CONTRACT BETWEEN THE

ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

AND

COLUMBUS PUBLIC HEALTH

CONTRACT YEAR 2026

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Article 1. Preliminary Recitals

1.1. Parties In accordance with O.R.C. §340.036, this agreement ("Contract") is by and between the Alcohol, Drug and Mental Health Board of Franklin County, 447 East Broad Street, Columbus, Ohio 43215–3822, (hereinafter "ADAMH Board") and Columbus Public Health, 240 Parsons Ave., Columbus, Ohi0 43215-5331 (hereinafter "Provider").

1.2. Term Except for termination pursuant to Article 14 below, this Contract shall be effective on the first day of January, 2026 and shall terminate on the 31st day of December 2026.

1.3. Conditions Precedent Approval by the governing boards of the parties are independent conditions precedent to the formation, validity and enforceability of this Contract.

Article 2. Definitions

2.1. ACCO means the Agency Chief Clinical Officer.

2.2. ADAMH Services means client services funded in whole or in part by the ADAMH Board.

2.3. Adjudicated Claim means a bill for mental health and/or alcohol and other addiction services that has been processed using the pricing and benefits plan rules in the board's claims and enrollments system.

2.4. Adult Serving Crisis means the coordinated, integrated system in Franklin County for crisis, assessment, stabilization, and referral services.

2.5. Agency Services Plan means a plan as defined in O.A.C. §5122–26–09. Plans shall include a description of the services provided, the target population to be served, hours of operation, the scope of services, and the responsibilities when services are offered through referral or affiliation with another organization.

2.6. All–Hazards Coordinator means the person designated by the provider to be available for contact 24/7 in the event of a community disaster or agency–specific emergency.

2.7. Applicable Law means those federal, state and local laws and regulations which govern the conduct of the parties to this Contract.

2.8. Applicable Requirements include all of the following to the extent that any of these requirements govern the conduct of the parties to this Contract:

2.8.1. Applicable law.
2.8.2. Protocols and guidelines from Ohio Department of Behavioral Health which require compliance by the Board and providers.
2.8.3. Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services ADAMH Board policies, procedures, and guidelines referenced in Section 3.4
2.8.4. The requirements of this Contract
2.8.5. ADAMH Policies referenced in Section 3.3

2.9. Assessment (or Diagnostic/Assessment) means the Provider's encounter with a client for the purpose of determining the nature of the issue(s) to be addressed via clinical services.

2.10. Benefits Plan is an agreement between provider, client, and payer that defines the services reimbursable per this contract. A client may be enrolled in one of two benefits plans, Standard or Crisis, as detailed under Section 4.5 of this Contract.

2.11. Calendar Year (CY) means the period January 1 through December 31. May also be referred to as Contract Year (KY).

2.12. **Capacity** means the total active case load potentially available based on staffing, frequency and intensity of services, and other pertinent clinical issues. Where budget capacity equals Direct service FTEs times Case Load per FTE, include open positions as an FTE.

2.13. **CCO** means a chief clinical officer who meets the requirements of O.R.C. §5122.01(K).

2.14. **Claims and Enrollments System** refers to the Board's current health care information system supporting client enrollment, benefits plan management, provider contracting, and claims processing.

2.15. **Client** means a person required to be served under this Contract and who may be eligible for services reimbursed in whole or in part by public funds. Clients may be assigned a unique identifying number in the Board's current claims and enrollments system for eligibility purposes. The use of the term "client" shall not be interpreted in a manner which will deny any person services if such person is entitled to services under Applicable Requirements.

2.16. **Community Disaster** means a natural, technological, or human–caused hazard that overwhelms local resources which results in the need to implement the Franklin County Emergency Operations Plan. The most likely hazards are pandemics, flooding, tornadoes, hazardous material spills and terrorism.

2.17. **Continuity of Operations Plan** means an agency's written plan describing contingencies for fiscal stability and service provision in the event of a catastrophic occurrence to the agency that may threaten the ability to conduct business (e.g., building fire, epidemic affecting many staff members).

2.18. **Contract** shall mean this agreement and any and all attachments hereto which are incorporated herein as if fully rewritten.

2.19. **CPST Rule** means the Community Psychiatric Support Treatment service rule set forth in O.A.C. §5122–29–17 as amended.

2.20. **Cultural Competency** the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.

2.21. **Encounter Claims** means service activity submitted to ADAMH that represents the value of the services provided (fee-for-service equivalency). Providers are not reimbursed based on the value of encounter claims, but select allocations are required to meet a defined percent threshold by year-end in order to substantiate expenses in the annual contract reconciliation.

2.22. **HIPAA** means the Health Insurance Portability and Accountability Act of 1996.

2.23. **Household Income** is the total gross income earned by all individuals who are counted for the purposes of Household Size, as defined in Section 2.24. This includes all types of income, including, without limitation, wages, tips, bonuses, retirement income, welfare payments, and social security benefits.

2.24. **Household Size** means the total number of individuals in a household who are dependent on the Household Income, as defined in Section 2.23. The number generally includes the client, their dependents, and other household family members who share expenses.

2.25. **Interim Services** means activities which facilitate health promotion, reduction of adverse effects of substance abuse, and reduction of the risk of transmitting disease. Interim services may include but are not limited to: education and counseling regarding HIV, tuberculosis, needle sharing and transmission of disease. For pregnant women, interim services may also include prenatal care referral and counseling regarding the effects of alcohol and drug use on the fetus.

2.26. **Lead Provider** means a Mental Health provider who desires and agrees to contract with the ADAMH Board of Franklin County to assure the continuity of care for mental health or alcohol or other drug services for the severely mentally disabled residents of Franklin County. Each lead provider signs the Continuity of Care Agreement with ADAMH and the Central Ohio Behavioral Healthcare Hospital. Lead providers include Central Ohio Behavioral

Healthcare–CSN, Community for New Direction, Concord Counseling Services, Maryhaven, North Central Mental Health Services, North Community Counseling Centers Inc., and Southeast Inc.

2.27. Level of Care means the intensity of treatment or other care for an individual based on needs identified in assessments, diagnostic evaluations, professional judgment, etc.

2.28. Linguistic Competence refers to compliance with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards).

2.29. Material means a substantial change in any of the following:

2.29.1. *Services Defined in the Provider's Agency Services Plan:* Any change in the amount, scope or duration of services for clients or any change in the ability of priority populations to access services. The characteristics of service are defined in the Board's procedure code taxonomy and described in the Provider's Agency Services Plan and the change is measured by a 10% or greater impact in amount, scope, duration, and/or access.

2.29.2. *Funding* Any changes in funding that constitute 10% or greater of the Provider's total funding.

2.29.3. *Business Structure/Administration* Any change in the corporate business structure or administration which significantly affects the Provider's ability to carry out its duties under this Contract or applicable requirements.

2.30. Medically Necessary Services means those services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

2.31. Minimum Necessary means the minimum amount of Protected Health Information (PHI) necessary to achieve the purpose of the use or disclosure.

2.32. National Provider Identification Number means the 10-digit unique identification number issued to Provider by the U.S. Centers for Medicare and Medicaid Services.

2.33. Nepotism means favoritism or tolerance shown by those in positions of control to relatives, significant others or friends that could lead to conflicts of interest and/or the appearance of impropriety.

2.34. O.A.C. refers to the Ohio Administrative Code and any amendment made effective during the term of this Contract.

2.35. O.R.C. refers to the Ohio Revised Code and any amendment effective during the term of this Contract.

2.36. ODJFS refers to the Ohio Department of Job and Family Services.

2.37. ODBH refers to the Ohio Department of Behavioral Health(formerly the Ohio Department of Mental Health and Addiction Services, or OMHAS).

2.38. Organizational Client means a unique identifier used to collect service activity and demographic data for individuals not enrolled in the Board's claims and enrollments system. The identifier is used to submit claims for services for which the Board has determined enrolling individual clients is not required.

2.39. Proprietary Information shall be defined in accordance with applicable law, except that the designation of information as "proprietary" shall not alter any requirement in this Contract for disclosure of such information.

2.40. Protected Health Information (PHI) means individually–identifiable health information transmitted by electronic media; maintained in any electronic media such as magnetic tape, disk, optical file; or transmitted or maintained in any other form or medium, i.e., paper, voice, fax, Internet, etc. PHI generally includes such individually identifiable health information as name, address, phone number, fax number, date of birth, social security number, or other unique identifying number(s), and other information as specified in 45 CFR 164.514(b)(2)(i)A–R.

2.41. Provider Performance Monitoring is an interdisciplinary performance management and quality improvement process focused on key provider indicators.

2.42. Providers are any entity certified to provide behavioral healthcare treatment, support or prevention services by the State of Ohio and have an executed contract with the ADAMH Board of Franklin County.

2.43. Public Subsidy means a person's eligibility to have a portion or all of their care funded with ADAMH resources. Eligibility is determined by a person's financial income and household size in accordance with applicable ADAMH policies.

2.44. Publicly–Funded means funded in whole or in part by any funds administered by the ADAMH Board from Federal, State or local governmental sources or from local levy or match reimbursed to ADAMH by another public entity.

2.45. Recovery means a personal process of overcoming the negative impact of a behavioral health care related illness despite its continued presence.

2.46. Recovery–Oriented Care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's recovery.

2.47. Resident of Franklin County means a person who is physically present in Franklin County at the point in time that a determination of eligibility for services is requested, as verified by acceptable documentation accepted by the Board, except that:

2.47.1. If a person is a client of and/or receiving mental health, alcohol, and other drug addiction treatment, supervision, support or other assistance in a specialized residential facility, program or service that includes nighttime sleeping accommodations, then the person is a resident of that county in which the person maintained their primary place of residence at the time the person entered the facility;

2.47.2. If a person is committed pursuant to O.R.C. §2945.38, 2945.39, 2945.40, 2945.401, or 2945.402, the person is a county resident where the criminal charges were filed.

2.48. SCCO means the System Chief Clinical Officer appointed by the ADAMH CEO.

2.49. State Fiscal Year (SFY) means the period of July 1 of one year through June 30 of the following year.

2.50. Subcontract shall mean any agreement, other than an employment agreement, between the Provider and any other person, corporation, or other entity under which such person, corporation or other entity is obligated to perform client services which are required to be performed by the Provider under this Contract.

2.51. SUD means substance use disorder.

2.52. SUD MAT means substance use disorder medication assisted treatment.

Any capitalized terms used and not defined herein shall have the meanings given to them in the Attachments hereto.

Article 3. Requirements Applicable to the Parties

3.1. General Requirements The Parties shall perform their respective duties under this Contract in accordance with applicable requirements. The Provider shall also comply with its Articles of Incorporation, Code of Regulation and/or By–Laws.

3.2. Applicability The requirements of this Contract shall apply only to programs and services funded or administered wholly or in part by the ADAMH Board as approved in the Provider's Agency Service Plan and Budget.

3.3. Policies of the ADAMH Board The policies of the ADAMH Board, which are applicable to the services that the Provider renders under this Contract, are available on the ADAMH website's provider portal. In the event

there is a conflict between any policy of the ADAMH Board and the terms of this Contract, then the terms of this Contract shall govern. The ADAMH Board shall make all policies available at the time of signing the Contract.

3.4. Community Planning The ADAMH Board shall use best efforts to include Providers in a collaborative and transparent process for community planning. Providers shall provide timely information requested by the ADAMH Board which is necessary for community planning and to qualify for federal, state and local funding.

3.5. Alternative Funding Sources The Provider shall make reasonable efforts to diversify its funding base. The ADAMH Board shall provide reasonably necessary technical assistance at the request of the Provider.

3.6. Medicaid, Medicare and Other Third-Party Coverage The ADAMH Board shall not provide payment for Medicaid, Medicare or other third-party-reimbursable services rendered by Provider to persons with Medicaid, Medicare, or other third-party coverage. Provider shall refer persons with Medicaid, Medicare, or other third-party coverage to the person's managed care organization (if applicable) for assistance in obtaining Medicaid, Medicare, or other third-party-reimbursable services.

3.7. System Information The ADAMH Board shall respond to reasonable requests for information within a reasonable time period upon request of the Provider, which are required for the Provider to carry out its duties under this Contract. In making requests for information under this section, the Provider shall specify the information being requested with reasonable particularity (i.e., source and types of information and the level of aggregation desired) and the reasons for the request. ADAMH may deny requests for information that it deems unreasonable or overly burdensome. Information exchanged between the Board and Providers shall adhere to federal HIPAA regulations, including 45 CFR Part 164 for HIPAA security and privacy.

3.8. HIPAA and Code of Federal Regulations Privacy Compliance The parties will be compliant with federal HIPAA Privacy Rule, which is located at 45 CFR Part 160 (General Administrative Requirements) and Subparts A and E of Part 164 (Security and Privacy).

3.8.1. Providers receiving this contract are considered by ADAMH to be "covered entities" under HIPAA regulations. Providers who are not covered entities under HIPAA provisions may be subject to entering into a Business Associate Agreement (BAA) with ADAMH as a requirement of fulfilling this contract.

3.8.2. Providers will post the ADAMH Notice of Privacy Practices in a visible location at all sites at which ADAMH funded services are delivered.

3.8.3. Providers will ensure each client enrolled in Board's claims and enrollments system during the contract period will receive the ADAMH Notice of Privacy Practices.

a. Promptly upon execution of this Contract, ADAMH will email a pdf file of its Notice of Privacy Practices to the Providers for distribution. Versions are available in English, Spanish, and Somali languages on the provider portal. Requests for additional translations can be sent to the ADAMH Privacy Officer at records@adamhfranklin.org.

b. The Provider may direct any client questions, concerns, or requests to exercise their rights to the ADAMH Privacy Officer at 614–224–1075, as noted in the Notice of Privacy Practices.

3.8.4. Providers will ensure any user account for the claims and enrollments system provided by the ADAMH Board adheres to the technical safeguards defined in 45 CFR, Part 164, including §164.312 a(2)(i) Unique user identification (Required).

a. ADAMH will assign a unique name and/or number for identifying and tracking individual user identity in accordance with the process detailed in the applicable claims and enrollments system user guides and manuals available and accessible by Providers at the location identified by the Board.

b. The account user agrees that they will not permit any other person to access an ADAMH system through the account user's account. The account user must keep their access credentials

confidential and not disclose the credentials to any other person. Failure to comply with the confidentiality and non-disclosure requirements may result in suspension or termination of the user account.

Article 4. General Service Requirements

4.1. Services and Staff

4.1.1. The Provider shall provide the services for populations identified in the Provider's ASP in accordance with applicable requirements.

4.2. General Assurances of the Provider Required by ADAMH

4.2.1. The Provider shall maintain compliance with applicable certifications and licensure standards, including Ohio Department of Behavioral Health (ODBH) certification for each funded system of care (SOC), if ODBH certification is available for the service.

4.2.2. The Provider shall develop and implement reasonable policies in accordance with current ADAMH Board policies which require that services are not denied to a client solely because of behavior that is symptomatic of the illness or condition causing the client to need services under this Contract.

4.2.3. No client shall be denied ODBH–certified services solely because of refusal to accept other ODBH–certified services offered by the Provider.

4.2.4. Services shall be provided in the least restrictive, most natural setting that is available and appropriate to the client's needs.

4.2.5. Providers shall deliver recovery/resiliency–oriented services and supports that are identified by clients and their families as effective in managing their behavioral health care disorder(s) and fulfilling valued roles in the community. Such services and supports shall address components including but not limited to clinical care, family support, peer support and relationships, work and other meaningful activity, community involvement, education and learning, access to resources, overcoming the effects of stigma and increasing personal responsibility and decision making.

4.2.6. Providers shall deliver culturally and linguistically appropriate services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs of people from diverse populations, including people of all ages, races, ethnicities, gender identities, sexual orientation and people with disabilities.

4.2.7. The Provider shall work with the ADAMH Board to identify and eliminate disparities in access to and quality of care, including but not limited to implementing guidelines for providing culturally and linguistically competent services.

4.2.8. Services provided under this Contract shall be coordinated with the provision of other services and systems appropriate to the needs of the client and family being served, including but not limited to child and adult protective services, justice systems, vocational rehabilitation, homeless shelters, developmental disabilities and schools.

4.2.9. The Provider shall respond to the client's physical health care needs and coordinate care with primary health care provider(s). The Provider shall also coordinate with health care payors, including but not limited to Medicaid and Medicare managed care entities.

4.2.10. The Provider shall operate facilities, programs and services in accordance with applicable requirements relating to client safety.

4.2.11. The Provider shall provide services in a manner that minimizes barriers to access and care in accordance with applicable requirements.

4.2.12. The Provider shall provide such other assurances as may be required by ADAMH, ODBH or other funding source.

4.3. Assurances for ODBH The Provider shall conform to the assurances set forth in Attachment F, regardless of the source of funding constituting Provider Allocations. ADAMH reserves the right to modify the mix of funds (local, state, federal) that support programs and services to maintain effective resource management.

4.4. Continuation of Services and Reimbursement Services and reimbursement shall be provided without interruption until modification or termination of the Contract except as provided in this Contract.

4.5. General Eligibility for Services

4.5.1. Eligibility for Emergency/Crisis Intervention services

a. If the Provider is certified to provide emergency/crisis intervention services, such services shall be provided based on need without regard to the county of residence of the individual presenting in crisis. If the Provider is not so authorized, a suitable referral must be provided to the individual.

b. Any individual presenting in crisis may be enrolled in the Board's claims and enrollments system as a client by a certified provider for the provision of emergency/crisis intervention services by the provider.

4.5.2. Resident of Franklin County

a. Any resident of Franklin County as defined in Section 2.45 of this Contract may be eligible for services of the Provider.

b. The Provider shall review and maintain a record of documentation verifying that a person seeking and/or being referred for ADAMH Services is a resident of Franklin County prior to enrolling the individual as a client in the Board's claims and enrollments system. The Provider shall submit documentation of residency during enrollment to establish eligibility for the Public Subsidy for ADAMH Services, and any subsequent changes regarding the client's residency status shall be submitted by the Provider in the Board's claims and enrollments system.

