

# Contract Cover Sheet

**Note: Shaded areas are for County Executive review.**

Res 329  
Significant

Department: HUMAN SERVICES	Contract/Addendum #: <b>83689D</b>																				
1. This contract, grant or addendum: <input checked="" type="checkbox"/> AWARDS <input checked="" type="checkbox"/> ACCEPTS	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Contract</th> <th style="width: 50%;">Addendum</th> </tr> <tr> <td colspan="2" style="text-align: center; font-size: small;">If Addendum, please include original contract number</td> </tr> <tr> <td><input type="checkbox"/> POS</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Grant</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Co Lease</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Co Lessor</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Intergovernmental</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Purchase of Property</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Property Sale</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/></td> </tr> </table>	Contract	Addendum	If Addendum, please include original contract number		<input type="checkbox"/> POS	<input checked="" type="checkbox"/>	<input type="checkbox"/> Grant	<input type="checkbox"/>	<input type="checkbox"/> Co Lease	<input type="checkbox"/>	<input type="checkbox"/> Co Lessor	<input type="checkbox"/>	<input type="checkbox"/> Intergovernmental	<input type="checkbox"/>	<input type="checkbox"/> Purchase of Property	<input type="checkbox"/>	<input type="checkbox"/> Property Sale	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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2. This contract is discretionary <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																					
3. Term of Contract or Addendum: <b>11/17-12/31/17</b>																					
4. Amount of Contract or Addendum: <b>\$ 257,097</b>																					
5. Purpose: NA – Not required when Human Services signs.																					

6. Vendor or Funding Source: **Journey mental Health Center**

7. MUNIS Vendor Code: **5152**

8. Bid/RFP Number:

9. Requisition Number:

10. If grant: Funds Positions?  Yes  No Will require on-going or matching funds?  Yes  No

11. Are funds included in the budget?  Yes  No

12. Account No. & Amount, Org & Obj. _____	Amount \$ _____
Account No. & Amount, Org & Obj. _____	Amount \$ _____
Account No. & Amount, Org & Obj. _____	Amount \$ _____

13. If this contract awards funds, a purchase requisition is necessary. Enter requisition # & year \_\_\_\_\_

14. Is a resolution needed?  Yes  No If yes, please attach a copy of the Resolution.  
If Resolution has already been approved by the County Board, Resolution No. & date of adoption **329**

15. Does Domestic Partner equal benefits requirement apply?  Yes  No

16. Director's Approval: *Symon Sheen*

Human Services Only	a. Dane County Res. #		Approvals	Initials	Date
	b. HSD Res. ID#		g. Accountant	<i>[Signature]</i>	11/17/17
	c. Program Manager Name	<b>Orabot</b>	h. Supervisor	<i>[Signature]</i>	11-28-17
	d. Current Contract Amount	<b>11,334,317</b>	i. To Provider	<i>[Signature]</i>	11-29-17
	e. Adjustment Amount	<b>257,097</b>	j. From Provider	<i>[Signature]</i>	11-29-17
	f. Revised Contract Amount	<b>11,591,414</b>	k. Corporation Counsel	<i>[Signature]</i>	11-29-17

Contract Review/Approvals				Vendor
Initials	Ftnt	Date In	Date Out	Vendor Name/Address
<i>[Signature]</i> Received	_____	<b>12/4/17</b>	_____	Contact Person   Phone No.   E-mail Address
<i>[Signature]</i> Controller	_____	_____	_____	
N/A Corporation Counsel	See "k" above	_____	_____	
<i>[Signature]</i> Risk Management	_____	<b>12/4/17</b>	<b>12/6/17</b>	
<i>[Signature]</i> Purchasing	_____	<b>12/6/17</b>	<b>12/6/17</b>	
_____ County Executive	_____	_____	_____	

**Footnotes:**

1.

2.

<b>Return to:</b> Name/Title: Spring Larson, CCA Phone: 608-242-6391 E-mail Address: Larson.spring@countyofdane.com	Dept.: Human Services Mail Address: 1202 Northport Drive
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**Certification**

The attached contract: *[check as many as apply]*

- conforms to Dane County's standard Purchase of Services Agreement form in all respects
- conforms to Dane County's standard Purchase of Services Agreement form with modifications and is accompanied by a revision copy<sup>1</sup>
- is a non-standard contract which has been reviewed or developed by corporation counsel and which has not been changed since that review/development
- is a non-standard contract previously review or developed by corporation counsel which has been changed since that review/development; it is accompanied by a revision copy<sup>1</sup>
- is a non-standard contract not previously reviewed by corporation counsel; it is accompanied by a revision copy
- contains non-standard/indemnification language which has been reviewed or developed by risk management and which has not been changed since that review/development
- contains non-standard insurance/indemnification language which has been changed since review/development or which has not been previously seen by risk management; it is accompanied by a revision copy
- contains non-standard affirmative action/equal opportunity language which has been reviewed or developed by contract compliance and which has not been changed since that review/development
- contains non-standard affirmative action/equal opportunity language which has been changed since the earlier review/development by contract compliance or which has not been previously seen by contract compliance; it is accompanied by a revision copy<sup>1</sup>

Date: 11-29-17

Signed: 

Telephone Number 242-6469

Print Name: Lynn Green

**Major Contracts Review (DCO Sect. 25.20)** This review applies only to contracts which both exceed \$100,000 in disbursements or receipts and which require county board review and approval.

