AGREEMENT FOR PURCHASE OF SERVICES
SHORT TERM BEHAVIORAL HEALTH SERVICE

This Agreement is entered into by and between Healthy Minds Fairfax (HMF) under the Fairfax County Department of Family Services (DFS), herein referred to as the "Buyer" and **PROVIDER NAME** hereinafter referred to as the "Provider." It is understood that this entire Agreement contains General Terms and Conditions which are to be adhered to by all Providers. Therefore, the parties hereto do mutually agree as follows:

I. SCOPE OF SERVICES TO BE PROVIDED

A. The Short Term Behavioral Health Service for Youth contractor(s) will provide:
   1. Services pursuant to the laws, rules, and regulations of the County of Fairfax.
   2. A schedule of supports and services as outlined below. Minimum Required Services:
      a. Initial appointment available within 3-5 business days following the receipt of a referral. ***Client capacity is potentially 1 client at any given time.***
      b. Complete the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) assessment tool, provided by HMF, upon the ***first session and after the 5th session.***
      c. Complete the STBH Clinical Assessment tool, provided by HMF (see Attachment A) ***or HMF-approved alternative tool following the first session.***
      d. ***Provide up to 8 counseling sessions inclusive of the assessment session.*** An additional two sessions may be requested when clinically appropriate with additional factors contributing to the family's ability to access services without public funding.
      e. Review and completion of Statement of Understanding with client and parent/caregiver (Attachment B) ***following the first session.***
      f. Inclusion of parents/caregivers in counseling sessions ***as much as clinically appropriate and possible****;* communication with parents/caregivers between sessions ***as appropriate.***
      g. Refer clients and families to the Fairfax-Falls Church Community Services Board (CSB) and other public or private behavioral health services as appropriate with notification to the referring party.
      h. A protocol for after-hours emergencies, communicated to clients through an after-hours office message.
      i. Individual records are the property of the Provider. If parent has signed a consent to exchange information with referral source, provider will comply.
      j. When the STBH Provider is "in network" with the youth and family's insurance, the STBH Provider ***may not*** utilize the youth and family's insurance ***until after STBH services have been completed and at the direction of the family.***
   3. ***Teletherapy: Teletherapy when appropriate if offered by the Provider***.

a. The youth will discuss their planned confidential location for teletherapy sessions during the initial session.
b. Youth with a previous history of suicide attempts, family history of suicide attempts, or completions and/or moderate to high risk of suicide may not be appropriate for teletherapy and will not receive teletherapy services without authorization from the Buyer.
c. The youth and guardian must consent to receive teletherapy services.
d. If the youth meets the criteria for teletherapy services, emergency contact information should be discussed during the initial session.
e. The Provider will have adequate information to determine whether a teletherapy appointment is appropriate.
f. The youth must have reliable high-speed internet, a laptop computer, and a smart phone. Should there be a disruption of the session due to technology, the Provider shall have a plan in place to connect with the youth via telephone.
g. The youth must be stable medically and emotionally in order to utilize teletherapy services.
h. The Provider shall confirm the youth's exact address prior to beginning the teletherapy session by having the youth provide verification of their location by displaying it to the Provider using their smartphone map application. The Provider will ask the youth whether anyone else is present in the home. The youth will confirm that they are in a confidential location by providing a 360-degree scan of the room so that the Provider can ensure that all doors and windows are closed and that there is no one else present in the room.
i. Teletherapy sessions shall not take place in vehicles or in communal settings.
j. It is strongly encouraged that teletherapy sessions take place within the same setting for continuity and to further ensure privacy and confidentiality.
k. Teletherapy appointments will be rescheduled at the discretion of the Provider should safety, privacy, or confidentiality be a concern.
l. The virtual therapy platform used by the Provider shall be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
m. In addition to complying with all state, federal, and local laws and regulations referenced in this Agreement, the Provider shall follow the guidance of the American Psychiatric Association and the American Telemedicine Association's Best Practices in Videoconferencing-Based Telemental Health. The document can be viewed at: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-

Telemental-Health.pdf .