4.5.3. Financial Eligibility and Financial Responsibility

a. The Provider shall review and maintain a record of documentation verifying if the person seeking and/or being referred for ADAMH Services is eligible for Medicaid, Medicare, and other third-party payors, prior to enrolling the individual with the ADAMH Board. The ADAMH Board may request documentation of Medicaid, Medicare, and other third-party payor eligibility at the time of enrollment and/or perform periodic record reviews at the Provider's location or via electronic request by the ADAMH Board.

b. The Provider shall ensure clients potentially eligible for Medicaid, Medicare, and other insurance receive reasonable assistance in applying for, securing, and maintaining coverage.

c. The Provider shall submit into the Board's claims and enrollments system the number of individuals within the client's household (household size) and proof of a client's household income to establish the client's financial eligibility for the Public Subsidy and responsibility for cost sharing and to enroll the individual with the ADAMH Board. Household size and household income refer to the information pertaining to the client at the time of enrollment. If updates to this information are warranted, enrollment updates may be submitted for redetermination of financial eligibility. Provider shall reserve enrollment of clients to individuals who meet the financial eligibility requirements of this contract and for whom claims for services rendered are planned to be billed to ADAMH.

4.5.4. Clients who qualify for ADAMH Services in accordance with Article 4.5 shall be enrolled in coverage for services by the Board as follows:

a. Clients who qualify for ADAMH Services in accordance with Article 4.5.1 are eligible for enrollment in the crisis benefits plan. Eligibility span for the crisis benefits plan shall be 30 days from the effective date of enrollment and can be renewed. For an individual who is a resident of another county in which the Provider has a contract with the county's ADAMH/MHRS board, Provider shall attempt to first bill that county's board for services rendered prior to billing the ADAMH Board of Franklin County.

b. Clients who qualify for ADAMH Services in accordance with Article 4.5.2 and Article 4.5.3 shall be enrolled in the standard benefits plan. The standard benefits plan shall expire after twelve months following the effective date of enrollment; a new enrollment request shall be necessary to extend or reestablish enrollment on the standard benefits plan.

c. If the individual does not qualify for services in accordance with Article 4.5, the individual will not be enrolled in an eligibility plan in the Board's claims and enrollments system until such time as qualification is made under Article 4.5.1 or Article 4.5.2. A new or updated enrollment request for the individual may be submitted at any time by the provider in accordance with the process detailed in available user guides and manuals.

d. Providers shall notify ADAMH of changes to a client's home address, residency status, and information related to financial eligibility by completing an updated enrollment in the Board's claims and enrollments system.

4.5.5. Establishing Medicaid, Medicare, or other Third-Party Payer Client's Eligibility for ADAMH Services

a. Providers seeking reimbursement for ADAMH services on behalf of an enrolled Medicaid, Medicare, or other third-party payer eligible client shall submit behavioral healthcare claims directly to the applicable payer to seek reimbursement for covered services prior to seeking reimbursement from the Board.

b. Provider shall not bill for, and Board will not pay for, services reimbursable by Ohio Medicaid for clients who are eligible for Medicaid but that have not enrolled unless:

i. The client or Provider provides a documented clinical reason exists that the Board approves prior to the provision of services.

ii. The client is a minor receiving confidential services pursuant to O.R.C. 5122-.04 or 3719.012; or

iii. Reimbursement is approved by the Board in writing.

c. Payment of ADAMH Services on behalf of an enrolled Medicaid, Medicare or other third-party payor client is subject to section 4.5 of this contract.

4.5.6. Medicaid, Medicare, or Other Third-Party Payor Denials

a. Through an electronic data interchange with the Ohio Department of Medicaid, the ADAMH Board claims and enrollments system shall maintain client Medicaid enrollment spans for purposes of coordination of benefits and automatic denial of services billed to the ADAMH Board where evidence of an applicable active Medicaid coverage plan exists on the billed date of service.

b. If the Provider believes ADAMH incorrectly denied any claims for third-party coverage, Providers must submit an appeal to the ADAMH Board using the prescribed form available on the Board website's provider portal. Provider must provide all required information and accompanying documentation necessary for review.

i. Third-party denial appeals shall not be accepted or approved by the Board more than 90 days following the date the claim is received in the claims and enrollments system or after March 10, 2027, whichever comes first.

ii. Following the submission of the Provider's appeal form, the Board has 15 days to review and respond with approval, rejection, or request for more information. After the Provider responds to the request for more information, the Board has 15 days to review and respond with an approval, rejection, or additional request for information.

4.6. Clients' Access to Care

4.6.1. Except as otherwise provided herein, the Provider shall ensure timely and appropriate access to services consistent with the client's assessed needs and level of care, making reasonable efforts to reduce the number of days between a person's initial contact with the agency, and the initial assessment, and then to the subsequent service, if ongoing treatment is indicated.

4.6.2. ***Required Access to Care for Referral Priorities****:* Consistent with the mutually agreed upon principle of providing services in the least restrictive, most natural setting, ADAMH identifies its highest "access to care" priority as civil patients with behavioral health care needs who are stepping down from more restrictive crisis levels of care and those who the probate court has determined are subject to court-ordered outpatient treatment. The Provider shall plan through the Agency Services Plan and Budget; adapt to changing community conditions; and must provide capacity for rapid linkage, clinical assessment, and community stabilization supports for the following categories of individuals who are stepping down:

a. Currently linked, re–linked and newly linked adults hospitalized at Central Ohio Behavioral Healthcare (COBH) and other ODBH Regional Psychiatric Hospitals (RPH).

i. Post–Discharge Response Timeframe: The Provider shall exercise reasonable and appropriate effort toward providing an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

ii. Pre–Discharge Response Timeframe: For currently linked clients, the client will be served at the hospital by their primary clinician/treatment team the third business day after admission and at least weekly during the stay. For re–linked or newly linked clients, the Provider shall conduct an assessment and coordinate with the hospital treatment team to determine the level of care or support needed, will provide the hospital the name of the primary clinician assigned for the client within three (3) business days of the linkage and will serve the client as agreed upon with the hospital treatment team during the stay. Telephone and video conferencing may be used minimally as needed and permitted.

b. Currently linked, re–linked and newly linked adults hospitalized at The Ohio State University, and Riverside Methodist Hospital or requiring a stay at a Crisis Stabilization Unit (CSU) or other ADAMH crisis stabilization beds.

i. Post–Discharge Response Timeframe: The Provider shall exercise reasonable and appropriate effort toward providing an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

ii. Pre–Discharge Response Timeframe: Concord Counseling Services, Community For New Directions, Maryhaven, North Central Mental Health Services, North Community Counseling Services and Southeast, Inc. shall provide an on–unit assessment or other linkage service within three (3) business days of receiving a referral from the unit, if the unit makes the referral at least two (2) business days prior to discharge. If the unit refers to other Providers, if the referral from the unit is delayed, or if discharge occurs prior to on–unit assessment or other linkage service, the Provider shall make all reasonable efforts to have

telephone contact with the client on the unit and offer the outpatient services within the timeframe identified in this Section. The Provider shall give notification to the unit of treatment assignment, time, date, and location of follow-up appointment prior to discharge.

c. Currently linked, re–linked, and newly linked children and adolescents who are referred from in–county or out–of–county private/community psychiatric hospitals and ADAMH–funded Crisis Stabilization Beds.

i. Post–Discharge Response Timeframe: The Provider shall exercise reasonable and appropriate effort toward providing an outpatient service in the community within seven (7) days of discharge, and if psychiatrically medicated at discharge, will facilitate an appointment with a physician in the community within thirty (30) days of discharge.

ii. Pre–Discharge Response Timeframe: The Provider shall provide an on–unit assessment or other linkage service within three (3) business days of receiving a referral from that unit, if the unit makes that referral at least two (2) business days prior to discharge. If the referral from the unit is delayed, or if discharge occurs prior to on–unit assessment or other linkage service, then that Provider shall make all reasonable efforts to have telephone contact with the client on the unit and offer the outpatient services within the timeframe identified in this Section. The Provider shall give notification to the unit of treatment assignment, time, date, and location of follow-up appointment prior to discharge. Telephone and video conferencing may be used in the case of out–of–county Hospitals.

d. Currently linked, re–linked and newly linked adults referred from Maryhaven, Inc. from its engagement center, addiction stabilization center, and withdrawal management services for SUD services only.

i. Post–Discharge Response Timeframe: The Provider shall exercise reasonable and appropriate effort toward providing services within seven (7) days of discharge from the designated Maryhaven services.

e. Currently linked, re–linked, and newly linked adults placed on outpatient commitment by order of the probate court.

i. Post–Probate Court Determination Response Timeframe: The Provider shall exercise reasonable and appropriate effort toward providing an outpatient service in the community within seven (7) days of discharge and an appointment with the Provider psychiatrist within fourteen (14) days of discharge.

4.6.3. ***Access to Care Based on Clinical Acuity, Risk and Protective Factors:*** The Provider shall holistically evaluate and effectively respond to clients' clinical acuity, factors which exacerbate risk or pose immediate threats to safety and the protective factors which might mitigate the risk.

a. Each Provider will have clear educational materials available to disseminate to each client and their family that provide a consistent message regarding expectations of ongoing care (e.g., average length of stay, discharge criteria, alternative resources available).

b. In addition to the highest priority referral categories of persons stepping down from more restrictive crisis levels of care or on outpatient commitment and commensurate with the size and scope of each program, the Provider shall plan for and serve new clients with urgent needs.

c. The Provider shall anticipate and effectively respond to the emergent and urgent clinical needs of current clients to prevent the escalation of crises and promote resolution in the least restrictive manner in the client's natural environment and with respect for client's treatment preferences.

d. The terms "urgent" and "emergent" are descriptors of dynamic episode–specific clinical acuity rather than static person–specific descriptors. Due to the nature of mental and addictive disorders, persons' intensity of clinical need may fluctuate, necessitating different provider response times and intensity.

e. The Provider shall meet the following access to care timeframes for persons assessed to have emergent, urgent or routine needs, as follows:

i. Persons with Emergent Treatment Needs:

a) Clinical Presentation: Indicates a need for immediate intervention due to the presence of factors that may place the person at imminent risk of harm to self, harm to others, or serious and acute deterioration in functioning. A person with emergent needs, if clinically indicated following the intervention, may require a prioritized referral into a more restrictive treatment environment.

b) Response Timeframe: Persons with emergent needs shall be assisted within three (3) hours by the Provider or the Provider will take appropriate measures to obtain assistance for the person from another provider

ii. Persons with Urgent Needs:

a) Clinical Presentation: Indicates a need for expedited treatment due to the presence of factors that could place the person at risk of harm to self, harm to others, or serious and acute deterioration in functioning. The person is not exhibiting such symptoms at present; however, these risks could increase without expedited access to treatment

b) Response Timeframe: Providers will make every effort towards serving a person with urgent needs within two (2) days (48 hours) where appropriate ODBH–certified services can be made available.

iii. Persons with Routine Needs:

a) Response Timeframe: Providers shall make every effort to provide timely access to services for persons with routine treatment needs within 72 hours. Persons who are not identified as having emergent or urgent needs may be placed on waiting lists. Persons on wait lists will be made aware of the potential length of time they may have to wait for treatment, an agency contact name and number, what to do if needs become urgent, and alternative services or supports that may be available.

b) Clinical Presentation: No identified factors that would suggest the person is currently exhibiting or at risk of exhibiting harm to self, harm to others, or serious and acute deterioration in functioning, such that more immediate access to treatment would be warranted.

iv. Notwithstanding the provisions of paragraphs i, ii, or iii above, Pregnant Women and Persons Who Inject Drugs shall be offered an assessment or clinical engagement appointment within 24 hours from initial contact or referral. Such clients shall be offered admission to a clinically appropriate treatment services within 24 hours from completion of the assessment. If assessment, engagement and/or treatment services are not available within the time required by this Section 4.6.3.e.iv, then a clinically appropriate referral to another provider shall be made immediately. If no clinically appropriate treatment referral is available through a provider funded by the ADAMH Board, then the client may be placed on a waiting list and the Provider shall offer or arrange for appropriate interim services.

v. Child Welfare, Disability Development and/or Juvenile Justice Involved Children: Notwithstanding the provisions of paragraphs i, ii, or iii above, the Provider shall participate

in the referral and linkage processes for children involved in multiple systems with behavioral health needs in particular, currently linked, re–linked and newly linked children and adolescents previously in Franklin County Children Services custody who are transitioning from in–county or out–of–county long term residential treatment.

vi. Adult Crisis Referrals (excluding Crisis Stabilization Unit as required above): providers shall accept referrals from adult crisis, in accordance with the Board priorities, outlined in this contract and in a volume commensurate with the provider's ADAMH Board allocation and Agency Services Plan/Budget. A referral from adult crisis based on crisis services or an assessment, shall have the same status as an initial request from the client directly. Urgent and routine protocols apply.

4.6.4. Consistent with Sections 4.6.1, 4.7.5, and 4.8, the Provider determines the appropriate level of care and maintains treatment as clinically appropriate and medically necessary.

4.6.5. If the Provider violates Section 4.6 and refuses referrals the ADAMH Board shall be notified immediately and take action accordingly. The ADAMH Board may review the pattern of referrals, providing communication of situations or concerns, prior to taking appropriate action, including, but not limited to suspending future referrals and withholding ADAMH–service payments.

4.6.6. If there are disputes regarding Section 4.6, the Provider shall provide services to the client until the dispute is resolved. Reimbursement for services under dispute shall be made in accordance with applicable requirements.

4.7. Provision of Services

4.7.1. *ADAMH Services* Subject to available funding per Attachment A, the Provider shall accept clients who are eligible for ADAMH paid services who meet the Provider's admission criteria and who are otherwise eligible for care under this Contract.

4.7.2. Subject to available funding, the Provider will offer services from within the ADAMH service taxonomy, and as outlined in the provider approved [illegible]6 budget, to clients enrolled, including face–to–face, telehealth, and outreach services as clinically appropriate.

4.7.3. The Provider shall manage ADAMH service funding to provide consistent access for clients throughout the contract year.

4.7.4. If the Provider anticipates that it will not have capacity to accept ADAMH service referrals for more than a 30–day period, the following procedure shall be followed:

a. The Provider shall notify the ADAMH Board thirty (30) days in advance of the discontinuation of referral acceptance and supply the following documentation to the ADAMH Board:

i. A narrative listing the affected services and explanation of the circumstances, anticipated date when referrals shall be again accepted, actions to mitigate the circumstances and maximize efficiencies, AND

ii. Current agency financial statements and other fiscal data requested by ADAMH related to ADAMH-financed capacity.

b. The ADAMH Board shall review all applicable supporting documentation.

c. If it is determined to be necessary after review of documentation, a Provider Performance Monitoring meeting shall be conducted.

4.7.5. The Provider retains the clinical responsibility for the development of a recovery/resiliency oriented, individualized service plan with the client or legal guardian that addresses the medically necessary

clinical needs of the client and the interventions that will be utilized to meet those needs. The client or legal guardian has the right to informed participation in the development, periodic review and revision of the individualized treatment plan, and to receive a copy of it. Nothing in this language will preclude a Provider from providing medically necessary services, to youth or adults, and being reimbursed for those services that are covered under this Contract.

4.8. Transfer and Termination of Services

4.8.1. The Provider shall not transfer or terminate services to any client until one of the following has occurred:

a. Services have been voluntarily terminated by the client;

b. The treatment or crisis plan has been completed;

c. Client cannot be located within sixty (60) days of referral or last contact;

d. Appropriate referrals and linkages have been developed and put in place;

e. The client has moved out of Franklin County with the intent to establish residency in another county;

f. Death of the client;

g. Involuntarily terminated by the court system which includes incarceration where Provider is prohibited from rendering services during the time an individual is incarcerated; or

h. A documented threat is present in order to protect the health and safety of the Provider.

4.8.2. Prior to transferring or terminating services to a client for the following in 4.8.2.a.–c., the Provider shall offer more than one notice to the client and shall determine that transfer or termination is not likely to result in harm to self or others:

a. The client refuses to enroll for other third–party payers for which client is eligible, client refuses to utilize third–party benefits when possessed, and/or client refuses to pay fees when other third–party benefits were not sought or used,

b. No clinical progress is being made; or

c. When it is determined that termination is clinically appropriate.

4.8.3. Providers will have policies and procedures in place to address and review terminations and transfers. These policies and procedures will be consistent with existing ODBH guidelines and standards.

4.9. Subcontracts Subcontracted services, including treatment and administrative services, shall operate in conformity with this Contract and other applicable requirements.

4.10. Crisis, Crisis Assessment and Referral Procedures

4.10.1. The Provider shall engage in good faith negotiations and shall enter into a mutually acceptable affiliation agreement with the current provider of 24/7 crisis services by the beginning of each contract period (January 1) for crisis services and shall do all of the following:

a. Mutual communication of appropriate clinical information to ensure continuity of care.

b. Mutual adherence to agreed–upon protocols for clinical continuity.

4.10.2. Policies, procedures and guidelines adopted by the Provider for crisis, assessment and referral shall be carried out in accordance with ADAMH Board policies, procedures and guidelines, the Contract, the

ADAMH Board Community Plan as required by ORC 340.03(A)(1)(c) and the Agency Services Plan or equivalent.

4.10.3. The Provider shall ensure that emergency crisis services are provided in accordance with professional standards to clients in need of such services.

4.11. Enrollment and Reporting

4.11.1. After verifying and documenting eligibility as defined in Section 4.5, the Provider shall enroll all individually eligible client who seek and/or are referred for ADAMH Services and for whom claims for services rendered are planned to be billed to ADAMH.

4.11.2. The Provider shall collect and provide to the ADAMH Board all individual demographic information for the purpose of enrolling clients in publicly funded services, establishing eligibility of clients and processing their claims for payment.

4.11.3. The Provider shall provide the client with the required disclosures; and shall have the client sign all consent for treatment, authorization to bill, and/or release forms in accordance with applicable requirements.

4.11.4. After meeting the requirements of Section 4.11.3, the Provider shall enroll the client in the Board's claims and enrollments system in accordance with ADAMH policies.

4.12. Client Management Provider shall submit changes to the client's enrollment information including, but not limited to, changes of address, residency, income, client name or other demographic data in accordance with ADAMH policies.

