Supports Provider shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is contracted to provide.

1.3 Accept and act upon Member referrals from Molina Healthcare for authorized Community Supports, unless the Community Supports Provider is at pre-determined capacity;

1.4 Conduct outreach to the referred Member for authorized Community Supports as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;

1.5 Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;

1.6 Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and the Molina Healthcare;

1.7 Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in contract(s) with the Molina Healthcare; and

1.8 Comply with non-discrimination requirements set forth in State and Federal law and the Contract with Molina Healthcare.

1.9 When federal law requires authorization for data sharing, Community Supports Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to the Molina Healthcare. Member authorization for Community Supports-related data sharing is not required for the Community Supports Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Community Supports Provider will be reimbursed only for services that are authorized by Molina Healthcare. In the event of a Member requesting services not yet authorized by Molina Healthcare, Community Supports Provider shall send prior authorization request(s) to Molina Healthcare, unless a different agreement is in place (e.g., if the Molina Healthcare has given the Community Supports Provider authority to authorize Community Supports directly). If an Community Supports is discontinued for any reason, Community Supports Provider shall support transition planning for the Member into other programs or services that meet their needs.

1.10 Community Supports Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to Molina Healthcare for authorization.

Payment for Community Supports

a. Community Supports Provider shall record, generate, and send a claim or invoice to Molina Healthcare for Community Supports rendered.

i. If Community Supports Provider submits claims, Community Supports Provider shall submit claims to Molina Healthcare using specifications based on national standards and code sets to be defined by DHCS.

ii. In the event Community Supports Provider is unable to submit claims to Molina Healthcare for Community Supports related services using DHCS-defined standard specifications and code sets, Community Supports Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports services rendered, and Community Supports Providers' information to support appropriate payment by Molina Healthcare, that will allow Molina Healthcare to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

b. Community Supports Provider shall not receive payment from Molina Healthcare for the provision of any Community Supports services not authorized by Molina Healthcare.

c. Community Supports Provider shall be able to accept payment from Molina Healthcare for Community Supports rendered.

i. Molina Healthcare shall pay 90% of all clean claims and invoices within 30 days of receipt and 99% of clean claims and invoices within 90 days of receipt.

ii. Molina Healthcare will provide expedited payments for urgent Community Supports (e.g., recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance

Data Sharing to Support Community Supports

a. As part of the referral process, Molina Healthcare will ensure Community Supports Provider has access to:

i. Demographic and administrative information confirming the referred Member's eligibility for the requested service; ii. Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and iii. Billing information necessary to support the Community Supports Provider's ability to submit invoices to Molina Healthcare

Quality and Oversight

a. Community Supports Provider acknowledges Molina Healthcare will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both the Molina Healthcare and the Community Supports Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities

AMENDMENT TO MOLINA HEALTHCARE OF CALIFORNIA
PROVIDER SERVICES AGREEMENT

Molina Healthcare of California ("Health Plan") and **The Illumination Foundatoin** ("Provider") enter into this Amendment as of the Effective Date set forth in this Amendment.

A. Whereas, Health Plan and Provider entered into a Provider Services Agreement, commensurate with this Agreement as amended from time to time ("Agreement"); and

B. Whereas, Provider agrees to amend their Attachment B, Community Supports; Now therefore, in consideration of the rights and obligations contained herein, Health Plan and Provider agree to admend the Agreement as follows:

1. **Attachment B, Community Supports** "Compensation Schedule", Community Supports Compensation Schedule is hereby deleted in it's entirety and replaced with a new Attachment B, Community Supports as attached and incorporated herein.
2. **Effective Date.** This Amendment shall become effective **July 1, 2022**
3. **Use of Defined Terms.** Capitalized terms utilized in this Amendment shall have the same meanings ascribed to such terms in the Agreement unless otherwise set forth in this Amendment.
4. **Full Force and Effect.** Except as set forth in this Amendment, the Agreement is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Agreement or an earlier Amendment, the terms of this Amendment will prevail.
5. **Counterparts.** This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

Attachment B, Community Supports Compensation Schedule, is deleted and replaced with the following:

I. Community Supports Rates

MCP agrees to reimburse Community Supports Providers for services at the rates outlined below. Payment for Covered Services. Covered Services shall be paid under the State of California Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

2.1 **Rates:**

Housing Transition Navigation Services:

H0043	Supported Housing	$ 350.00 Monthly Case Rate Per Member

Housing Deposits:

H0044	Supported Housing,	Cost not to exceed member lifetime $5,000.00

Housing Tenancy and Sustaining Services:

T2041	Financal management, self directed	$430.00 Monthly Case Rate Per Member

Recuperative Care:

T2033	Residential Care	$220.00 Per Diem

Day Rehabilitation:

H2014	$20.00 Per Hour

Short-Term Post-Hospitalization Housing:

H0044	$130.00 Per Diem

2.2 **Codes: HCPCS and Modifiers** Community Support Provider must submit the correct HCPCS codes and modifier combined as defined by DHCS. All telehealth services must be provided in accordance with DHCS policy.

MEDI-CAL/ DUALS PROGRAM

PROVIDER STANDARD TERMS AND CONDITIONS

MEDI-CAL/ DUALS CALAIM IN LIEU OF SERVICES PROGRAM

In Community Supports are medical appropriated and cost-effective alternatives to services covered under the State Plan. The Community Supports option within CAlAIM builds upon work done in WPC Pilots to address social needs, with Community Supports to be provided as a substitute for, or to avoid, higher-cost covered services such as hospital or nursing facility admissions, discharge delays, and emergency department (ED) use as determined appropriate for the member's needs.