**Executive Summary** (attach additional pages, if needed).

1. **Department Head**  Contract is in the best interest of the County.  
Describe any deviations from the standard contracting process and any changes to the standard Purchase of Services Form Agreement.

Date: 11-29-17

Signature: 

2. **Director of Administration**  Contract is in the best interest of the County.  
Comments:

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

3. **Corporation Counsel**  Contract is in the best interest of the County.  
Comments:

Date: 11-29-17

Signature: 

<sup>1</sup> A revision copy is a copy of the contract which shows the changes from the standard contract or previously revised/developed contract by means of overstrikes (indicating deletions from the standard language) and underlining (showing additions to the standard language).

ADDENDUM

THIS ADDENDUM is made and entered into by and between the County of Dane (hereinafter referred to as "COUNTY") and Journey Mental Health Center, Inc. (hereinafter "PROVIDER") as of the date representatives of both parties have affixed their respective signatures.

WHEREAS the COUNTY and PROVIDER have previously entered into a Purchase of Service Agreement No. 83689 (hereinafter the "Master Agreement"), pursuant to which PROVIDER has agreed to provide the COUNTY certain services more fully described in the Master Agreement; and


WHEREAS COUNTY and PROVIDER now wish to amend said Master Agreement,

NOW, THEREFORE, in consideration of the above premise and the mutual covenants of the parties the receipt and sufficiency of which is hereby acknowledged by each party for itself, the COUNTY and PROVIDER do agree that the Master Agreement shall continue in full force and effect unchanged in any matter by this addendum, except as specifically set forth herein. This addendum consists of three (3) pages.

<u>Current Cost</u> <u>for 2017</u>	<u>Addendum Amount</u>	<u>Revised Maximum</u> <u>Cost for 2017</u>
\$11,334,317	\$257,097	\$11,591,414

IN WITNESS WHEREOF, COUNTY and PROVIDER, by their respective authorized agents, have caused this addendum and its attachments, if any, to be executed, effective as of the date by which all parties hereto have affixed their respective signatures, as indicated below.

Date Signed: 11/29/17

FOR PROVIDER  
  
\_\_\_\_\_  
Signature  
Karen Nitzel, COO  
Print Name and Title of Signer


Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Signature  
\_\_\_\_\_  
Print Name and Title of Signer

Date Signed: \_\_\_\_\_

FOR COUNTY:  
\_\_\_\_\_  
JOE PARISI, County Executive  
(when applicable)

Date Signed: 11-29-17

  
\_\_\_\_\_  
LYNN GREEN, Director,  
Department of Human Services  
(when applicable)

Created 10/10/16 Contract # 83689 Provider: Journey Mental Health Center  
 Revised 11/22/16 11:17:47 Division: Adult Community Services Funding Period: January 1, 2017 through December 31, 2017

Contract Maximum Service Costs. Subject to the provisions specified elsewhere in this contract, the following summarizes and sets forth the rates and maximum payments available for services under this contract.

Program Number	Program Group	Orig. #	Obj. #	Program Name	S.P.C.	# of Clients	# of Slots	Unit Cost	Unit Quantity	County Cost	Other Revenue*	Total Cost	Reporting
a	10070	ACFCRSDN	CVIPAA	Recovery House	205	114	4	231.55	904	\$ 209,320	\$	\$ 209,320	600/610
b	10071	ACFCRSDN	IPC HAA	Crisis Home Program	205	25	15	133.54	8,375	\$ 1,118,440	\$	\$ 1,118,440	600/610
c	6357	ACFCRSDN	IFGHAA	Crisis Stabilization Program	702	1100	N/A	76.47	6,534	\$ 496,678	\$	\$ 496,678	600/610
d	9220	ACFCRSDN	IPCHAA	Crisis Stab. Emergency Fund	702	60	N/A	100.00	120	\$ 12,000	\$	\$ 12,000	Itemized Report
e	10591	ACFCRMHC	BCMHAA	Bayside Place	508.64	7	7	381.01	78	\$ 30,000	\$	\$ 30,000	600/610
f	1303	ACFCIMHC	CVUJAA	ESU-Crisis Intervention	501	1,419	0	123.16	15,250	\$ 1,878,187	\$	\$ 1,878,187	600/610
g											\$	\$	
h											\$	\$	
Total:										\$ 3,747,603	\$	\$ 3,747,603	

\*Other Revenue-Include here the source and related amount for each program.