4. GAIN-SS assessment certification: Post award of an APOS, the Provider will be required to complete the GAIN-SS assessment on-line training prior to serving the first referral. This training will be provided at no cost to the Provider. Each Provider is allowed to bill for one hour of service for the training once the training has been completed and documentation of such has been provided to the HMF office.
    a. The GAIN-SS will be completed at the beginning and ***middle (after the 5th session)*** of the service period for each youth and forwarded to the HMF office with other required documentation.

B. Outcome Measures, Data Reporting, and Performance Requirements:

1. The desired outcomes of this project are a reduction of behavioral and emotional health symptoms for individual youth facing barriers to short term behavioral health care.
2. Reporting Requirements: The contractor will complete the following documents during the course of treatment:
    a. Clinical Assessment on STBH provided template (Attachment A).
    b. Completed Statement of Understanding with signatures (Attachment B).
    c. Progress notes, to be maintained in the client record with the Provider.
    d. Discharge summary on STBH provided template (Attachment C) to be provided upon completion of authorized sessions with final invoice.
3. The reporting requirements are the minimum requirements for the measurements that must be reported to the HMF office within 30 days of the termination of the last session. If documents requested above are not submitted in the required time period, payment for services may not be made. ***Reports should be sent to the HMF office via facsimile or email.***
4. ***Within 24 hours of knowledge of a serious incident, whether actual or alleged, the Provider shall report the incident by sending an email to the HMF Office and notifying the legal guardian as appropriate. Serious incidents can include, but are not limited to abuse or neglect, criminal behavior, death, emergency medical treatment, serious injury (accidental or otherwise), physical assault/other serious acts of aggression, sexual misconduct/assault, suicide attempt, other incidents which jeopardize the health, safety, or wellbeing of the youth.***

C. Provider Requirements:

1. Credentialing:

a. Participating clinicians must be licensed in the Commonwealth of Virginia or, at a minimum, a master's level clinician (counseling resident, social work supervisee, psychology resident) under the supervision of a licensed clinician. ***The clinician may be enrolled in an APA accredited clinical psychology doctorate program in their third year or above. Doctorate students must be under the supervision of a clinician who is licensed in psychology in the Commonwealth of Virginia***.

b. Participating clinicians must present documentation of at least 12 hours/CEU's or graduate coursework in Cognitive Behavioral Therapy, at least 12 hours/CEU's or graduate coursework in ***trauma***, and at least 2 hours/CEU's in ***Suicide***/Risk Assessment.

c. Participating clinicians must have experience working with children, youth, and families.

Participating clinicians may be granted a six-month waiver of training requirements in order to complete training in Cognitive Behavioral Therapy, ***trauma***, and ***Suicide/***Risk Assessment. Training may be acquired on-line and/or in workshops. ***The trainings can also be acquired by attending a training through the Fairfax Consortium for Evidenced-Based Training.***

2. Capacity:
   a. Potential client capacity for the Provider will include ***1 client*** at any given time for the short-term intervention and upon completion, acceptance of an additional client(s) within 3-5 business days following receipt of a referral.
3. Only clinicians who meet the stated requirements above and are approved by and registered with HMF may be assigned to serve under this Agreement.

II. GENERAL TERMS AND CONDITIONS

A. ADHERENCE TO THE LAW: This Agreement is subject to the provisions of all applicable State and federal laws and regulations, as they may be amended from time to time. This Agreement shall be governed in all respects, whether as to validity, construction, capacity, licensure, performance or otherwise, by the laws of the Commonwealth of Virginia without reference to the conflict of laws principles.

B. SPECIFIC INTERPRETATIONS: The failure of the Buyer to enforce at any time any of the provisions of this Agreement, or to exercise any option which is herein provided, or to require at any time performance by the Provider of any of the provisions hereof, shall in no way affect the validity of this Agreement or any part thereof, or the right of the Buyer to thereafter enforce each and every provision. All remedies afforded in the Agreement shall be taken and construed as cumulative, i.e., in addition to every other remedy provided herein by law.