4.13. Disclosures and Releases of Information

4.13.1. Prior to enrollment and claim submission, the Provider shall make every reasonable effort to ensure that each client who is seeking publicly funded services signs applicable releases, reviews the disclosure statement which conforms to applicable requirements of O.R.C. 1347 and O.R.C. 5119.28, and which informs the client of required information including, but not limited to:

a. The purpose of the Personal Information System currently in use by the Board,

b. How information will be used by the State Departments, the ADAMH Board and other public funders,

c. The security provision to prevent re–disclosure.

4.13.2. The Provider shall ensure that clients sign all releases which are necessary under applicable laws and rules, including, but not limited to, releases of information (written consent) on drug and alcohol treatment and prevention which conform to requirements of Federal 42 CFR, Part 2 (for SUD confidentiality) and State law (ORC 5119.27 Confidentiality of Records Pertaining to Identity, Diagnosis or Treatment). Any uses or disclosures of PHI will be made in accordance with the HIPAA regulations and when applicable, any stricter or more stringent requirements of other federal or state law will be adhered to.

4.13.3. Requests for and disclosures of PHI will comply with the minimum necessary standard as required by federal HIPAA regulations, including 45 CFR Part 164 for HIPAA security and privacy and, consistent with ADAMH's policy.

Article 5. Administration

5.1. Acknowledgment

5.1.1. For those services funded by the ADAMH Board, the Provider's letterheads, annual reports, marketing materials including advertisements, newsletters, brochures and social media promotion shall

include the ADAMH Board logo or the statement that the Provider is a contract agency of the Alcohol, Drug and Mental Health Board of Franklin County.

5.1.2. The Provider's website shall include the ADAMH Board logo and link to www.adamhfranklin.org.

5.1.3. The Provider shall work in partnership with the ADAMH Board to increase awareness of and access to the publicly-funded community safety network of care that addresses alcohol, drug and mental health needs of Franklin County residents. The Provider shall promote 988 as the single preferred behavioral health crisis line. Legacy Crisis lines may be used but will not be promoted.

5.1.4. The ADAMH Board shall provide the Provider with a sign which is appropriate for the Provider's location, and which identifies the ADAMH Board as a funder of the Provider. The Provider shall display such sign in a visible, publicly accessible and appropriate location in all facilities which are used by the Provider for services required under this Contract. The ADAMH Board shall display a sign at the ADAMH Board listing Board–funded Providers.

5.1.5. The Provider may notify and request representation from the ADAMH Board at any public annual meeting or events where ADAMH Board–funded services are highlighted. The ADAMH Board shall provide advance notice to the Provider of any public meeting or event held by ADAMH where the Provider will knowingly in advance be discussed or highlighted.

5.2. Agency Services Plan/Budget

5.2.1. The Provider must have an approved Agency Service Plan ("ASP")/Budget prior to the execution of this Contract. The ASP/Budget is hereby incorporated as a deliverable to this contract.

5.2.2. The Provider agrees that the ASP/Budget will be used as a primary means for the ADAMH Board to manage system access, capacity and service mix/intensity.

a. The Provider agrees that the ADAMH Board has the right and responsibility to monitor whether ASP/Budget projections for ADAMH Board services or claims are on track in terms of numbers of people served and units of services rendered.

b. The Provider agrees that the Board may use scheduled Provider Performance Monitoring meetings, quality assurance processes, as well as other data collection methods to determine whether the expectations outlined in the ASP/Budget are being met with respect to system access, capacity, service mix/intensity, and quality.

c. The Provider understands and agrees that the targets and projections outlined in the ASP/Budget are used by the Board to formulate and present a total system effort, individual Provider effort and that these data are presented to community regulatory authorities and others for system funding and support.

d. The Provider understands and agrees to the necessity to be forthcoming and accountable with respect to projections and targets set forth in the ASP/Budget.

e. The Provider agrees that projections made in the ASP/Budget and data collected throughout the year with respect to these projections shall be used in quality improvement processes, system planning processes, and subsequently in system funding and planning decisions that might evolve from such processes.

5.2.3. The ADAMH Board shall allocate ODBH Ohio Pharmacy Service Center/Central Pharmacy Line of Credit and may supplement this with ADAMH discretionary resources. The results of this allocation are to meet the psychotropic medication needs of high risk/high priority indigent clients, thereby reducing unnecessary hospitalization because of the inability to afford required medications; to provide subsidized support for SUD MAT costs; and to promote recovery.

a. *Regulatory Compliance*: The Provider shall comply with all federal and state laws and regulations, including the Ohio Pharmacy Service Center requirements; Ohio Department of Behavioral Health Central Pharmacy Outpatient manual and the ADAMH Board Provider Services Contract, or any other funding sources where requirements may be more stringent.

b. *Eligibility Determination*: Prior to utilizing this allocation for a client, the Provider shall determine financial and clinical eligibility. Eligibility re–determination shall be made quarterly thereafter, except as required for temporary assistance where financial eligibility shall be determined monthly.

c. *Financial Eligibility and Cost–Sharing*: The Provider shall determine financial eligibility in accordance with contract Section 11.7 Fees and Duty to Bill; Section 11.8 Duty to Appeal, and the Client Financial Eligibility, Fee Administration, and Public Subsidy Schedule specified in available users guides, manuals, and related documentation and policies.

i. Ohio Pharmacy Service Center/Central Pharmacy Line of Credit or ADAMH discretionary allocations shall not be used for clients with other payer or medication sources, including but not limited to medication samples; pharmaceutical assistance; Medicaid; managed care, third-party insurance, and/or self–pay.

ii. If a client urgently needs medication, appears to be eligible for alternate payer or medication sources and the Provider has assisted them to apply for those sources, the Provider may use Ohio Pharmacy Service Center/Central Pharmacy temporarily, and shall conduct a financial eligibility review monthly until the alternate sources are available.

d. *Clinical Eligibility:* The Provider shall determine clinical eligibility.

i. For psychiatric treatment, the Provider shall comply with the Ohio Pharmacy Service Center requirements and document the medical necessity for this pharmaceutical intervention. A client must be:

a) An adult with Severe Persistent Mental Illness or a youth with Severe Emotional Disturbance; or

b) At risk of psychiatric hospitalization if the medications were discontinued; or

c) Discharged from a mental health inpatient facility, residential treatment facility, jail or prison within three (3) month period prior to eligibility determination

ii. For SUD MAT, the Provider shall comply with the Ohio Pharmacy Service Center requirements and document the medical necessity for this pharmaceutical intervention.

e. The Provider shall implement procedures to ensure that Ohio Pharmacy Service Center/Central Pharmacy Emergency Prescriptions are utilized as a last resort, arranging for next–day delivery as an alternative.

f. The Provider shall implement procedures to maximize credits for returned unused medications.

g. Ohio Pharmacy Service Center/Central Pharmacy medications shall not be used for resale or redistribution to others.

5.2.4. Pursuant to Article 14 below, the Provider shall not make material changes, as defined in this Contract, in the services defined in its Agency Services Plan, funding or business structure/administration unless such changes have been approved in advance in writing by the ADAMH Board. Provider also affirms, understands and agrees that Provider and its subcontractors are under a duty to disclose to the Board any change or shift in location of services performed by Provider or its subcontractors before, during and after

execution of this Contract with the Board. Provider agrees it shall so notify the Board immediately of any such change or shift in location of its services.

a. Thirty (30) days prior to planning a significant change, the Provider shall submit a written request for consultation with the ADAMH Board to determine materiality under this Contract.

b. If the ADAMH Board notifies the Provider that the proposed change is material, the Provider shall submit any requests for approval of material changes in its services to the ADAMH Board in writing no less than sixty (60) days prior to the anticipated change, in accordance with ADAMH Board procedures. This includes, but may not be limited to, a revised Agency Services Plan and Budget.

c. Nothing in this section should be interpreted as deterring the Provider from developing plans for more efficient strategies in areas of quality and services defined in the Provider's ASP, funding, and/or business structure and administration.

5.2.5. The Provider shall maintain an Agency Disaster Mitigation and Recovery Plan that addresses Continuity of Operations during an emergency. This plan shall include, at minimum:

a. Plans for staffing the agency if many staff are unable to get to work.

b. Contingency plans for operations if there is substantial physical damage to the agency building(s).

c. Plans for quick data recovery, particularly current client contact information and medication information.

d. Plans for fiscal continuity in the event of interrupted business.

e. Contingency plans for care for current clients.

f. If the agency provides residential services or services in a congregate setting, plans to evacuate and care for clients separate from emergency community efforts such as police and the Red Cross.

g. The Provider shall comply with all federal and state laws and regulations, and funding source requirements, including those of the Ohio Department of Behavioral Health, the Substance Abuse and Mental Health Services Administration or any other funding source where requirements may be more stringent.

5.3. Provider Autonomy Despite public funding that may be received by the Provider from ADAMH, the Provider is a fully independent and autonomous contractor and retains the ultimate responsibility for the care and treatment of clients to whom services are rendered under this Contract. The ADAMH Board recognizes the Provider as an independent contractor in carrying out its duties under this Contract. The ADAMH Board acknowledges that the Provider has full and sole authority to determine its governing structure and employees.

5.4. Training, Technical Assistance and Consultation The ADAMH Board shall provide the Provider with training, technical assistance and consultation when such services are reasonably necessary to meet applicable contract requirements.

Article 6. Information and Reports

6.1. General Access by ADAMH Board

6.1.1. The Board shall have the right to inspect the Provider's service, personnel, accounting, client residency and financial eligibility documentation, and clinical records, while complying with HIPAA minimum necessary standards, as required to discharge their legal responsibilities including the following:

a. Monitor and evaluate the Provider's compliance with the terms of this Contract, including ensuring quality, effectiveness, and efficiency of services and ensuring the accuracy of client eligibility and claims submitted for reimbursement under this Contract through chart reviews, desk audits, or other verification measures as determined by the ADAMH Board,

b. Verify that costs of services, including all administrative, direct and indirect costs, are being computed in accordance with Article 10,

c. Verify the sources and amount of all income received by the Provider for services provided under this Contract and services similar to those provided under this Contract,

d. Investigate alleged misuse of client funds or funds provided under this Contract, and

e. Perform its duties under applicable requirements.

6.1.2. The Board and Provider shall maintain the client's right to confidentiality as required by law or as provided by Provider policies to the extent the latter does not conflict with legal responsibilities.

6.1.3. The Provider shall not be required to provide proprietary information unless such information is required to be provided under applicable law or this Contract.

6.1.4. Except under circumstances listed in Section 6.1.5, information shall be provided by the Provider during ordinary business hours and the ADAMH Board shall provide reasonable prior notice of the time and date of the visit.

6.1.5. The ADAMH Board may obtain immediate access to information without prior notice, including access to staff, individual client records, and client accounts, under any of the following circumstances:

a. Such information is reasonably related to allegations of abuse or neglect of a client being investigated in accordance with Section 6.5,

b. To prevent imminent harm to clients,

c. When the ADAMH Board reasonably believes, based on facts known at the time, that immediate access is essential to prevent removal or destruction of property or records required to be maintained under this Contract, or

d. When the ADAMH Board reasonably believes, based on facts known at the time, that there is a substantial violation of client rights because of actions by the Provider.

6.2. Basic Documents Upon request of the ADAMH Board, the Provider shall provide the ADAMH Board with the most recent versions of the following documents:

6.2.1. Articles of Incorporation and By–Laws for the Provider.

6.2.2. Evidence of certification as necessary under applicable requirements.

6.2.3. Risk management procedures.

6.2.4. Current policies and procedures which conform to the ADAMH Board's policies regarding client financial eligibility and Public Subsidy.

6.3. Essential Reports and Data Submissions

6.3.1. The Provider shall provide the reports listed in Attachment B at such times as are specified in said Attachment.

a. Any information or report which is required under this Contract shall be submitted in the format prescribed by the ADAMH Board. If no prescribed format is known or available on the Board website's provider portal, Provider may contact via email Data@adamhfranklin.org for guidance, and the ADAMH Board shall provide the required format

6.3.2. Provider shall ensure the accuracy of all reports in Attachment B.

6.4. Grants Within thirty (30) days of receipt of new grant funds over the year from any funding source for behavioral healthcare services, which equal or exceed 25% of the Provider's total revenue, the Provider shall provide the ADAMH Board with written notice of receipt of such grant(s); a copy of the budget approved for the grant(s); and an explanation of how the grant may materially impact its ADAMH Board allocation and services to targeted populations outlined in its ASP/Budget.

6.5. Major Unusual Incidents The Provider and the ADAMH Board shall agree to comply with all applicable requirements in accordance with Ohio Revised Code § 340.03 and Ohio Administrative Code § 5122-26-13.

Article 7. Evaluation and Accountability

7.1. General The Provider shall cooperate with the ADAMH Board in all monitoring activities, including, but not limited to service reviews, audits and other fiscal monitoring, verification of client residency and financial eligibility and claims reimbursement. Requests for information shall be made in accordance with the requirements of Section 6.1.

7.1.1. The Provider shall process reversals on ADAMH services claims determined to be ineligible as a result of a review conducted by ADAMH. Reversals must be processed in accordance with ADAMH procedures.

7.1.2. The Provider shall submit encounter claims for all non–exempt block grants. ADAMH will determine if the Provider's block grants are exempt from encounter claiming and if claims are to be submitted under an individual client's identification number or an organizational client's identification number in the Board's claims and enrollments system.

7.2. Accounting

7.2.1. The Provider shall maintain complete and accurate financial records with respect to all undertakings required by this Contract. The Provider is responsible for ensuring that its financial statements are consistently reported and fairly presented in accordance with generally accepted accounting principles.

7.2.2. All financial reports to the ADAMH Board shall be made on an accrual basis, whether or not the accounts are maintained on a cash basis.

7.3. Audits

7.3.1. The Provider shall submit to an annual financial and compliance audit conducted by a qualified certified public accountant (Audit Contractor) in accordance with generally accepted government auditing standards (i.e., standards for financial audits contained in government auditing standards issued by the U.S. Comptroller General) and the uniform guidance in 2 CFR Chapter II, Part 200 titled *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*. Failure to meet the requirements of 2 CFR Chapter II, Part 200, and the State audit requirements referenced below could result in the withholding of current funds or the denial of future awards.

7.3.2. The Provider shall comply with the following Board audit requirements and standards.

a. The Provider and Audit Contractor shall make audit work documents available to the ADAMH Board unconditionally. The Provider shall permit access by representatives of the Audit Contractor and the ADAMH Board to all information, including, but not limited to, financial,

program, staff, and other data, which is, in the sole discretion of such representatives of the Audit Contractor or the ADAMH Board, necessary to complete the audit.

b. The Audit Contractor shall calculate key financial performance indicators using the Provider's audited financial statements. Key financial performance indicators shall be reported as a supplemental schedule and included in the audited financial statements. A list of key financial performance indicators will be provided upon request.

c. Providers are considered vendors (contractors) related to Medicaid services. For all other programs funded with federal funds, Providers are considered subrecipients of Federal funds as defined in 2 CFR Chapter II, Part 200.

d. When conducting the audit, the standards adopted by the American Institute of Certified Public Accountants (AICPA) shall be utilized. Auditors should be familiar with Generally Accepted Auditing Standards (GAAS) established by the AICPA; Generally Accepted Government Auditing Standards (GAGAS), also referred to as the Yellow Book; AICPA pronouncements, publications, and audit and accounting guides for state and local governments, not-for-profit entities, and healthcare entities; and the Public Company Accounting Oversight Board's Auditing Standards 6110 (AS 6110) - Compliance Auditing Considerations in Audits of Recipients of Governmental Financial Assistance.

e. Auditing procedures shall conform to the standards set forth by the AICPA Statement on Standards for Attestation Engagements (SSAE).

f. Providers expending less than $1,000,000 in federal funding for a fiscal year starting on or after October 1, 2024, must obtain a financial statement audit in accordance with generally accepted government auditing standards (GAGAS) and in accordance with OAC 5122:1–5–01 (D)(1)(a).

g. Providers expending $1,000,000 or more in federal funding for a fiscal year starting on or after October 1, 2024, must obtain an organization-wide or program-specific audit of the uniform guidance in 2 CFR Chapter II, Part 200, titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

h. For ADAMH block grant funds, the Audit Contractor must: make inquiries to management regarding the methods used to prepare the overall budget and the allocation of non–personnel expenses and administrative overhead to each service; document budgetary procedures used, evaluate the adequacy of procedures and make recommendations as needed; verify that all methods were consistently applied; make inquiries regarding the Provider's method for separately recording expenditures against block grants; document procedures used for recording expenditures against block grant funds, evaluate the adequacy of procedures and make recommendations as needed; compare the Provider's listing of expense items charged to the grant to the Agency Service Plan; select block grant expenditure reports for fiscal year being audited and trace expenditures to the statement of revenues and expenses generated by the Provider's accounting system; examine actual costs (including the type of services provided to individuals and individual's eligibility) to ensure that no unallowable costs have been included (for federal funding, see 2 CFR Chapter II, Part 200 for guidance in determining allowable cost; for local funding, including levy and state-level non-federal funding, see the Agency Service Plan and State Assurance Statements); and quantify results related to the accuracy and completeness of block grant expenditure reports.

i. For the ADAMH claims and enrollments system related to membership, make inquiries to management regarding procedures used to determine if a client is eligible for membership in Franklin County ADAMH Board's standard or crisis benefits plan, evaluate the adequacy of procedures, and make recommendations for improvement as needed. From paid claims records,

select a representative sample of ADAMH Board-funded clients enrolled in a standard benefits plan at the time of service. Perform the following procedures:

i. Determine if payments were for services provided to a valid client, as defined by the ADAMH Board.
ii. Examine documentation used to verify income to determine if it meets income requirements as defined by the ADAMH Board.
iii. Verify that the Provider follows ADAMH Board procedures for client financial eligibility and ADAMH public subsidy schedule as outlined in the provider services contract and accompanying documentation (i.e., Public Subsidy Scale).
iv. Examine documentation used to verify residency to determine if it meets residency verification as defined by ADAMH.
v. Verify that completed consent for treatment forms are on file.
vi. Verify that completed release of information forms are on file.
vii. Verify that notice of privacy practices was given to members.
viii. Quantify results related to the accuracy and completeness of client enrollment.

j. For the ADAMH claims and enrollments system related to billing, make inquiries to management regarding procedures used for ADAMH billing, evaluate the adequacy of procedures, and make recommendations for improvement as needed. Select a representative sample of ADAMH clients from paid claims records and perform the following procedures:

i. Trace the information from the billing reports to service/progress notes that are maintained in members' individual records, considering if type of services provided to individuals are allowable and that individuals are eligible for ADAMH funding.
ii. Verify the date of service.
iii. Verify duration of service.
iv. Verify the type of service.
v. Examine documentation to verify that the Provider appropriately billed all third–party primary payers, including Medicaid, Medicare, and commercial insurance, before billing ADAMH, when applicable.
vi. Quantify results related to the accuracy and completeness of billing submitted through the ADAMH claims and enrollments system and paid by ADAMH.

k. ADAMH Board revenue and accounts receivable must be clearly identified in the financial statements as a separate line item or as a note to the financial statements.

l. Medicaid revenue and accounts receivables must be clearly identified in the financial statements as a separate line item or as a note to the financial statements.