- The section below is to be used to further define the information above.
- a. Unit is a day of service. Units estimated at 904 days (4 beds @ 62% occupancy). 11-22-16 contract increased by \$2697 due to COLA. MG
  - b. Funding includes payments to crisis home and AFH sponsors. All homes are either certified or licensed as Adult Family Homes or Community Based Residential Facilities. Cost of each placement is individually determined. Crisis Homes shall not exceed \$100 per day unless approved by County. Adult Family Home rates shall be determined by County and Rate setting loop. Any deviations from rate-setting tool shall be approved by County. Lengths of stay vary from one day to several months. Any crisis leading to placement shall be as defined in DHS 34 MA Crisis shall be billed for all eligible services. Service units are measured in days. 11-22-16 contract increased by \$3281 due to COLA. MG
  - c. 11-17-17 \$257,097 added due to actual costs. MG
  - d. Funding includes payment for staff to monitor the entire ACS MH MA CHOS program, clinical supervision oversight, and Outreach Workers MA Crisis is billed for all eligible services. Service units are measured in hours. 11-22-15 contract increased by \$14,218 due to COLA. MG
  - e. Service unit is one person receiving emergency funding from this account. Quarterly, the Provider will provide a detailed report showing how these funds were used. Refer to Schedule A for specification of use.
  - f. Unit of service is a one day
  - g. Service unit is a client hour. Inpatient Diversion Specialist is part of this program. Provider shall fund 2.0 FTEs to work directly with the Madison Police Department. 11-22-16 contract increased by \$23,756 due to COLA. MG
  - h.
  - i.
  - j.

Standard Program Category (S.P.C.) Code Description

a	205	Shelter care	c	702	Systems Management	e	506	64	CORF
b	205	Shelter Care	d	702	Systems Management	f	501		Crisis Intervention

Contract Manager(s): Programs      Grabo@countymdane.com      Accountant(s): Programs      Laura Yundt

**JOURNEY MENTAL HEALTH CENTER, INC.**

**SCHEDULE B - FISCAL**

**PROGRAM #'S 10071 AND 6357 – CRISIS HOME AND CRISIS STABILIZATION PROGRAMS**

1. Regarding funding for Crisis Home Program #'s 10071 & 6357:

Revenue Type	Non-Contingent Amount	Contingent Amount	Total Amount
Co GPR	\$ 100,489		\$ 100,489
SSI	\$ 89,849		\$ 89,849
MA Crisis		\$ 1,427,778	\$ 1,427,778
Total	\$ 190,338	\$ 1,427,778	\$ 1,618,116

2. Regarding method of payment for Crisis Home Program #'s 10071 & 6357:

- A. The "Non-Contingent" funding for this program shall be vouchered using the method of payment in Section C, XXVIII, B, 3 of this contract.
- B. The "Contingent" funding for this program will be paid to PROVIDER, up to the contract amount, only if PROVIDER earns the funding through billing the Wisconsin Medical Assistance (ForwardHealth) Program.

PROVIDER shall submit monthly vouchers to COUNTY for the amount of MA Crisis services paid by the State to the COUNTY based on Remittance and Status Advice reports received by PROVIDER that indicate the amount paid (which may or may not equal the amount billed).

COUNTY will pay PROVIDER on a cash basis; meaning PROVIDER payments will be based on the dates COUNTY receives payment from the State rather than the dates of billed services. In the event PROVIDER no longer delivers MA Crisis services due to the conclusion of the contractual relationship, PROVIDER shall continue to be paid under this agreement and only up to the contracted amount for this program, for up to three months for MA Crisis revenue earned by PROVIDER and paid to COUNTY.

3. The COUNTY reserves the right to withhold payments for any unearned Medicaid revenues or to require the PROVIDER to reimburse the COUNTY for overpayment of Medicaid revenues.
4. Regarding ForwardHealth Audits: Any cost resulting from audit findings by ForwardHealth or other entity that adversely affects the COUNTY will be apportioned between the COUNTY and PROVIDER as follows: (a) The PROVIDER will be responsible for all disallowed expenses that can clearly be attributed to the PROVIDER'S failure to keep complete comprehensive and orderly records and for expenses inappropriately billed to ForwardHealth. The COUNTY, at its sole discretion, may choose to cover some or all of the PROVIDER'S disallowance, and (b) The PROVIDER will be responsible for any fine(s) resulting from non-compliance with written processes and procedure.

October 2016

Revised November 2016

Revised November 2017