C. SERVICE QUALITY: The Provider shall permit representatives authorized by the Buyer to conduct treatment, facility, and fiscal reviews/visits in order to assess service quality. The Provider will assure that the treatment plan for the child and family is developed in conjunction with the youth and family. The Provider will assure that the treatment services delivered by the Provider are consistent with the treatment plan for the child and family. The Provider will assure that the child and the family is progressing toward the treatment goals. The Buyer will reserve the right to review the procedures related to emergencies, client satisfaction and service delivery to assure implementation of all aspects of the treatment plan. The Buyer will reserve the right to integrate formal assessment of outcomes with the Provider and client perceptions of satisfaction and outcomes.

D. HEALTHY MINDS FAIRFAX SYSTEM OF CARE PRACTICE STANDARDS: Practice standards are guidelines used to determine what a human services professional involved with a youth with serious behavioral or emotional issues should or should not do. Standards may be defined as a benchmark of achievement which is based on a desired level of excellence. They are based on our values and principles and articulate our common agreement on how youth and families should be served. The Standards were developed by an inter-agency team of practitioners who work with youth and families with behavioral and/or emotional issues or development disabilities with a significant behavioral component. The Standards are consistent with the philosophy and practices of family partnership meetings and intensive care coordination. (Document can be viewed at: https://www.fairfaxcounty.gov/healthymindsfairfax/principles-and-practice-standards)

1. Participation in Service Planning: Our system supports families to fulfill their primary responsibility for the safety, the physical and emotional health, the financial and educational well-being of their children. Voices of youth and parents are heard, valued, and considered in the decision-making regarding safety, permanency, and well-being as well as in service and educational planning and in placement decisions.
2. Service Integration and Care Coordination: Our system embraces the concepts of shared resources, decision making and responsibility for outcomes. All stakeholders work collaboratively with each other and the family to gain maximum benefits from available resources. Youth with emotional, intellectual, or behavioral challenges receive integrated services and care coordination in a seamless manner.
    a. Team-based planning processes encompass a variety of structures and models. A group of people, chosen by the family and connected to them through natural, community, and formal support relationships work together to develop and implement the family's plan; address unmet needs; and work toward the family's vision. Best practice models for team-based planning include family team meetings, wraparound teams, and family group conferencing.
    b. Care Coordination is a process-oriented activity that ensures ongoing communication and collaboration with youth and families with multiple needs.

The activity can include: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating, and participating in team meetings at which strengths and needs are identified and safety planning occurs. The activity provides for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

3. Equitable Access & Cultural Competency: County, community and private agencies embrace, value, and celebrate the diverse cultures of their children, youth and families and will work to eliminate disparities in outcomes. Families receive culturally and linguistically responsive services.
4. Accountability: We are accountable at the individual youth and family, system, and community levels for desired outcomes, safety, and cost effectiveness.
5. The CPMT has adopted the Columbia-Suicide Severity Rating Scale (C-SSRS) as a system-wide evidence-based tool for the identification of suicide risk. Case managers, home-based providers, and care coordinators who are working with youth with intensive needs ***are encouraged to use this tool***. Staff who work with HMF funded youth are strongly encouraged to complete the C-SSRS training available online at http://cssrs.columbia.edu/training/training-options/. The live webinars, pre-recorded sessions and video tutorials are made available free of charge by the Columbia Lighthouse Project. All providers are urged to incorporate this rating scale into their practice models and access the on-line training.