7.3.3. The Provider shall direct the Audit Contractor to submit its report to the ADAMH Board within six (6) months after the end of the Provider's fiscal year being reported. The audit report shall include a report of independent auditors, audit reports required under 2 CFR Chapter II, Part 200, and audit reports required under government auditing standards.

7.3.4. If the Audit Contractor's report as required herein is not submitted in a timely manner, then ADAMH may require an audit conference. The ADAMH Board may allow up to 75 additional days for the Provider to submit the Audit Contractor's report. If the report is not submitted within the required time limit, or the time limit as extended, then the ADAMH Board may resort to suspension procedures set forth in Section 11.6.7 or to termination procedures set forth in Article 14 of this Contract. Failure to submit a timely, complete annual financial audit may result in the ADAMH Board assuming responsibility for contracting with an Audit Contractor to ensure a satisfactory completion of the audit. If the Board assumes this responsibility, the costs shall continue to be borne by the Provider.

7.3.5. The Provider shall direct the Audit Contractor to provide an electronic copy of the Audit Contractor's report and the management letter, if applicable, to the ADAMH Board promptly after the audit's completion.

7.3.6. ADAMH may require that the Provider (or the Provider and the Audit Contractor) meet with ADAMH upon receipt of a draft or final audit.

7.3.7. In the event the audit contains findings in the Schedule of Findings and Questioned Costs, exceptions, or the Provider's records are deemed not auditable, or a qualified opinion is received on the financial statements, then:

a. The parties shall immediately arrange an audit conference.

b. The Provider shall submit a Corrective Action Plan ("CAP") within 30 days. For single audits, CAP should address all material and reportable findings and questioned costs as required under the uniform guidance in 2 CFR Chapter II, Part 200. The CAP submitted by the Provider should be prepared and submitted with written approval of the Provider's executive committee or designee representing the board of directors/trustees. A CAP shall be prepared to address any qualified opinions and findings reported in a management letter.

i. Any overpayment resulting from duplicate billings, erroneous billings, deceptive claims, unallowable costs, or any falsification shall be refunded to ADAMH Board in full.

ii. To be deceptive means knowingly to deceive another or cause another to be deceived by a false or misleading representation by withholding of information or by any other act, conduct, or omission which creates, confirms or perpetuates a false impression of another, including a false impression as to law, value, state of mind or other objective or subjective fact.

iii. For any duplicate, erroneous, or deceptive claims discovered during the term of this Contract, regardless of the date such claims were initially made, the Provider shall submit detailed claim corrections to the ADAMH Board to allow the ADAMH Board to make manual claims corrections within the Board's current claims and enrollments system.

c. The Provider shall provide the ADAMH Board with quarterly updates on progress made toward implementation of CAP until full implementation is achieved.

d. The CAP should include Provider responses indicating corrective actions already taken, additional actions to be taken, or a statement supporting the Provider's belief that the corrective action is unnecessary. The executive committee or designee representing the board of directors/trustees of the Provider should acknowledge and signify approval of the comments and CAPs by signature before submitting the final CAP to the ADAMH Board. The content of the CAP must include, at a minimum, the following:

e. A citation of each audit or audit/engagement finding describing the weakness or the adverse findings.

i. A description of the activities that will take place to correct the situation(s) for each finding.
ii. The timeframes for completion of the corrective activities.
iii. The name(s) of contact person(s) responsible for corrective action(s).
iv. A statement signed by the Board's/Provider's executive director and a written resolution by the responsible board of directors/trustees that the CAP is acceptable, and its implementation will be monitored to ensure correction of cited conditions during the subsequent fiscal year.

7.3.8. The Provider shall pay for audit costs directly and may include audit costs in costs for services.

7.4. Additional Audits and Reviews

7.4.1. If the Provider is required to submit a CAP as provided in Section 7.3.7.b or a CAP for any other reason, the ADAMH Board may require the Provider to submit to a further examination to determine whether the deficiencies have in fact been corrected.

a. Costs of additional audits shall be the responsibility of the Provider.

7.4.2. The Provider shall retain financial records, including supporting documentation, for at least six (6) years after records have been audited. Notwithstanding the above, if there is litigation, claims, audits, negotiations or other actions that involve any of the records cited and that have started before the expiration of this time period, such records shall be retained until completion of the actions and resolution of all issues, or the expiration of the six–year period, whichever is the last to occur.

7.4.3. Provider shall direct the Audit Contractor to obtain a review, by an attorney licensed to practice law in the State of Ohio, of all suspected illegal acts and non-compliance findings discovered by the Audit Contractor during the engagement which are incorporated in the Report on Internal Control over Financial Reporting and on Compliance and Other Matters Required by Government Auditing Standards that have a direct and material effect on the determination of financial statement amounts. In this review, the attorney must determine whether there is sufficient evidence to support a written determination that the suspected illegal act or non-compliance occurred. Provider shall direct Auditor Contractor to document this legal review in the Audit Contractor's work papers. The legal review may be performed by the Audit Contractor firm's in-house attorney(s) or by subcontract with an attorney not employed by the Audit Contractor.

7.5. Reconciliations

7.5.1. *Cash Payment/Expenditure Reconciliation*—The ADAMH Board will reconcile Provider block grant and claims expenditures to ADAMH Board cash payments and allocations in accordance with ADAMH Board reconciliation procedures as described in Attachment D of this Contract.

7.6. Documentation and Records

7.6.1. The Provider shall keep accurate, current and complete clinical records for each client as required by law.

7.6.2. The Provider shall submit to the Board data it has collected regarding client outcomes, counts of clients served, and client demographics in accordance with Attachment B and Attachment E of this Contract.

7.6.3. The ADAMH Board shall monitor the Provider's reporting and data submissions in accordance with Attachment B of this Contract. The Board shall review the information received and communicate to the Provider issues identified with respect to completeness and quality of the data. The Provider shall upon request submit corrected information following notice from the Board.

7.6.4. Providers shall submit clinically accurate primary and secondary billable diagnoses on all claims submitted in the Board's current claims and enrollments system, including:

a. Updating the clinical paper and electronic record/module to reflect the most current diagnoses

b. Updating the billing record/module to reflect the most current diagnoses, in the case where the clinical and billing modules of a Provider's MIS are not integrated

c. Ensuring that the software vendor "sets" the Provider's billing module to release/include both the primary and secondary diagnosis on the claims.

7.6.5. The Provider shall notify the ADAMH Board immediately upon the occurrence of any breach to its billing or communications system.

7.6.6. The Provider shall adopt a record retention policy in accordance with applicable requirements, identify the types and locations of client records, and make that policy available to the ADAMH Board upon request.

7.7. Utilization Review, Monitoring, and Levels of Care

7.7.1. Providers shall cooperate with the ADAMH Board in the development and implementation of utilization review activities and other activities which will assist in improving the quality, efficiency and cost–effectiveness of care under this Contract.

7.7.2. Upon request of the ADAMH Board, Providers shall participate in an annual review session.

a. Providers will ensure that a client or family member associated with the Provider attends the review session.

b. The client or family member attending the review session shall be actively involved (Provider Board member or a Consumer Advocacy Council) with providing recommendations and advice on the delivery of mental health and alcohol and other drug addiction services.

Article 8. Conflicts of Interest

8.1. Nepotism Policy The Provider shall adopt and implement a policy which prohibits conflicts of interest arising from nepotism which meets applicable requirements.

8.2. Prohibition No member or employee of the ADAMH Board or prohibited family member of a member or employee of the ADAMH Board shall serve on the board of the Provider or as an employee of the Provider. A prohibited family member is a spouse, child, parent, brother, sister, grandchild, stepparent, stepchild, stepbrother, stepsister, father–in–law, mother–in–law, son–in–law, daughter–in–law, brother–in–law, or sister–in–law or a person who stands in the place of such a family member.

8.3. Recruitment of Clients No employee of either party shall recruit clients receiving services under this Contract into their private practices. Recruitment shall mean referral to the employee or the employee's business in a manner which results in financial gain to the employee when other suitable alternatives for providing services to the client are reasonably available.

Article 9. Transition Procedures

9.1. Applicability Article 9 shall apply when any service provided under this Contract is terminated for any reason or when this Contract is terminated for any reason including the dissolution or termination of the Provider's business.

9.2. General Requirement The Provider shall work cooperatively with the ADAMH Board to assist in the transition of services as needed to a Provider or Providers designated by the ADAMH Board. Throughout the transition, the parties shall take all steps reasonably necessary for continuity of client care and to protect client interests.

9.3. Client Records To the extent authorized by the client and permitted under applicable law, copies of client records shall be transferred promptly to the designated Provider or Providers. In the event the Provider is ceasing all operations, the Provider shall comply with federal and state record keeping requirements.

9.4. Property Transfers Personal property in which the ADAMH Board has any ownership interest either under applicable requirements shall be made available to the ADAMH Board for transfer. Personal property in which the ADAMH Board is acting as fiduciary on behalf of ODBH or the Federal Government who has any ownership interest in such property, either under applicable requirements shall be made available to the ADAMH Board for transfer. The ADAMH Board shall be responsible for the transfer of such property. The ADAMH Board shall have the right of first refusal to buy out any property in which the ADAMH Board has a full or partial interest.

Article 10. Standards for Budgets, Costs, Rates and Fees

10.1. Budget Development and Revision The Provider shall develop and revise budgets in accordance with ADAMH Board budget procedures.

10.1.1. Provider may submit budget revisions at any time during the term of this Contract. Such submissions must comply with Section 5.2 of this Contract.

10.2. Allowable Costs ADAMH funds allocated in this contract shall not be used for unallowable expenses as defined by the uniform guidance in 2 CFR Chapter II, Part 200 titled *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

10.2.1. Compliance Supplements of the applicable Federal financial assistance program(s), or

10.2.2. Award correspondence from ODBH or the ADAMH Board.

10.3. Minimum Reimbursement Rates for ADAMH Services. When setting unit rates for reimbursement of services, the ADAMH Board shall consider the rate set by the Ohio Department of Medicaid for procedure codes appearing in both the ADAMH Board's and Ohio Medicaid's code taxonomies. The ADAMH Board will attempt to set unit rates no lower than that of the corresponding Medicaid rate, but is not required to. In the event that the ADAMH Board sets rates lower than the corresponding Medicaid rate, the ADAMH Board shall provide an explanation for the rate being lower than the corresponding Medicaid rate (for example, budgetary considerations).

10.4. Maximum Reimbursement Rates for ADAMH Services. The ADAMH Board shall not compensate a Provider for any service at an amount which, accounting for prior reimbursements from other payers, exceeds the rate approved by the ADAMH Board or the amount charged by the Provider, whichever is lower.

Article 11. Reimbursement by ADAMH Board

11.1. General The ADAMH Board shall make reimbursement required under this Contract for services rendered under this Contract.

11.1.1. Unless this Contract specifically provides otherwise, all reimbursement shall be made in full for services actually provided and for which there is appropriate documentation as set forth in this Contract.

11.1.2. Reimbursement shall be made within the normal course of ADAMH Board business.

11.1.3. There shall be no alteration in the amount of reimbursement or the allocation of such reimbursement without prior notice as set forth in Article 14, unless the parties have agreed to such changes.

11.1.4. Attachment A of this contract reflects the maximum funding level by allocation.

11.1.5. All reimbursements shall be made via monthly block grant funding requests. For non-claims based funds, ADAMH may require additional documentation to ensure funds are being requested by the Provider on a reimbursement basis and to verify the expenses that are to be reimbursed by ADAMH.

11.1.6. All claims for services submitted in the Board's current claims and enrollments system will be treated as encounter claims regardless of the disposition indicated in the HIPAA 835 electronic remittance advice file.

11.2. Block Grant Reimbursement Reimbursement shall be made monthly in accordance with ADAMH Board block grant draw–down procedures and availability of local, state and federal funds.

11.2.1. The Provider shall submit block grant funding requests by the date specified by the ADAMH Board in order to receive a block grant payment during that month. All late requests may be held until the following month for payment.

11.2.2. ADAMH shall process payments for up to 10% of allocated levy funds as soon as possible in early January for contracts fully executed by December 31, 2025, and by January 31, 2026, for contracts fully executed by January 15, 2026. Contracts not fully executed by January 15, 2026, will not have access to the up to 10% upfront payment of levy allocations. If a provider wishes to opt out of this upfront payment, they may email blockgrants@adamhfranklin.org by the above deadlines of January 3 or January 15 according to when their contract is executed.

11.2.3. On a monthly basis, Providers may request up to 1/12 of allocated levy funds. ASO-funded allocations will be excluded from the 1/12 limit. At ADAMH's discretion, it may make other exceptions to the 1/12 limit in limited circumstances upon written request. Local, state, and federal funds may be requested in accordance with award requirements and payment will be dependent on availability of funds. State and Federal funds must be requested on a reimbursement basis and substantiated with proper documentation. If provider has under requested in previous months for allocated levy funds, they may request the remaining percentages allowable from previous months in addition to their current months request. Requests will be capped based on allocation totals.

11.2.4. ADAMH may notify a provider of the intent to place an allocation on hold, and place an allocation on hold, any time after June block grant payments are made if cash paid in the current contract year is more than 20% greater than, as relevant, reported expenses or encounter claim values reported. Holds will be released once the current threshold is met or ADAMH has reason to believe the hold is no longer necessary.

11.2.5. Providers are required to submit quarterly allocation expenses for exempt block grants on their May, August, November, and February 2026 block grant funding request. Exempt block grants may be held if this reporting is not received. Annual detailed expense reporting is due February 15, 2027.

11.2.6. To ensure accurate and timely contract payment reconciliation, the Provider shall submit its correctly completed final Block Grant Funding Request and Block Grant Expense Report(s) for the year no later than contractual claim submission deadline of February 15, 2027 for Contract Year 2026. ADAMH shall not accept any block grant reports after this deadline. The Provider shall forfeit any funds not drawn down or reported as expenses by this deadline.

11.2.7. Encounter claims must be submitted on or before the Contract Year cut-off date of February 15, 2027. All encounter claims submitted after this date will be denied.

a. Providers may process and clean denied and pended claims to correct them for re-adjudication on or before the deadline of March 19, 2027. After this date, all claims will be considered to be in their final statuses, and no further corrections are allowable.

11.2.8. The Provider shall follow Sections 4.11, 4.12, 7.1 and 7.5.1 for all block grants.

11.2.9. Failure to comply with Section 11.2.1 may result in ADAMH withholding payments per ADAMH's payment withhold policy until corrective action has been taken.

11.2.10. Incentives reimbursed via block grants shall adhere to the approved ASP/Budget and are subject to all applicable reconciliation and service requirements addressed in Attachment D.

11.3. ADAMH Services Encounter Claims

11.3.1. The Provider shall electronically submit all claims for services rendered using a HIPAA 837 electronic format through the Board's current claims and enrollments system or other electronic entry method authorized by the ADAMH Board.

11.3.2. The ADAMH Board shall publish an annual claims processing and reimbursement schedule. The ADAMH Board shall take all steps reasonably necessary to process payments in accordance with such schedule and availability of local, state and federal funds, except that no payment shall be made later than the time set forth in applicable requirements.

a. Subject to allocation limits, otherwise eligible claims for ADAMH services shall be applied toward block grant encounter claims data if the Provider submits the claims within four hundred twenty-five (425) days of the date of service but prior to the contractual claim file submission deadline specified in Section 11.2.7. The 425–day period shall be calculated from the date of service the Provider enters in the Board's current claims and enrollments system.

11.4. Advances The ADAMH Board may grant advances in accordance with the ADAMH Board Policy. The ADAMH Board shall deduct the amount of an advance from any balance remaining of the Provider's allocation(s).

11.5. Title XX Reimbursement

11.5.1. The Provider shall maintain Title XX records in accordance with applicable requirements and shall include Title XX funds in any audits conducted under this Contract.

11.5.2. The ADAMH Board shall reimburse claims for Title XX services which are submitted in accordance with ADAMH policy, Article 11 of this Contract, and other applicable requirements.

11.6. Restrictions on Reimbursement

11.6.1. The ADAMH Board shall not make reimbursement to the Provider in excess of the annual amount allocated to the Provider included in Attachment A or allocation added subsequently through an Action of the ADAMH Board, unless such reimbursement is required under applicable law.

11.6.2. Reimbursement for services is subject to available County Spending Authority as authorized by the Franklin County Board of Commissioners.

11.6.3. If the ADAMH Board has made a determination, based on substantial evidence, that there has been a violation of Article 10 or this Article 11, then the ADAMH Board shall have the right to set off the amount in dispute from future reimbursement which is due under this Contract, subject to dispute resolution sections.

11.6.4. Except as otherwise provided by law, the ADAMH Board shall be the payor of last resort.

11.6.5. The Provider shall accept any reimbursement from Medicaid and Medicare for services as payment in full and shall not bill any unpaid charge to ADAMH.

11.6.6. No reimbursement shall be made if such reimbursement is not permitted under applicable law. If there is a dispute as to whether a reimbursement is permitted under Federal or State law, the matter shall be submitted to ODBH, whose decision shall be followed pending the exhaustion of the procedures as set forth in Article 13 and Article 14 or until no further administrative or judicial appeals are permitted through waiver or otherwise.