DEFINTIONS:

1.1 **Beneficiary** means a person who is eligible to receive Community Supports Services.

1.2 **Community Supports:** Pursuant to 42 CFR 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost effective alternatives to services or settings under the State Plan. Community Supports are optional for both the Molina Healthcare and the Member and must be approved by DHCS. DHCS already has pre-approved the list of Community Supports included in Section 2: DHCS-Approved Community Supports. services [See Community Supports Section 2: DHCS Pre-Approved Community Supports].

1.3 **Community Supports Provider:** a contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and/or training providing one or more of the Community Supports approved by DHCS.

I. Overview:

1.1 The Community Supports Provider may elect to offer the following DHCS-authorized Community Supports to Members (check as applicable):

IZIHousing Transition Navigation Services

IZIHousing Deposits

IZIHousing Tenancy and Sustaining Services

IZl Short-term Post-Hospitalization Housing

IZl Recuperative Care (Medical Respite)

IZl Day Habilitation Programs

II. Community Supports Provider Requirements

1.1 Community Supports Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004

a) If APL 19-004 does not apply to an Community Supports Provider, the Community Supports S Provider will comply with the Molina Healthcare's process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be an Community Supports Provider.

b) Experience and training in the elected Community Supports. The Community Supports Provider shall have experience and/or training in the provision of the Community Supports being offered. The Community Supports Provider shall have the capacity to provide the Community Supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by the Molina Healthcare.

1.2 If the Community Supports Provider subcontracts with other entities to administer its functions of Community Supports, the Community Supports Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.

III. **Delivery of** Community Supports

1.1 Community Supports Provider shall deliver contracted Community Supports services in accordance with DHCS service definitions and requirements

1.2 Community Supports Provider shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is contracted to provide.

1.3 Accept and act upon Member referrals from Molina Healthcare for authorized Community Supports, unless the Community Supports Provider is at pre-determined capacity;

1.4 Conduct outreach to the referred Member for authorized Community Supports as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;

1.5 Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;

1.6 Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and the Molina Healthcare;

1.7 Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in contract(s) with the Molina Healthcare; and

1.8 Comply with non-discrimination requirements set forth in State and Federal law and the Contract with Molina Healthcare.

1.9 When federal law requires authorization for data sharing, Community Supports Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to the Molina Healthcare. Member authorization for Community Supports-related data sharing is not required for the Community Supports Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Community Supports Provider will be

reimbursed only for services that are authorized by Molina Healthcare. In the event of a Member requesting services not yet authorized by Molina Healthcare, Community Supports Provider shall send prior authorization request(s) to Molina Healthcare, unless a different agreement is in place (e.g., if the Molina Healthcare has given the Community Supports Provider authority to authorize Community Supports directly). If an Community Supports is discontinued for any reason, Community Supports Provider shall support transition planning for the Member into other programs or services that meet their needs.

1.10 Community Supports Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to Molina Healthcare for authorization.

Payment for Community Supports

a. Community Supports Provider shall record, generate, and send a claim or invoice to Molina Healthcare for Community Supports rendered.

i. If Community Supports Provider submits claims, Community Supports Provider shall submit claims to Molina Healthcare using specifications based on national standards and code sets to be defined by DHCS.

ii. In the event Community Supports Provider is unable to submit claims to Molina Healthcare for Community Supports related services using DHCS-defined standard specifications and code sets, Community Supports Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports services rendered, and Community Supports Providers' information to support appropriate payment by Molina Healthcare, that will allow Molina Healthcare to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

b. Community Supports Provider shall not receive payment from Molina Healthcare for the provision of any Community Supports services not authorized by Molina Healthcare.

c. Community Supports Provider shall be able to accept payment from Molina Healthcare for Community Supports rendered.

i. Molina Healthcare shall pay 90% of all clean claims and invoices within 30 days of receipt and 99% of clean claims and invoices within 90 days of receipt.

ii. Molina Healthcare will provide expedited payments for urgent Community Supports (e.g., recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance

Data Sharing to Support Community Supports

a. As part of the referral process, Molina Healthcare will ensure Community Supports Provider has access to:

i. Demographic and administrative information confirming the referred Member's eligibility for the requested service; ii. Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and **iii.** Billing information necessary to support the Community Supports Provider's ability to submit invoices to Molina Healthcare

Quality and Oversight

a. Community Supports Provider acknowledges Molina Healthcare will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both the Molina Healthcare and the Community Supports Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities

IN WITNESS WHEREOF, the Parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth in the Agreement. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider, and does so freely with the intent to fully bind Provider, to the provisions of this Agreement. This Agreement is being executed in accordance with all applicable federal and state statutes, regulations, policies, procedures and rules.

Provider: The Illumination Foundation **TAX ID: 71-1047686** **BILLING NPI : 1073863056**		**Molina Healthcare of California**	
Provider Signature:	Pooja Bhalla	Molina Signature:	
Signatory Name (Printed):	Pooja Bhalla	Signatory Name (Printed):	**Jennifer Elsberg**
Signatory Title (Printed):	Executive Director Healthcare Services	Signatory Title (Printed):	**VP Network Management & Ops**
Date:	6-14-22	Date:	**06/14/2022**