11.6.7. A reimbursement under this Contract may be suspended if the Provider fails to submit or make available for inspection any information or report listed below, or does not allow access in accordance with terms of this Contract, except that reimbursement may only be suspended until such information is furnished or access to information is permitted for the following items:

a. Certification and Licensing as required in Section 4.2.1

b. Approved ASP/Budget as required in Sections 3.2 and 5.2.1

c. Submission of approved Annual Audit as required in Section 7.3

d. Encounter claim thresholds are met as required in Section 11.2.3

e. Client counts and demographics reports per Attachment E and as required in 7.6.2

11.6.8. With the exception of 11.7.7(d), no reimbursement shall be withheld unless the ADAMH Board has given the Provider notice of the ADAMH Board's intent to withhold reimbursement and a statement of the reasons for the proposed action. Notice shall be in writing and received by the Provider not less than ten (10) working days prior to the withholding of reimbursement. Reimbursement shall only be suspended until such information is furnished or access to information is permitted.

a. Funding holds associated with minimum encounter claim thresholds (11.2.3) will be executed based on the claim submission dates identified in the annual claims processing and reimbursement schedule as described in 11.3.2.

b. Extensions will be considered when the Provider submits a written request with explanation of the reason for submission delay.

c. If the Provider can demonstrate in writing that the Provider's annual audit is delayed due to an ADAMH Board delay, the Provider shall have an additional 60 days to finalize their audit.

11.7. Fees and Duty to Bill

11.7.1. The Provider shall implement measures to implement ADAMH policies regarding client financial eligibility and the Public Subsidy.

11.7.2. The Provider shall establish and implement procedures to recover payment from Medicaid, Medicare or private insurance and other third-party payors.

11.7.3. ADAMH Board reimbursement will not be requested until third-party payors verify non–coverage related to third-party coverage plan enrollment or related to individual billable services within a client's existing third-party coverage plan.

11.8. Duty to Appeal In the event that payment by a third–party payor, including, but not limited to, Medicaid, Medicare or private insurance has been denied and there is a reasonable basis for appeal, the Provider shall either:

11.8.1. Take steps reasonably necessary to perfect and pursue appeals of denial of payment by third-party payors, or

11.8.2. Provide to the client or entity filing the appeal, information reasonably necessary to pursue the appeal, to the extent that such information may be released in accordance with applicable requirements.

11.9. Loss of Funds

11.9.1. The ADAMH Board is not required to make reimbursement in full or in part if funds to the ADAMH Board have been reduced or eliminated. Reductions in levy fund awards shall be subject to 120-day notice.

11.9.2. In the event ADAMH Board receives notice from a funding source that funding from that source shall be reduced or eliminated, the ADAMH Board shall give the Provider prompt notice of the reduction or elimination.

11.9.3. In the event that funds for one or more services are eliminated by the ADAMH Board or by a funder whose funds are used as match for ADAMH–funded services, the Provider shall provide the ADAMH Board with a transition plan with such information as is reasonably necessary to carry out the transition, including, but not limited to the clients being served and the services required to be provided to such clients. The Provider shall continue to provide services required by the clients until the Provider has arranged for alternative services or for a period of 30 days after receipt of the notice required under Section 11.9.2, whichever period is shorter. The ADAMH Board shall assist in locating appropriate services for the clients being served by the Provider and shall pay for services actually provided by the Provider during such period.

11.9.4. In the event that ADAMH receives notice from a funding source that funding from that source shall be reduced or eliminated occurs after said funds have been claimed or drawn down by the Provider and

paid by ADAMH, any necessary reduction to the Provider's associated fund source allocation will occur in the next monthly cycle.

Article 12. Insurance

12.1. Responsibility for Claims and Liability To the extent permitted by law and without waiving any statutory defenses that may be available, the Provider shall hold and save the Board, and employees, acting in the course of their employment, harmless for all third party claims, damages, lawsuits, costs, judgments, expenses, and any other liabilities that arise from the Provider's performance or negligent acts or due to the performance or negligent acts of the Provider's sub–contractors, agents or employees responsible for executing the work encompassed in this Contract. The foregoing obligation to hold harmless the Board shall not apply to a Provider which is the State of Ohio or any department, board, office, agency, or instrumentality thereof, or any political subdivision of the State of Ohio.

12.2. General Liability The Provider shall carry comprehensive general liability insurance in no less than the amounts set forth in Attachment C.

12.3. Automobile The Provider shall insure that there is automobile liability insurance for passenger vehicles for all such vehicles used to transport clients, whether such vehicles are owned by the Provider or its agents or employees in no less than the amount set forth in Attachment C. The Provider shall also conduct appropriate due diligence on the individual's driving record.

12.4. Employee Dishonesty It is recommended that the Provider provide coverage against employee dishonesty. The ADAMH Board shall not make any payments to cover losses incurred as a result of employee dishonesty and the ADAMH Board reserves the right to recover amounts due to the ADAMH Board as a result of employee dishonesty.

12.5. Employers' Liability To the extent permitted by law, the Provider shall carry employers' liability insurance in no less than the amount set forth in Attachment C.

12.6. Professional Liability The Provider shall carry professional liability insurance providing single limit coverage in no less than the amount set forth in Attachment C.

12.7 Cyber Insurance The Provider shall carry cyber insurance in no less than the amount set forth in Attachment C.

12.7. Additional Insured If applicable, the ADAMH Board shall be named as an additional insured and "Certificate Holder" in its liability insurance policies. Providers must name the ADAMH Board by an Endorsement to the agency's insurance policies and require its insurance company to provide notification to the ADAMH Board on a standard "Certificate of Liability" form, which summarizes insurance coverage and/or changes reflected in the insurance policies.

12.8. Workers' Compensation The Provider shall provide evidence of proper worker's compensation coverage.

12.9. Claims–made Policies To the extent permitted by law, in the event that the Provider meets any of its obligations under this Article 12 by obtaining a "claims–made" policy, to the extent permitted by law, the Provider shall provide evidence of either of the following for each type of insurance which is provided on a claims–made basis.

12.9.1. Unlimited extended reporting period coverage which allows for an unlimited period of time to report claims from incidents that occurred after the policy retroactive date and before the end of the policy period (tail coverage), or

12.9.2. Continuous coverage from the original retroactive date of coverage. The original retroactive date of coverage means original effective date of the first claims–made policy issued for similar coverage while the Provider was under contract with the ADAMH Board.

12.10. Evidence of Coverage If the Provider is not self-insured as permitted under this Agreement, the Provider shall provide the ADAMH Board with a certificate of insurance evidencing each type of coverage required or provided

under Article 12 at the time of renewal, and shall immediately provide the ADAMH Board notice of cancellation or non–renewal of any such.

Article 13. Dispute Resolution

13.1. General Procedures

13.1.1. Dispute resolution procedures under this Article 13 shall apply to disputes arising out of the termination, renewal or non–renewal of this Contract, disputes arising out of services covered by this Contract or disputes arising out of clinical issues which involve member care. All other disputes shall not be subject to any requirement for dispute resolution under this Contract and may be pursued by the parties under applicable law.

13.1.2. The procedures for dispute resolution under this Article 13 shall be completed within 60 days after service of the 120–day notice unless the parties otherwise agree.

13.1.3. Parties shall meet at least once to resolve the issues prior to the expiration of 60 days.

13.1.4. The parties shall engage in good faith efforts to resolve disputes informally.

13.1.5. Either party may require the other party to convene a meeting of the board of the other party to review the dispute.

13.1.6. If the parties cannot agree informally to a resolution of the dispute, the matter shall be submitted to ODBH for further proceedings.

a. Any decision by ODBH shall be non–binding.

b. The decision by ODBH shall be presented to the ADAMH Board and the Provider and shall be made a part of the record of any further proceedings, regardless of forum.

c. In the event that either party rejects the decision of ODBH, then it shall provide written reasons which shall also be a part of the record of any further proceedings, regardless of forum.

13.1.7. Except as otherwise noted provided herein Sections 11.2, 11.6, and 16.1, status quo shall be maintained during review by ODBH through final decision by the ADAMH Board.

13.1.8. The Provider reserves all rights to legal representation and/or court proceedings and does not waive any rights or protections afforded by law or by operation of this contract.

13.2. Clinical Disputes Any dispute regarding clinical issues involving client care shall be initially resolved by the Agency Chief Clinical Officer (“ACCO”) or an individual with equivalent clinical authority. If a dispute arises concerning clinical issues involving appropriate client care under standards agreed to by the parties, then the System Chief Clinical Office (“SCCO”) for the ADAMH Board and the ACCO shall meet to attempt to resolve the matter. In the event the ACCO and SCCO cannot resolve the matter, then the matter shall be referred to a neutral third party selected by agreement of the parties whose decision shall be final and binding. In the event that the parties cannot agree on a neutral third party, the parties shall request that the Medical Director of ODBH appoint such neutral third party.

Article 14. Modification, Renewal and Termination

14.1. Modifications This Contract, including, without limitation, the term, may be modified by the mutual consent of the parties in writing.

14.2. Content of 120–day Notice

14.2.1. In the event that either party is required to provide a 120–day notice under applicable Ohio law, ADAMH Board policies or this Contract, the notice shall include all of the following:

a. A summary of the rationale for the proposed Contract change, non–renewal, or termination and

b. A summary of the following:

i. A summary of the nature and approximate scope of the projected change, and

ii. The approximate timing of the projected change and,

iii. If relevant, a reasonably approximate estimate of the financial impact of the projected change.

14.2.2. The content of the notice required under Section 14.2.1 shall be based on information which is reasonably available at the time of the issuance of the notice and may be supplemented by information after the date of the notice.

14.3. Coordination of Notice Requirements

14.3.1. A 120–day notice of termination or non–renewal, which is served by the ADAMH Board in accordance with the requirements of this Contract, shall satisfy the notice requirements in contracts between ODBH and the ADAMH Board to the extent notices are required in such contracts.

14.3.2. A copy of any notice provided under this Section 14.3 shall be served on the ODBH Office of Fiscal Administration.

14.4. Dispute Resolution Any dispute arising under this Section 14.3 shall be subject to the dispute resolution procedure as set forth in Article 13.

14.5. Non–Renewal In the event either party proposes not to renew this Contract, notice of non–renewal shall be given to the other party at least 120 days prior to the expiration of this Contract.

14.6. Renewal With Contract Changes

14.6.1. If either party proposes to make changes in the terms of this Contract, the party desiring to make such changes shall give the other party notice of the proposed changes in accordance with Chapter 340 of the Ohio Revised Code and at least 120 days before the expiration of this Contract. The notice of proposed changes shall conform to the requirements of Section 14.2.

14.6.2. The parties shall engage in good faith efforts to negotiate a new contract.

14.6.3. In the event the parties are unable to negotiate a new contract, then either party may give the other notice of non–renewal in accordance with Section 14.5, which notice shall be given as soon as practicable.

14.6.4. In the event a notice of non–renewal is served under the circumstances of this Section 14.6, then the Contract shall be extended as necessary to provide the other party with 120 days' notice of termination.

14.7. Termination without 120 Day Notice

14.7.1. This Contract may be terminated by the ADAMH Board without the requirement for a 120–day notice under the following circumstances:

a. In the event of any Provider loss of certification status, the ADAMH Board may terminate sections of the contract consistent with, but not in excess of, the specific certification loss with ODBH;

b. Serious and imminent risk to the health or safety of clients;

c. Bankruptcy, dissolution, receivership or other court order which effectively removes the Provider from control of services;

d. Any audit disclosures of uncertainties about a Provider's ability to continue as a going concern; or

14.7.2. Material, uncured breaches of this Contract.

14.7.3. This Contract may be terminated by the Provider without the requirement for a 120–day notice if the ADAMH Board fails to make reimbursements as required in this Contract.

14.7.4. Procedure

a. If either party believes that the conditions listed in Sections 14.7.1 or 14.7.2 exist, the party shall notify the other party of the fact in writing.

b. Immediately upon notification, the parties shall arrange a meeting with ODBH to review whether conditions warranting termination exist.

c. In the event ODBH agree the conditions warranting termination exist, the parties shall cooperate in an immediate transfer of services to an alternative Provider, if applicable. If ODBH does not agree that conditions warranting expedited termination exist, then the matter will be resolved in accordance with Article 13 for as long as services under this Contract continue to be delivered by the Provider, the Provider will be reimbursed for its services.

14.8. Transition Requirements Continue In the event that services are terminated under Section 14.7 the requirements of Article 9 shall remain in full force and effect until the completion of the transition.

Article 15. Duties of Designated Agencies Under O.R.C. Chapter 5122 – Hospitalization of Mentally Ill

15.1. General Requirements

15.1.1. The Provider shall provide such services as the SCCO shall designate in writing in accordance with the requirements of O.R.C. Chapter 5122 and this Article 15.

15.1.2. Services designated by the SCCO to be provided by the Provider under this Section 15.1 shall be provided to all eligible clients.

15.1.3. Services shall include only those which have been designated by the SCCO to be the responsibility of the Provider. Designated services may include the following:

a. Evaluation and approval of all voluntary admissions to psychiatric hospitals as required by O.R.C. §5122.02(B).

b. Evaluation of all emergency admissions to any hospital as required by O.R.C. §5122.05(A).

c. Upon request by the ADAMH Board, evaluation of all affidavits referred by probate court as required by O.R.C. §5122.13.

d. Upon request by the ADAMH Board, evaluate, examine and produce a report of findings to the probate court as required by O.R.C. §5122.14.

e. Treatment of all clients committed to the Provider pursuant to O.R.C. §5122.15 or committed to the ADAMH Board pursuant to O.R.C. §5122.15 and referred to the Provider by the ADAMH Board.

15.2. Acceptance of Court Commitments. In the event that the Provider has been designated by the SCCO to receive commitments from the Probate Court, or if the commitment has been made to the ADAMH Board and the SCCO has designated the Provider to provide treatment, the ACCO shall ensure that the requirements of this Section 15.2 are met.

15.2.1. *General Requirement*. The Provider shall provide or arrange for all available treatment, facilities and services required by clients who have been either:

a. Committed to the Provider under O.R.C. §5122.15(C), or
b. Committed to the ADAMH Board and placed by the SCCO at the Provider for treatment.

15.2.2. Outpatient Commitment Response Timeframe: The Provider shall provide an outpatient service in the community within seven (7) days of notification that a client has been committed to the Provider or committed to the ADAMH Board and placed by the SCCO at the Provider for treatment. An appointment with the psychiatric provider within fourteen (14) days notification that a client has been committed to the Provider of committed to the ADAMH Board and placed by the SCCO at the Provider for treatment.

15.2.3. *Notice of Final Disposition.* The ACCO shall notify the SCCO, counsel for the client, and the court of the final placement within three (3) working days after the placement is made.

15.3. Applications for Continued Commitment

15.3.1. The ACCO shall notify the SCCO of the necessity for further commitment pursuant to court order not less than twenty days prior to the expiration of time limits set forth in O.R.C. §5122.15(H).

15.3.2. The ACCO shall notify the SCCO of the request to discontinue the commitment pursuant to the court order not less than twenty (20) days prior to the expiration of the time limits set forth in O.R.C. §5122.15(H).

15.3.3. The ACCO shall prepare all applications for continued commitment required under O.R.C. §5122.15(H) within the time limits set forth in the statute. A copy of such application shall be provided to counsel for the client and counsel for the ADAMH Board.

15.4. Availability of Records The ACCO shall ensure that all records required to provide treatment or services to the client are transferred in a timely manner.

15.5. Change of Status The ACCO may accept an application for voluntary treatment from any client committed by the court to the ADAMH Board. Upon acceptance of such application, the ACCO shall provide notice of such acceptance as required by O.R.C. §5122.15(G)(1).

15.5.1. If at any time after the first ninety-day period the ACCO determines that the client has demonstrated voluntary consent for treatment, the ACCO shall provide notice as required by O.R.C. §5122.15(H).

15.6. Evaluation and Approval of Voluntary Admissions

15.6.1. In the event that the Provider has been designated by the SCCO to evaluate and approve voluntary admissions to public hospitals, the ACCO shall ensure that the requirements of this Section 15.6 are met.

15.6.2. The ACCO shall review all applications for voluntary admission to the hospitals and approve such admissions as the ACCO deems appropriate using standard industry practices.

15.6.3. Evaluations shall be completed within four court hours after application.

15.6.4. The ACCO shall submit monthly reports to the ADAMH Board on evaluations and approvals of admissions under this Section 15.6.

15.7. Evaluation of Affidavits Referred by Probate Court In the event that the Provider has been designated by the SCCO to evaluate and approve affidavits referred by the Probate Court, the ACCO shall ensure that the requirements of this Section 15.7 are met.

15.7.1. The ACCO shall review all affidavits referred by the Probate Court for involuntary commitment.

15.7.2. Evaluations shall be completed no later than three (3) days after referral or at such other time as is specified by the Probate Court.

15.7.3. The ACCO shall report the results of evaluations of affidavits to the Probate Court and to the ADAMH Board.

15.8. Evaluation of Emergency Admissions

15.8.1. In the event that the Provider has been designated by the SCCO to evaluate and approve emergency admissions, the ACCO shall ensure that the requirements of this Section 15.8 are met.

15.8.2. The ACCO shall review all applications for emergency admission to all hospitals and approve them as the ACCO deems appropriate using standard industry practices.

15.8.3. Evaluations to determine whether emergency admissions are in compliance with criteria under Ohio Revised Code Chapter 5122 shall be completed in advance of admissions where possible, but in no case longer than 72 hours after admission.

15.8.4. The ACCO shall ensure that prompt reports are made orally, by fax transmittal or in writing to the facility receiving the emergency admission immediately upon completion of the evaluation. The report shall include the following information:

a. Name of the client,
b. Date of admission,
c. Place of admission,
d. Conclusion on whether the client is mentally ill, subject to hospitalization by court order, with specific facts to support the conclusion,
e. Recommendation for the least restrictive alternative, with specific facts to support the recommendation.

15.8.5. The ACCO shall submit a written summary report of evaluations of emergency admissions to the ADAMH Board each month. Such summary reports to the ADAMH Board shall include the name of the client, the date of admission, the place of admission, the results of the evaluation, the expected discharge date and the name of the assigned community support worker.

15.9. Evaluation of Appropriateness for Outpatient Commitment

15.9.1. In the event that the Provider has been designated by the SCCO to evaluate clients for outpatient commitment, the ACCO shall ensure that the requirements of this Section 15.9 are met.

15.9.2. The ACCO shall review all requests for outpatient commitment referred by the Probate Court for consideration of appropriateness for outpatient commitment using standard industry practices (ORC 5122.01).

15.9.3. An evaluation to determine whether the client meets criteria for outpatient commitment shall be completed no later than three (3) days after referral or at such other time as is specified by the Probate Court.

15.9.4. The ACCO shall report the results of evaluations to the Probate Court and the SCCO in the form of a written report, in open court or in chambers, or as directed by the Probate Court. This report shall contain the following information:

a. If the client is a mentally ill individual subject to court-ordered treatment.
b. What is the least restrictive environment that is appropriate for treatment.
c. The availability of appropriate treatment alternatives.
d. Additional information as directed by the Probate court.

15.10. Hearings before Probate Court In the event that the Provider has been designated by the SCCO to accept commitments from the Probate Court, or if the SCCO has determined that the Provider has information which is necessary to present a case before the Probate Court, the ACCO shall ensure that the requirements of this Section 15.10 are met.

15.10.1. The Provider shall cooperate with the attorney for the ADAMH Board in the preparation and presentation of the case.

15.10.2. The Provider shall make necessary documents and personnel available to the attorney, subject to all requirements of privilege and/or confidentiality that apply under Federal law, State law, or ADAMH Board policies.

15.11. Notices The ACCO shall be responsible for providing all notices required under this Contract and O.R.C 5122 for clients committed by court order. Notices shall conform to the requirements of the court, O.R.C 5122 and other applicable law. Unless this Contract or applicable law requires otherwise, notices to the ADAMH Board shall be addressed to the SCCO in writing and shall be made within ten days of the event required to be reported.

15.12. Periodic Evaluations The ACCO shall evaluate all clients committed by the court to the ADAMH Board. Such evaluations shall be conducted in accordance with the requirements of O.R.C 5122 and ADAMH Board policies. The ACCO shall discharge all clients found not to be mentally ill clients subject to court order as defined by O.R.C. §5122.01(A) and (B).

15.13. Transfers

15.13.1. All transfers to a less restrictive setting shall be at the discretion of the ACCO.

15.13.2. The ACCO shall ensure that any transfer to a more restrictive setting is carried out in accordance with procedures required under O.R.C 5122 and shall transport or arrange for the transport of clients.

15.14. Lead Agency Involvement In situations where the ACCO involved in the processes described herein is not the lead agency ACCO for the client, the lead agency ACCO will receive all pertinent information and be involved in these processes as possible and appropriate.

Article 16. Lead Providers Serving Adults with Serious Persistent Mental Illness

16.1. Assignment, Acceptance and Transfer of Clients with SPMI For those Providers who have entered into the Continuity of Care Agreement with ADAMH and Central Ohio Behavioral Healthcare, the following shall apply:

16.1.1. *Lead Provider Assigned* Central Ohio Behavioral Healthcare, all other ODBH Regional Psychiatric Hospitals, The Ohio State University, Riverside Methodist Hospital, the Franklin County Crisis Care Center (FCCCC), and the Crisis Stabilization Unit (CSU) will link new clients to a Lead Provider for all clinically appropriate community services and care coordination.

a. The FCCCC/hospitals/CSU shall work with the client to make an assignment that considers client choice and needs, and that considers provider location, services and service capacity.

b. The Lead Provider shall be subject to the requirements of Article 15.14 only during the period when the client's claims and enrollments system eligibility record reflects assignment of the client to the Lead Provider.

c. The effective date of Lead Provider assignment shall be the later date of either:

i. client hospitalization, or

ii. Provider notification of the assignment from COBH;

iii. Client's Consent for Treatment documented on the COBH Supplied Consent Form.

16.1.2. *Acceptance of Clients* The Lead Provider shall accept all clients with SPMI assigned by the participating hospital/FCCCC/CSU and shall provide services to such clients under this Contract. Services will be rendered as outlined in the Providers' ASP and the Continuity of Care Agreement. Services shall be provided to all clients until the client is transferred or terminated in accordance with Section 4.8.

a. The Provider agrees to:

i. Accept all referrals from participating hospitals, FCCCC, and the CSU consistent with Section 4.8 of this Contract and commensurate with proportion of allocation for this service, including referrals of clients with no payor source.

ii. Keep participating hospitals and crisis stabilization units informed of names and contact information for hospital linkage clinicians, clinical supervisors and others performing work under this agreement.

b. If the Provider violates this Section 16.1 and refuses referrals the ADAMH Board shall document such violations. The ADAMH Board may review the pattern of referrals and may take appropriate action, including, but not limited to suspending future referrals and withholding ADAMH–service payments.

c. If there are disputes, regarding Section 16.1, the Provider shall provide services to the client until the dispute is resolved. Reimbursement for services under dispute shall be made in accordance with applicable requirements.

16.1.3. *Client Request for Another Lead Provider* In the event that the client requests a transfer to another Lead Provider, the Lead Provider shall encourage the client to address any concerns with the client's current Lead Provider. The current Lead Provider shall cooperate fully in the transfer to the new Lead Provider, including, but not limited to the transfer of records and other information to ensure continuity of care, subject to the requirements of applicable law.

16.2. Inpatient/Crisis Care Utilization This Section 16.2 applies to all clients assigned to the Lead Provider in accordance with Section 16.1.1.

16.2.1. The following procedures outline the utilization and monitoring of inpatient and crisis care use:

a. The Lead Provider shall have a Strategic Action Plan for Crisis and Hospitalization Management, updated annually, that is focused on risk reduction, programmatic efficiency, fiscal management, and achieving clinically sound and satisfying results for clients and families. The plan shall offer well–defined strategies for the crisis prevention, crisis intervention and resolution, and crisis post–intervention phases and shall identify the specific clinical, utilization management, technological and fiscal action steps, timelines and lead persons responsible for plan implementation. The Board and Provider shall routinely monitor the effectiveness of the plan.

b. The Lead Providers shall work with COBH and other hospitals identified in 16.1.1 to conduct discharge planning in a timely manner.

c. The ADAMH Board reserves the right to conduct utilization reviews on hospitalized individuals and will work with the hospital staff and the Lead Provider staff when it is determined that further action is warranted. The results of the ADAMH Board's utilization review will be forwarded to the lead provider within three (3) business days of the review.

d. The Provider, the hospital and the ADAMH Board will work together to coordinate utilization review.

16.2.2. If the Lead Provider disagrees with any decision made by the staff at COBH which affects the Lead Provider under this Contract, the Clinical and Discharge Dispute Process in the Continuity of Care Agreement shall be used to seek resolution to this disagreement.

16.3. Residential Care Facilities and Service Enriched Housing Providers shall ensure continuity of care for all clients residing in ADAMH–funded Residential Care Facilities and Permanent Supportive Housing units.

Article 17. Miscellaneous

17.1. Attachment Incorporation The attachments are hereby incorporated as a part of this Contract. In the event that any section of any attachment is inconsistent with any requirement of this Contract, the terms of this Contract shall be binding on the parties unless otherwise legally required.

17.2. Debarment and Suspension The Provider certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this agreement by any federal department or agency.

17.3. Entire Agreement It is acknowledged by the parties hereto that this Contract supersedes any and all previous written or oral agreements between the parties concerning the subject matter of this Contract.

17.4. Severability Should any portion of this Contract be deemed unenforceable by any administrative or judicial officer or tribunal of competent jurisdiction, the balance of this Contract shall remain in full force and effect unless revised or terminated pursuant to Article 14 of this Contract.

17.5. Notices All notices, requests and approvals shall be made in writing and shall be deemed to have been properly given if and when personally delivered or sent, postage prepaid, by certified mail:

TO: ERIKA CLARK JONES, CEO
ADAMH BOARD OF FRANKLIN COUNTY
447 E BROAD ST
COLUMBUS OH 43215-3822

TO: DR. MYSHEIKA ROBERTS, HEALTH COMMISSIONER
COLUMBUS PUBLIC HEALTH
240 PARSONS AVE.
COLUMBUS, OH 43215-5331

17.6. Governing Law of Ohio. This Contract shall be governed by the laws of the State of Ohio (regardless of the laws that might be applicable under principles of conflicts of law) as to all matters, including but not limited to matters of validity, construction, effect and performance. Any action arising from or related to this Contract shall be brought only in a court of competent jurisdiction located in Franklin County, Ohio.

17.7. Captions The paragraph captions and headings in this Contract are inserted solely for the convenience of the parties and shall not affect the interpretation or construction of this Contract or any of the terms of this Contract

17.8. Waiver The waiver of breach of any term of this Contract shall not be interpreted as waiver of any other term of this Contract.

17.9. Electronic Signatures This Contract may be executed by electronic signatures or signatures delivered through electronic facsimile. The parties shall use commercially reasonable efforts to deliver to each other a fully executed original following the initial closure of the Contract through facsimile or electronic copies. Copies of such signatures so delivered shall be deemed originals.

17.10. Cyber Breach Provider and ADAMH Board (each a "Party" and collectively the "Parties") shall have a plan and adequate resources to address telecommunications and computer systems breach, and shall maintain intrusion detection services and procedures and/or data breaching systems to detect and address "hacking" and "phishing operations" into each Party's telecommunications system, that includes services and systems to detect any unauthorized access to or unauthorized activity on each Party's telecommunications system, networks, computer systems, and network devices associated with the use of and access to ADAMH's management systems, databases, and ADAMH information and data. Each Party will ensure that all intrusion detection measures and data breach systems are maintained and functional on a regular basis. Each Party shall notify the other Party, as soon as reasonably possible, of its detection of any potential or suspected intrusions that may affect the other Party with regard to disbursement of payments or access to ADAMH systems, networks, data, or information. Failure by either Party to provide this notification shall be a breach under the contract.

17.11. Off Shore By Provider's signatures hereto, Provider affirms that it does not have an offshore presence in a specific country with which the United States has a declaration of war by Congress or the President has authorized war on a specific country.

17.12. Unresolved Findings of Recovery Ohio Revised Code (O.R.C.) §9.24 prohibits the ADAMH Board from awarding a contract to any party against whom the Auditor of the State has issued a finding for recovery if the finding for recovery is "unresolved" at the time of the award. By signing this Agreement, Provider warrants that it is not now, and will not become subject to an "unresolved" finding for recovery under O.R.C. §9.24.

17.13. Anti–Discrimination Provisions Per Ohio Revised Code, Provider warrants and agrees to the following:

17.13.1. That in the hiring of employees for the performance of work under the contract or any subcontract, Provider shall not, by reason of race, color, religion, sex, sexual orientation, Vietnam–era veteran status, age, handicap, national origin, or ancestry, discriminate against any citizen of this state in the employment of a person qualified to perform the work in which the contract relates; and

17.13.2. That neither Provider nor any of its subcontractors or any person acting on behalf of Provider shall in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of work under the contract on account of race, color, religion, sex, sexual orientation, Vietnam–era veteran status, age, handicap, national origin, or ancestry.

17.13.3. Provider warrants that it has a written affirmative action program for the employment and effective utilization of economically disadvantaged persons, as defined in section 122.71 of the Ohio Revised Code. Annually, Provider shall file a description of the affirmative action program and a progress report on its implementation with the Ohio civil rights commission and the minority business development office established under section 122.92 of the Ohio Revised Code.

17.14. Independent Status of the Provider

17.14.1. The parties will be acting as independent contractors. The partners, employees, officers, and agents of one party will act only in the capacity of representatives of that party and not as employees, officers, or agents of the other party and will not be deemed for any purpose to be such. Each party assumes full responsibility for the actions of its employees, officers, and agents, and agents while performing under this Contract and will be solely responsible for paying its people. Each party will also be alone responsible for withholding and paying income taxes and social security, workers compensation, disability benefits and the like for its people. Neither party will commit, nor be authorized to commit, the other party in any manner.

17.14.2. The Provider shall have no claim against ADAMH for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or other employee benefits or any kind.

[*No further text on this page; signature page follows.*]

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their duly authorized officers as of the day and year first above written.

The Alcohol, Drug And Mental Health Board Of Franklin County

Erika Clark Jones, CEO
Alcohol, Drug and Mental Health Board of Franklin County

Columbus Public Health

Mysheika W. Roberts

Dr. Mysheika Roberts, Health Commissioner Signature

Mysheika W. Roberts, MD, MPH Columbus

Provider CEO Name (Print)

NPI NUMBER (NPID): 1811080096

UNIQUE ENTITY ID (SAM.GOV): FAMWPY11Z6K8

APPROVED AS TO FORM:

Shayla D. Favor
Prosecuting Attorney
Franklin County, Ohio

By: Jeanine Hummer
Assistant Prosecuting Attorney

Date: 01/05/2026

SUMMARY OF ATTACHMENTS

Attachment	Description
A	Allocation summary identifying MH and SUD allocations by ADAMH–services and by block grants.
B	Essential Reports and Data Submissions
C	ADAMH Board Insurance Limits
D	ADAMH Board Contract Reconciliation Procedures
E	Outcome Data Submissions
F	ODBH Contract Agency Assurance Statement, Certifications and Disclosure of Lobbying Activity

The ADAMH Board may exclude individual attachments not applicable to specific providers from this contract.

ATTACHMENT B
ESSENTIAL REPORTS AND DATA SUBMISSIONS

If the 15th of the month falls on a weekend or ADAMH recognized holiday, reporting due that day will be due the following business day.

Title	Applicable Provider Agencies	Frequency	Required By	Due Date(s)
ADAMH Crisis Intake and Discharge Report	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for discharges that occurred during the prior calendar month
ADAMH Risk & Resilience Questionnaire Data	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
ADAMH Transitional Housing Move-Out Report	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for move-outs that occurred during the prior calendar month
AOT/Forensic Monitors Update Report	Central Ohio Behavioral Healthcare Community Support Network	Monthly	ADAMH	15th of each month
Brief Addiction Monitor Data	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
Client Roster	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for program enrollments occurring during the prior calendar month

If the 15th of the month falls on a weekend or ADAMH recognized holiday, reporting due that day will be due the following business day.

Title	Applicable Provider Agencies	Frequency	Required By	Due Date(s)
OQ Measures OQ-45.2 Data	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
OQ Measures Y-OQ 30.2 Data	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
Perceived Stress Scale	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
Recovery Assessment Scale	Providers of identified ADAMH-funded services; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Monthly	ADAMH	15th of each month for expected outcomes administrations occurring during the prior calendar month
SUD Pregnant Women Referral Tracking	Substance Abuse Prevention and Treatment Block Grant (SAPT)-funded providers	Monthly	ADAMH	15th of each month for prior calendar month service referrals
Residential Care Facility (RCF) Aggregate Occupancy Report	Providers operating RCF(s)	Monthly	ADAMH	15th of each month for prior calendar month occupancy details
Client Complaints & Grievances Reports	All	Quarterly	ADAMH	1st Q - April 15, 2026 2nd Q - July 15, 2026 3rd Q - October 15, 2026 Year-end Report - January 15, 2027

If the 15th of the month falls on a weekend or ADAMH recognized holiday, reporting due that day will be due the following business day.

Title	Applicable Provider Agencies	Frequency	Required By	Due Date(s)
Aggregate Client Count and Demographics Report	Providers delivering services to clients not uniquely enrolled in the current claims and enrollments system; see section 7.6.2 and Attachment E of this contract; refer to the outcomes expectations memo supplied by the ADAMH Board	Annually	ADAMH	Programs operating on a calendar year: February 1, 2027 Programs operating on an academic year: June 30, 2026 Summer programming; September 15, 2026
ODBH Block Grant Expenditure/GFMS Reports	ODBH-funded providers	Quarterly	ODBH	As specified
Provider Audit Corrective Action Plan Updates	As indicated	As specified	ADAMH	As specified
Six Month Incident Data Report	All	Semi-annually	ADAMH; ODBH	1st Six Months - July 31, 2026 2nd Six Months - January 31, 2026
Evidence of Insurance Coverage	All	Annually	ADAMH; ODBH	As specified
Federal & State Block Grant Year-End Fiscal & Service Reports	Recipients of pass-through state or other government funds	Annually	ODBH; Other Government Entity	As specified
Block Grant Funding Request Forms	All	Monthly	ADAMH	15th of each month for payments to be processed by said month's end; February 15, 2027, for final KY26 request
Exempt Block Grant Expense Reports	All	Quarterly	ADAMH	May 15, 2026 August 15, 2026 November 15, 2026 February 15, 2027
Annual Expense Report	All	Annually	ADAMH	February 15, 2027
Financial and Compliance Audit	All	Annually	ADAMH; ODBH	6 months after Provider's fiscal year end

If the 15th of the month falls on a weekend or ADAMH recognized holiday, reporting due that day will be due the following business day.

Title	Applicable Provider Agencies	Frequency	Required By	Due Date(s)
Signed Contract Year Expenditure/Payment Reconciliation Report	All	Annually	ADAMH	As specified
Notice of Placement in Residential Facility	Providers admitting individuals in residential facility	As needed	ODBH	Within 7 days of the resident's admission

ATTACHMENT C
INSURANCE LIMITS

Treatment Providers

Note: ADAMH Board of Franklin County shall be named as an additional insured for all coverages listed below:

A. General Liability

1. In an amount of at least $1,000,000 each occurrence/$3,000,000 general aggregate
2. In an amount of at least $3,000,000 products aggregate. Coverage shall include any volunteers employed by the provider.

B. Professional Liability

In an amount of at least $1,000,000 on each claim/$3,000,000 annual aggregate. Occurrence form if available. If Claims–Made form, then must have continuous retroactive coverage from date the first policy was written. Coverage shall include any volunteers providing professional services for the agency.

C. Employers' Liability

In an amount of at least $100,000 each person/$100,000 each injury or disease/$500,000 each policy.

D. Automobile

1. In an amount of at least $1,000,000 Combined Single Limits for vehicles not carrying passengers.
2. In an amount of at least $3,000,000 Total Limits (Auto and Umbrella) for vehicles/vans carrying up to 10 passengers at any one time.
3. In an amount of at least $5,000,000 Total Limits (Auto and Umbrella) for vans/busses carrying more than 10 passengers at any one time. $1,000,000 Combined Single Limits for Non-Owned and Hired Automobile if provider has exposure for this liability.

E. Workers' Compensation

As required by the State of Ohio

F. Employee Dishonesty

Limits should be equal to the amount of funds passed on to the Provider or $2,000,000, whichever amount is less.

G. Directors and Officers and/or Errors and Omissions Insurance

1. In an amount of at least $1,000,000 each occurrence/$3,000,000 general aggregate
2. In an amount of at least $3,000,000 products aggregate. Coverage shall include any volunteers employed by the Provider

H. Cyber

In an amount of at least $1,000,000 each occurrence/$1,000,000 general aggregate limit.

INSURANCE LIMITS

Non–Treatment Providers

Note: ADAMH Board of Franklin County shall be named as an additional insured for all coverages listed below:

A. General Liability

1. In an amount of at least $500,000 each occurrence/$1,000,000 general aggregate.
2. In an amount of at least $1,000,000 products aggregate. Coverage shall include volunteers employed by the Provider.

B. Automobile

In an amount of at least $1,000,000 Combined Single Limits for Non-Owned and Hired Automobile if provider has exposure for this liability.

C. Workers Compensation

As required by the State of Ohio.

INSURANCE LIMITS

Non–Treatment Providers Who Transport Clients

Note: ADAMH Board of Franklin County shall be named as an additional insured for all coverages listed below:

A. General Liability

1. In an amount of at least $1,000,000 each occurrence/$3,000,000 general aggregate
2. In an amount of at least $3,000,000 products aggregate.
3. Coverage shall include any volunteers employed by the Provider.

B. Automobile

1. In an amount of at least $1,000,000 Combined Single Limits for vehicles not carrying passengers.
2. In an amount of at least $3,000,000 Total Limits (Auto and Umbrella) for vehicles/vans carrying up to 10 passengers at any one time.
3. In an amount of at least $5,000,000 Total Limits (Auto and Umbrella) for vans/busses carrying more than 10 passengers at any one time. $1,000,000 Combined Single Limits for Non-Owned and Hired Automobile if Provider has exposure for this liability.

C. Workers Compensation

As required by the State of Ohio.

D. Cyber

In an amount of at least $1,000,000 each occurrence/$1,000,000 general aggregate limit.

SELF INSURANCE

Notwithstanding the foregoing, any Provider with a total annual revenue of at least five hundred million dollars ($500,000,000.00), or any provider which is the State of Ohio or any department, board, office, agency, or other instrumentality thereof, or any political subdivision of the State of Ohio, may self-insure to meet the minimum insurance requirements of Article 12 and this Attachment C. Providers who do not meet the foregoing requirement may make a request to the ADAMH Board to self-insure to meet the minimum insurance requirements of Article 12 and this Attachment C, which request may be approved or denied by the ADAMH Board in its sole discretion.

ATTACHMENT D
CONTRACT RECONCILIATION PROCEDURES

A. Purpose: To ensure that ADAMH Board payments equal amounts earned through claims submission, block grant reports, and state reported expenses.

B. Expenditure/Payment Reconciliation Procedures:

1. Timelines—Expenditure/Payment Reconciliation:

   a. The expenditure/payment reconciliation will begin in the first week in March. Reconciliation schedules will be sent to Providers by April month end.

   b. Block grant payment reconciliation will begin as soon as Provider's year–end block grant expense reports are received, and payments are made. To ensure accurate and timely contract payment reconciliation, the Provider shall submit its correctly completed final Block Grant Funding Request and Block Grant Expense Report for the year no later than the contractual claim file submission deadline. ADAMH shall not accept any block grant reports after this deadline. The Provider shall forfeit any funds not drawn down or reported as expenses by this deadline

   c. Reconciliation payments between ADAMH and the Provider will not occur until a "final" reconciliation schedule is obtained by the ADAMH Board of Franklin County via one of the following:

      i. A signed reconciliation schedule showing agreement with the reconciled totals, or

      ii. By May month–end, no written disagreement has been submitted by the Provider

   d. If payment is due from the ADAMH Board, payment will be remitted within 60 days of receiving the signed reconciliation schedule.

   e. If payment is due from the Provider, the ADAMH Board will invoice the Provider within 60 days of receiving the signed reconciliation schedule.

   f. On receipt of an ADAMH Board invoice, the Provider will remit payment to the ADAMH Board within 60 days. If the Provider is unable to pay in full within 60 days, arrangements can be made for extended repayment. If payment is not remitted in the full receivable amount listed on reconciliation schedule within 60 days of the invoice, and the Provider has not arranged for extended repayment, the ADAMH Board will hold payments until repayment is received. If the Provider fails to honor the terms of any extended repayment plan, the ADAMH Board will hold payments until repayment currently due is received.

2. Expenditure/Payment Reconciliation

   a. The ADAMH Board will prepare an Expenditure/Payment Reconciliation Schedule for each Provider.

   b. The Expenditure/Payment schedule will reflect actual block grant expenses through year–end Block Grant Funding Request Forms, actual encounter claimed block grant expenses and accepted/approved units through the current claims and enrollments system and State Reports (i.e. Ohio Pharmacy Service Center/Central Pharmacy). The expenses will be compared to ADAMH allocations and ADAMH payments.

   c. Required claiming allocations (Non Exempt)

      i. For levy funds, the Provider will need to submit encounter claims data representing 90% of the allocation in order to receive 100% of allocated funds for the contract year.

Encounter Claim Value	Ending Cash Paid
<50% of allocated levy funds	$1-for-$1 with what is encounter claimed

50-<90%	Encounter claim value + 10% allocated levy funds
90%+	100% of allocated levy funds

ii. Non-levy funds will be paid $1 for $1 based on encounter claim value

iii. Providers who have not submitted encounter data as noted above for approved units as defined in Attachment A for each Contract Year 2026 block grant may be required to reimburse ADAMH for unearned/unclaimed payments from ADAMH.

iv. Encounter claims must be for services delivered from January 1 through December 31 for the contract year being addressed.

v. Encounter claim submissions must be in compliance with all of the other contractual claiming requirements (e.g. contractual claim file deadline, billing terms, etc.)

d. All other allocations (Exempt and Exempt from 90%Threshold (or "Exempt 90% T"))

i. ADAMH Board of Franklin County exempt and exempt 90%T levy, local, state, and federal allocations will be compared to actual reported expenditures for reconciliation. Differences will be reflected in the schedule as ADAMH payable to the Provider or ADAMH (receivable) from the Provider.

e. Upon receipt of the ADAMH prepared reconciliation schedule, the Provider will review for accuracy. If the schedules represent an accurate statement, the Provider's executive director will sign and date the schedule. The signed original will be returned to the ADAMH Board, where a payment or an invoice may be generated based on the reconciliation.

3. Incentive Payment Requirements and Reconciliation

a. Incentives reimbursed via Block Grants are subject to all requirements of Attachment D, Sections B(1) and B(2).

4. Federal Funds Report Summary

a. For Federal funding sources, ADAMH will prepare upon request a summary for each payment group and federal fund.

b. The schedule will reflect an accrual basis of accounting.

c. The schedule will show the Assistance Listing Number (ALN) (ALNs have replaced Catalogue of Federal Domestic Assistance (CFDA) numbers) as required under federal auditing guidelines.

d. All federal funds paid to the Provider for the Fiscal Year will be listed by payment group.

e. Upon receipt of the ADAMH prepared Federal schedule, the Provider will review this information for accuracy.

ATTACHMENT E
OUTCOMES DATA SUBMISSIONS

General Scope

Provider shall submit any data collected according to the specifications outlined in this attachment. The data expectations below are based on the standardized ADAMH evaluation framework measures of client outcomes and client volumes/demographics. Reporting expectations for each system of care and identified programs/services are specified in the outcomes expectations memo delivered with approved provider budgets. (Please note that the outcomes expectations memo may be revised and delivered to the Provider in the event of significant funding changes approved and agreed upon by the Provider and Board.) These outcome data submissions apply to client-oriented ADAMH-paid services, i.e., direct services delivered to one or more individuals. The following types of investments are **EXCLUDED** from the scope of these data expectations:

- Advertising/marketing campaigns (Z5042, Z5045)
- Capacity building or infrastructure
- Capital improvements
- Operational or administrative expenses
- Planning and consultation (Z1658, Z1665, Z1727, Z1985, Z4002, Z5110)
- Sponsorships or awards
- Supplies and materials (Z2028)
- Systems-level/macro practice (Z5016, Z5017, Z5019, Z5020, Z5021, Z5025, Z5028, Z5044, Z5060, Z5111, Z5117, Z5129)

All categories

Client counts and demographics

Client volume and demographic characteristics are vital to accurately assessing outcomes and the equity of delivered services. For claims involving enrolled clients, client volume and demographic characteristics will be derived from client records and associated ADAMH-paid claims in our claims and enrollments system. For claims involving organizational clients, two separate data collections are outlined here.

- Aggregate Client Count and Demographics
    - **Contributes to performance measures**: number of clients served; equity analysis
    - **Applicable population**: Individuals receiving prevention, recovery supports, or family supports services which are claimed for the organizational client type or equivalent funded through an exempt allocation
    - **Data collection**: tracked by service location/site as services are rendered
    - **Data submission**: Submit aggregate client counts and demographics once per year, per program via ADAMH online form. Each program will have one deadline based on program operations (academic year, summer, or calendar year) as specified on the Provider's outcomes expectations memo.
- Client Roster with Demographics
    - **Contributes to performance measures**: number of clients served; equity analysis
    - **Applicable population**: Individuals receiving one-on-one supports in the family supports system of care category (Family Advocate Program, Mentor Program)
    - **Data collection**: tracked by service location/site as services are rendered
    - **Data submission**: Submit roster and demographics monthly via ADAMH-supplied Excel workbook template

Client Satisfaction

Providers in all system of care categories shall promote our client satisfaction survey during two identified periods per year. No later than 30 days prior to the survey period start, ADAMH will notify Providers of the survey period window, supply guidance on the client populations to be surveyed, and make surveying materials available to Providers. Providers will distribute the surveying materials according to ADAMH guidelines during the surveying period. ADAMH will publish a report of the survey results at least once per year.

System of Care Category: Crisis Services

Discharge disposition

Measures the proportion of clients receiving ADAMH-funded services who are discharged and not placed in inpatient or other similarly restrictive, costly level of care.

- **Contributes to performance measure:** increased discharges to lower acuity levels of care
- **Applicable population:** Individuals receiving at least one of the following crisis services:
  - Psychiatric urgent care and observation (Z3036, Z3040)
  - Crisis stabilization (Z3004, Z3007, Z3037, Z3041)
  - Short-term MH residential (Z3030, Z3038, Z3042)
- **Data collection:** document information at discharge
- **Data submission**: Submit aggregate counts of discharges, dispositions, and client demographics each month via ADAMH online form
- **Output for monitoring:** number of clients with a reported discharge disposition

System of Care Category: Family Supports

Perceived Stress Scale (PSS)

A 10-item global self-report assessment of stress developed by Cohen, Kamarck, & Mermelstein.

- **Contributes to performance measure:** reduced stress
- **Applicable population:** individuals receiving respite services (Z1977, Z1990) or one-on-one supports (Family Advocate Program, Mentor Program)
- **Data collection:** administer online at intake (baseline) and 90 days later (follow-up)
- **Data submission:** Submit individual responses each month via ADAMH online from or ADAMH-supplied Excel workbook template
- **Output for monitoring:** number of baseline and follow-up administrations matched to an individual receiving qualifying services (administration of PSS must occur within 365 days of intake)

System of Care Category: Housing

Move-out disposition

Disposition indicating whether permanent housing was obtained at move-out.

- **Contributes to performance measure:** positive transition from temporary housing
- **Applicable population:** residents of transitional housing (Z1966, Z0300), temporary housing (Z1112), or recovery residence (Z0911, Z0912).
- **Data collection:** document information at move-out
- **Data submission:** Submit aggregate counts of move-outs, dispositions, and client demographics each month via ADAMH online form
- **Output for monitoring:** number of clients with a reported move-out disposition

System of Care Category: Prevention

ADAMH Risk & Resilience Questionnaire

An instrument that combines the personal resilience subscale of the Child & Youth Resilience Measure-Revised (CYRM-R) with AOD risk items aligned to Ohio Healthy Youth Environments Survey (OHYES) assessment of substance use behaviors.

- **Contributes to performance measures**: increased knowledge of risk of using alcohol & other drugs, increased resiliency
  Applicable population: Participants in youth-oriented prevention programming as identified based on the Provider's Agency Services Plan and specified on the Provider's outcomes expectations memo
- **Data collection**: administer at end of service (post-only)
- **Data submission**: Submit individual responses each month via ADAMH online form
- **Output for monitoring**: number of questionnaire responses

System of Care Category: Recovery Supports

Recovery Assessment Scale (RAS) (24-Item)

Self-report assessment of factors related to progress in recovery.

- **Contributes to performance measure:** improved or maintained recovery

- **Applicable population:** Adults (age 18 and older) receiving at least one of the following recovery support services:
    - Peer support (H0038, Z1703)
    - Clubhouse (H2031)
    - Employment services (H2023, Z1300, Z1301, Z1302, Z1303, Z1304, Z1306)
    - Financial counseling (Z1975)
    - Individualized recovery supports (Z0171)
    - Supportive services in a housing setting (Z1251, Z1970)
- **Data collection:** administer at intake and every 6 months until discharged
- **Data submission:** Entry in OQ-Analyst or dedicated online collection system, either directly or via electronic health record system integration, transmitted to ADAMH at least monthly
- **Output for monitoring:** number of RAS administrations matched to an individual receiving qualifying services

System of Care Categories: Recovery Supports and Treatment

Brief Addiction Monitor (BAM)

Self-report assessment of substance use, risk, and protective factors.

- **Contributes to performance measure:** reduced substance use
- **Applicable population:** Adults (age 18 and older) with a substance use disorder (SUD) diagnosis (not including nicotine) on their claims receiving at least one of the treatment and/or recovery support services as described under OQ-45.2 or Recovery Assessment Scale above.
- **Data collection:** administer at intake and every 6 months until discharged
- **Data submission method:** Entry in OQ-Analyst system, either directly or via electronic health record system integration, transmitted to ADAMH at least monthly
- **Output for monitoring:** number of BAM administrations matched to an individual receiving qualifying services

System of Care Category: Treatment

OQ Measures OQ-45.2

Self-report assessment of global functioning designed for adults.

- **Contributes to performance measure:** improved functioning
- **Applicable population:** Adults (age 18 and older) receiving at least one of the following treatment services:
    - Individual psychotherapy or counseling (90832 [without KX modifier], 90833, 90834, 90836, 90837, 90838, H0004 [without KX modifier], Z2000)
    - Family psychotherapy or counseling (90846, 90847, T1006)
    - Group psychotherapy or counseling (90849, 90853, H0005, Z2030)
    - Office or other outpatient visit for a new or established patient (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355)
    - Home visit for a new or established patient (99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350)
    - SUD ambulatory withdrawal management, intensive outpatient or partial hospitalization (H0014, H0015)
    - Medication-assisted treatment (H0020, J0571, J0572, J0573, J0574, J0575, J2315, J8499, S5001, T1502)
    - Intensive home-based treatment, functional family therapy, or multi-systemic therapy (H2015, H2033, Z1674)
- **Data collection:** administer at intake and every 6 months until discharged
- **Data submission:** Entry in OQ-Analyst system, either directly or via electronic health record system integration, transmitted to ADAMH at least monthly
- **Output for monitoring:** number of OQ-45.2 administrations matched to an individual receiving qualifying services

OQ Measures YOQ-30.2
Self-report or caregiver-report assessment of global functioning designed for youth.

- **Contributes to performance measure:** improved functioning
- **Applicable population:** Youth (ages 4-17) receiving at least one of the following treatment services:
    - Individual psychotherapy or counseling (90832 [without KX modifier], 90833, 90834, 90836, 90837, 90838, H0004 [without KX modifier], Z2000)
    - Family psychotherapy or counseling (90846, 90847, T1006)
    - Group psychotherapy or counseling (90849, 90853, H0005, Z2030)
    - Office or other outpatient visit for a new or established patient (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355)
    - Home visit for a new or established patient (99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350)
    - SUD ambulatory withdrawal management, intensive outpatient or partial hospitalization (H0014, H0015)
    - Medication-assisted treatment (H0020, J0571, J0572, J0573, J0574, J0575, J2315, J8499, S5001, T1502)
    - Intensive home-based treatment, functional family therapy, or multi-systemic therapy (H2015, H2033, Z1674)
- **Data collection:** administer at intake and every 6 months until discharged
- **Data submission:** Entry in OQ-Analyst system, either directly or via electronic health record system integration, transmitted to ADAMH at least monthly
- **Output for monitoring:** number of YOQ-30.2 administrations matched to an individual receiving qualifying services

ATTACHMENT F

ODBH CONTRACT AGENCY ASSURANCE STATEMENT CERTIFICATIONS AND DISCLOSURE OF LOBBYING ACTIVITY

Attachment A

Contract Year (KY) 2026 Allocation Summary

Allocation Line (SOC)	Allocation Line Subtype	Allocation Amount	Hold Amount	Hold Reason	Carry Over	Project	Project Description	CFDA# (if applicable)	Encounter Claim Requirement*
Family Supports	Gun Violence	$ 259,059.60				H1014	Levy		Exempt
Prevention	NA	$ 29,652.79				H1014	Levy		Exempt 90%T
Prevention	NA	$ 12,400.00	$ 12,400.00	Award		H2866	OhioMHAS State Prevention & Wellness		Exempt 90%T
Prevention	NA	$ 12,400.00	$ 12,400.00	Award		H2867	OhioMHAS State Prevention & Wellness		Exempt 90%T
Prevention	NA	$ 465,708.00				H5056	OhioMHAS 3G40 Federal AoD SAPT Prevention Per Capita	93.959	Exempt 90%T
Prevention	NA	$ 465,708.00	$ 465,708.00	Award		H5057	OhioMHAS 3G40 Federal AoD SAPT Prevention Per Capita	93.959	Exempt 90%T
Treatment	Grief Counseling	$ 78,030.00				H1014	Levy		Exempt
Treatment	NA	$ 370,233.62				H1014	Levy		Required
Treatment	General Operating Funds	$ 81,886.22				H1014	Levy		Exempt
Treatment	Women's Treatment	$ 50,837.50	$ 50,837.50	Award		H5246	OhioMHAS 3G40 Federal AoD SAPT Block Grant (Women's Treatment) - Columbus Health	93.959	Exempt
Treatment	Women's Treatment	$ 50,837.50	$ 50,837.50	Award		H5247	OhioMHAS 3G40 Federal AoD SAPT Block Grant (Women's Treatment) - Columbus Health	93.959	Exempt
Total		**$1,876,753.23**	**$ 592,183.00**						

Total amount not on hold:**	**$1,284,570.23**

** Encounter Claim Requirement: "Required" = encounter claiming required and 90% threshold applies; "Exempt 90%T" = encounter claiming required and not required to meet the 90% threshold; "Exempt" = Exempt from encounter claiming entirely*

*** The amount on hold represents the awards not received by ADAMH to-date from the respective funding source for the contract year, cash on hand for prior year payment, or due to contract hold.*

Note: The contract year allocations are contingent on receipt of planned federal, state, and local award amounts to ADAMH.

Signature - Executive Director: Mysheika W Roberts, MD, MPH

Date: 01/05/2026

Ohio Department of Mental Health and Addiction Services SFY2025 Agreements and Assurances (Signature Pages)

Department of Mental Health & Addiction Services

Original Release – May 31st, 2024

Directions for Completion of Agreement and Assurances by Applicant for Award or Sub-Award:

1. Type into or select the appropriate box that is highlighted blue and gray.
2. Please note that paragraphs 33-41 apply only to sub-awards funded in whole or part with federal funds, including federal block grant funds, paragraph 42 applies only to sub-awards funded in whole or part with Community Mental Health Block Grant (CMHBG) funds, paragraphs 43-51 apply only to sub-awards funded in whole or part with Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant funds, and paragraphs 52-55 apply only to sub-awards to programs serving women funded in whole or part with SUPTRS BG funds.
3. Sign the signature page.
4. Read and Sign Attachment 2: "Certifications," Attachment 3: "Non Construction Programs" for sub-awards funded in whole or part with federal funds and Attachment 4: "Standard Affirmation and Disclosure—Executive Order 2019-12D and 2022-02D" for all sub-awards.

NOTE: *Changes and/ or modifications to the Agreement and Assurance will not be accepted by OhioMHAS.*

AGREEMENT and ASSURANCES (Attachment 1)

In accepting an award or sub-award from the Ohio Department of Mental Health and Addiction Services, hereinafter "DEPARTMENT",

Columbus Public Health **("SUB-AWARDEE"),**

located at: 240 Parsons Ave Columbus OH 43215

Agrees and makes the following assurances:

1. SUB-AWARDEE has received an allocation or applied for an award or sub-award ("sub-award") from one or more of the following fund sources:
   a. Community Mental Health Block Grant (CMHBG) (CFDA No. 93.958)
   b. Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS) (CFDA No. 93.959)
   c. Social Services Block Grant (Title XX) (CFDA No. 93.667)
   d. 5AU0 Rotary; OhioMHAS Account for Receipt of federal funds (CFDA No. TBD)
   e. Projects for Assistance in Transition from Homelessness (PATH) Grant (CFDA No. 93.150)
   f. GRF Line Item (ALI) Grant
   g. Probate Court reimbursement for costs, fees, and expenses pursuant to ORC 5122.43
   h. Title XX (CFDA No. 93.667)
   i. Child Care Quality (CFDA No. 93.713)
   j. Ohio Promoting Integration of Primary and Behavioral Health Care (CFDA No. 93.243)
   k. Zero Suicide (CFDA No. 93.243)
   l. Supported Employment Program (CFDA No. 93.243)
   m. Ohio Strategic Prevention Framework, Partnerships for Success (CFDA No. 93.243)
   n. Ohio ENGAGE Grant (CFDA No. 93.104)
   o. SPF-RX (CFDA No. 93.243)
   p. State Opioid and Stimulant Response Grant (CFDA No. 93.788)
   q. State Opioid and Stimulant Response Carryover Grant (CFDA No. 93.788)
   r. Medication Assisted Treatment-Prescription Drug and Opioid Addiction Grant (CFDA No. 93.243)
   s. Promoting Integration of Primary and Behavioral Health (CFDA No. 93.243)
   t. 988 Quality Assurance (CFDA No. 93.243)
   u. Project Aware (CFDA No. 93.243)
   v. SERG Grant (CFDA No. 93.243)
   w. Certified Community BH Clinic Planning Grant (CCBHC) Grant (CFDA No. 93.829)
   x. CCP – RSP Grant (CFDA TBD)
   y. State and Local Fiscal Recovery Funds (CFDA No. 21.027)
   z. ESSER (CFDA No. 84.425)
   aa. Recovery Housing Support Act (CFDA No. 14.218)
   bb. Residential Substance Abuse Treatment (CFDA No. 16.593)
   cc. Comprehensive Opioid, Stimulant, and Substance Abuse Program (CFDA No. 16.838)
   dd. 1490 Line Item, OhioMHAS Rotary Account (CFDA No. TBD)
   ee. 4750 Line Item, OhioMHAS Rotary Account (CFDA No. TBD)

   - Other: [include CFDA # for federal funds]
   - Other: [include CFDA # for federal funds]
   - Other: [include CFDA # for federal funds]

   NOTE: Any new federal awards received throughout the year and allocated to grantees shall be included in this Agreements and Assurances.

B. Includes:
   I. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b).
   II. A for-profit organization.

iv. "Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. 7102).

41. SUB-AWARDEE assures DEPARTMENT that it or its parent organization holds permanent 501(c) non-profit status, or is a general or special purpose government entity. [CFDA 93.958; 42 USC 300x-5(a); OMB Guidance 0930-0168; 45 CFR 96.135] Check one:
    ○ Non-profit 501 (c) program ● Government entity

Paragraph 42 applies only to the Community Mental Health Block Grant

42. Use of Funds – Federal CMH Block Grant funds must be used for treatment and recovery supports for adults with serious mental illness and children with serious emotional disturbances, as well as the planning, administration, educational, and evaluation activities related to providing these services described in the combined Mental Health Block Grant Plan.

Paragraphs 43-51 apply to the Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant

43. The purpose of these funds is to provide financial assistance to programs for the delivery of alcohol and other drug services/activities. Any use of funds for equipment, furniture, or computer software, or for food purchases must be justified in terms of the relationship of the equipment, furniture or computer software, or the food purchases, to the program or activity. Justification to purchase equipment, furniture, computer software, or food must be submitted to DEPARTMENT for prior approval and include consideration of how the equipment, furniture or computer software, or the food, will be used, why the purchase is necessary, what alternatives were considered, how the cost was determined and why the program considers the cost reasonable. Funds cannot be expended for equipment, furniture or computer software, or food, until approved by OhioMHAS.

44. Treatment Alternatives to Street Crime (TASC) and drug court programs receiving funds from the DEPARTMENT may use only addiction treatment providers that hold current certification or license from the DEPARTMENT.

45. Charitable Choice Provisions and Regulations of SUPTRS Block Grant Funds [42 C.F.R. 54.8] require DEPARTMENT, along with DEPARTMENT SUB-AWARDEEs and providers to:

    a. Ensure that religious organizations that are certified treatment providers offer notice of a client's right to alternative services to all potential and actual program beneficiaries.
    b. Ensure that religious organizations that are certified treatment providers refer program beneficiaries to alternative services.
    c. Fund and provide alternative services.

or inhale illegal scheduled substances.

l. Pay for promotional items including, but not limited to, clothing and commemorative items, such as pens, mugs/cups, folders/folios, lanyards, and conference bags. (45 CFR 75.421(e)(3))
m. Pay for housing other than recovery housing, which includes application fees and security deposits.
n. Purchase firearms.
o. Only medications approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid use disorder and/or opioid overdose can be purchased with SOR funds.
p. Funds may not be expended through the award or a subaward by any agency which would deny any eligible client, patient, or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone; buprenorphine products, including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations; naltrexone products, including extended-release and oral formulations; or long-acting products, such as extended release injectable or buprenorphine.). Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a practitioner who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's OUD. Similarly, medications available by prescription or office-based injection must be permitted if it is appropriately authorized through prescription or administration by a licensed prescriber or provider. In all cases, MOUD must be permitted to be continued for as long as the prescriber or treatment provider, in conjunction with the patient, determines that the medication is clinically beneficial. Recipients must ensure that clients will not be compelled to no longer use MOUD as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

Signature

The Executive Officer signing below is authorized to obligate the SUB-AWARDEE and he/she represents that he/she has reviewed and approved this AGREEMENT and ASSURANCES including all attachments on behalf of the SUB-AWARDEE.

For the SUB-AWARDEE:

Type in Sub Awardee Name:

Mysheika W Roberts, MD, MPH — 01/05/2026

Executive Officer or Authorized Signature — Date

Type in Executive Officer Name Below — Title

Mysheika W. Roberts, MD, MPH — Columbus Public Health, Health Commissioner

ATTACHMENT INSTRUCTIONS

If applicable, please SIGN and insert the following Attachments:

State of Ohio agencies or instrumentalities that have executed and submitted to the DEPARTMENT a set of Certifications and Assurances current through this sub-award period do not need to execute or attach Attachments 2, 3 and 4.

Attachment 2 is the "Certifications" document - **Signature Required**
Attachment 3 is the "Assurances – Non-Construction Programs" – **Signature Required**
Attachment 4 is the "Standard Affirmation and Disclosure—Executive Order 2011-12K" **Information & Signature Required**

Guidance in Completing Attachment 4

Per guidance from the Office of Legal Services at the Ohio Department of Administrative Services, this attachment should include contracts that are entered into for services purchased for the State.

Based on this guidance, Boards should include all entities contracted with, regardless of funding source, under ORC 340.03 (8)(a): "Enter into contracts with public and private facilities for the operation of facility services and enter into contracts with public and private community addiction and mental health service providers for the provision of community addiction and mental health services."

Attachment 5 is the "List of Additional Sub-awardee(s) Documents," if multiple documents are attached, designate as 5A, 5B, 5C, etc. – **Information Required as Appropriate**

Attachment 6 is the Notice of Sub-Award (NOSA) or the Intrastate Transfer Voucher (ISTV) - **to be provided by DEPARTMENT upon award**

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S.C. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties.
The undersigned agrees that the applicant organization will comply with the terms and conditions of this award.

1. Certification Regarding Environmental Tobacco Services

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early
childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee.

The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/SUB-AWARDEE (for grants certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The federal awarding agency strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Mysheika W Roberts, MD, MPH	Columbus Public Health, Health Commissioner
APPLICANT ORGANIZATION	DATE SUBMITTED
Columbus Public Health	01/05/2026

federally assisted construction sub-agreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et. Seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§ 7401 et. Seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et. Seq.) Related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. § 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et. seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§ 2131 et. seq.) Pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4831 (b) et. seq.) Which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will comply with the Single Audit Act of 1984, as amended, and 45 CFR, Part 75, Subpart F. SUB-AWARDEES must submit to DEPARTMENT the communications specified in 45 CFR §75.512(a)within the earlier of 30 days after receipt of the auditor's report(s) or nine months after the end of the audit period. DEPARTMENT reserves the right to require SUB-AWARDEE's submission of copies of the audit reporting package described in 45 CFR §75.512(c) and any management letters issued by the auditor, in accordance with 45 CFR §75.512(e).

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Mysheika W Roberts, MD, MPH	Columbus Public Health, Health Commissioner
APPLICANT ORGANIZATION Coumbus Public Health	DATE SUBMITTED 01/05/2026

Attachment 4

STATE OF OHIO
DEPARTMENT OF ADMINISTRATIVE SERVICES

STANDARD AFFIRMATION AND DISCLOSURE FORM
EXECUTIVE ORDER 2019-12D

Banning the Expenditure of Public Funds on Offshore Services

CONTRACTOR/SUBCONTRACTOR AFFIRMATION AND DISCLOSURE:

By the signature affixed to this response, CONTRACTOR/SUBCONTRACTOR affirms, understands, and will abide by the requirements of Executive Order 2019-12D. If awarded a contract, CONTRACTOR/SUBCONTRACTOR becomes Contractor and affirms that both Contractor and any of its subcontractors shall perform no services requested under this Contract outside of the United States.

CONTRACTOR/SUBCONTRACTOR shall provide all the name(s) and location(s) where services under this Contract will be performed in the spaces provided below or by attachment. Failure to provide this information as part of the response will deem CONTRACTOR/SUBCONTRACTOR not responsive the contract will not be executed. If CONTRACTOR/SUBCONTRACTOR will not be using subcontractors, indicate "Not Applicable" in the appropriate spaces.

1. Principal location of business of Contractor:

Columbus Public Health	240 Parsons Ave Columbus OH, 43215
(Address)	(City, State, Zip)

Name/Principal location of business of subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

2. Location where services will be performed by Contractor:

Columbus Public Health	240 Parsons Ave Columbus OH, 43215
(Address)	(City, State, Zip)

Name/Location where services will be performed by subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

3. Location where state data will be stored, accessed, tested, maintained or backed-up, by Contractor:

Columbus Public Health	240 Parsons Ave Columbus OH, 43215
(Address)	(Address, City, State, Zip)

Name/Location(s) where state data will be stored, accessed, tested, maintained or backed-up by subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

4. Location where services to be performed will be changed or shifted by Contractor:

Columbus Public Health	240 Parsons Ave Columbus, OH 43215
(Address)	(Address, City, State, Zip)

Name/Location(s) where services will be changed or shifted to be performed by subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

DEPARTMENT OF ADMINISTRATIVE SERVICES

STANDARD AFFIRMATION AND DISCLOSURE FORM

EXECUTIVE ORDER 2022-02D

State of Ohio's Response to Russia's Unjust War on the Country of Ukraine
March 2022

Contractor affirms that Contractor has read and understands the applicable Executive Order regarding the prohibition on purchasing from Russian institutions or companies.

Contractor shall provide all the name(s) and location(s) where services under this Contract will be performed and where data is located in the spaces provided below or by attachment. Failure to provide this information may result in no award. If Contractor will not be using subcontractors, indicate "Not Applicable" in the appropriate spaces.

1. Principal location of business of Contractor:

Columbus Public Health	240 Parsons Ave Columbus, OH 43215
(Address)	(City, State, Zip)

Name/Principal location of business of subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

2. Location where services will be performed by Contractor:

Columbus Public Health	240 Parsons Ave Columbus, OH 43215
(Address)	(City, State, Zip)

Name/Location where services will be performed by subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

3. Location where state data will be stored, accessed, tested, maintained or backed-up, by Contractor:

Columbus Public Health	240 Parsons Ave Columbus, OH 43215
(Address)	(Address, City, State, Zip)

Name/Location(s) where state data will be stored, accessed, tested, maintained or backed-up by subcontractor(s):

n/a	n/a
(Name)	(Address, City, State, Zip)
n/a	n/a
(Name)	(Address, City, State, Zip)

Contractor also affirms, understands and agrees that Contractor and its subcontractors are under a duty to disclose to the State any change or shift in location of services performed by Contractor or its subcontractors before, during and after execution of any contract with the State. Contractor agrees it shall so notify the State immediately of any such change or shift in location of its services. The State has the right to immediately terminate the contract, unless a duly signed waiver from the State has been attained by Contractor to perform the services outside the United States.

On behalf of Contractor, I acknowledge that I am duly authorized to execute this Affirmation and Disclosure Form and have read and understand that this form is a part of any Contract that Contractor may enter into with the State and is incorporated therein.

By: Mysheika W Roberts, MD, MPH
Contractor

Print Name: Mysheika W. Roberts, MD, MPH

Title: Columbus Public Health, Health Commissioner

Outcomes Expectations Memo

Provider: Columbus Public Health **Contract Year:** 2026 **Effective Date:** 1/1/2026

Data submission expectations are outlined below by system of care category, based on the provider's approved budget and Agency Service Plan documents for the specified contract year. Each outcomes-qualifying service found in the approved budget is listed along with the name of the associated data submission(s). Refer to the ADAMH Outcomes Compendium (https://adamhfranklin.jotform.com/app/data/outcomes) for detailed guidance on each data submission.

Note that outcomes expectations do not apply to every service within a system of care category; therefore, a provider budget may include services within a given category and no associated outcomes expectations are applicable. For the complete list of outcomes-qualifying services in each category, please refer to Attachment F of the contract.

Crisis

no outcomes data submission expected

Family Supports

no outcomes data submission expected

Housing

no outcomes data submission expected

Prevention

Program	Aggregate Client Count Due	Risk & Resilience Questionnaire expected?
Prevention Wellness	6/30/2026	Yes
School-based (YES/SUCCESS)	6/30/2026	Yes
SAGE 420	6/30/2026	Yes
REAL Life	9/15/2026	Yes
After school/summer	9/15/2026	Yes – closed groups only
Community Prevention	2/1/2027	No
SAGE – adult programming	2/1/2027	No
Early Intervention Services	2/1/2027	No
Latina Women and Family	2/1/2027	No

Recovery Supports

no outcomes data submission expected

Treatment

Qualifying services:

- Individual psychotherapy or counseling (90832, 90834, 90837)
- Office or other outpatient visit for the evaluation and management of an established patient (99213-99215)
- Prolonged visit (99354, 99355)
- SUD group counseling (H0005)
- SUD intensive outpatient group counseling (H0015)

Expected data submissions:

- Brief Addiction Monitor (clients with SUD diagnosis only)
- OQ-45.2 (clients age 18 and older only)
- Y-OQ 30.2 (clients age 4-17 only)