E. RECORDS MAINTENANCE: The Provider and any subcontractor shall maintain an accounting system and supporting records adequate to assure that invoices are in accordance with applicable State and Federal requirements. Such supporting records shall reflect all direct and indirect costs, of any nature, expended in the performance of this Agreement and all income from any source. If required, the Provider shall also collect fiscal and statistical data on forms designated by the Buyer. The Provider shall maintain such program records as may be required by the Buyer. The Provider covenants to retain all books, records, and other documents relative to this Agreement for three (3) years after final payment, except when a longer period of retention is necessary for purposes of complying with the requirements of an unresolved federal or state audit, state or federal law, or court order. The Buyer, its authorized agents, and/or state and federal auditors shall have full access to and the right to examine any of said materials specific to children served by this Agreement during said period. In the event of a determination that the Provider received funds improperly or did not provide the authorized services or goods for which funds were received, the Provider shall provide the Buyer full restitution of any such funds.

The Buyer, based upon findings, may require that the Provider, within thirty (30) calendar days from the date of the request, submit an independent Certified Public Accountant prepared compilation, review, or audit so long as such compilation, review or audit was

completed within the last two fiscal years of the Provider.

F. CONFIDENTIALITY:

1. Any information obtained by the Provider concerning any client pursuant to this Agreement shall be maintained as confidential. Use and/or disclosure of such information by the Provider shall be limited to purposes directly connected with the Provider's responsibilities for services under this Agreement. If applicable, it is further agreed by both parties, that this information shall be safeguarded in accordance with the provisions of Title 63.2, Sections 102 and 104 of the Code of Virginia (1950), as amended, and any other applicable provisions of State and federal laws and regulations including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.
2. The Provider shall comply with the confidentiality provisions of VA. Code Section 2.2-5210. This includes, among others, not photographing the child/youth nor permitting media coverage of the child/youth without the written permission of the parent(s) or the legal guardian, as the case may be. It further precludes audiovisual recording of the child/youth as well as prohibits the child's/youth's participation in any research projects without the written permission of the parent(s) or the legal guardian, as the case may be.

G. SUBCONTRACTORS: The Provider shall not enter into subcontracts for any of the services to be provided under this Agreement. The Provider shall not assign this Agreement without prior written approval of the Buyer, which approval shall be attached to this Agreement and subject to such conditions and provisions as the Buyer may deem necessary. Nothing in this Agreement shall be construed as authority for either party to make commitments which will bind the other party beyond the scope of service contained herein. All direct client services must be provided solely by the Provider. The Provider shall not be deemed an employee or agent of the Buyer while performing under this Agreement. The Provider has the sole responsibility for his/her work, personal conduct, and compensation.

H. HOLD HARMLESS: The Provider shall indemnify, keep and save harmless the County, its agents, officials, employees and volunteers against claims of injuries, death, damage to property, patent claims, suits, liabilities, judgments, cost and expenses which may otherwise accrue against the County in consequence of the granting of a contract or which may otherwise result therefrom, if it shall be determined that the act was caused through negligence or error, or omission of the Provider or his or her employees, or that of the subcontractor or his or her employees, if any; and the Provider shall, at his or her own expense, appear, defend and pay all charges of attorneys and all costs and other expenses arising therefrom or incurred in connection therewith; and if any judgment shall be rendered against the County in any such action, the Provider shall, at his or her own expense, satisfy and discharge the same. Provider expressly understands and agrees that any performance bond or insurance protection required by this agreement, or otherwise provided by the Provider, shall in no way limit the responsibility to indemnify, keep and save harmless and

defend the County herein provided.

I. CLIENT GRIEVANCES: In the event of a grievance, fair hearing or an appeal, the Provider agrees to appear on request of the Buyer in any proceeding arising from such claim and provide all verbal or written evidence within his/her control, relevant to such claim.

J. RATES:

1. The Buyer will pay an all-inclusive hourly rate of **$___/hr**. for the therapy services described in Section I of this Agreement. This rate takes into account the time for indirect services related to this service and potential no shows and late cancellations. Rates may be increased over the term of this contract at the discretion of the Buyer. The Buyer maintains sole discretion regarding any rate increase.
2. Providers will invoice with the per session rate based on a 50-minute session. For the intake session only, the Provider may bill at 1.5 times the hourly rate for a session lasting 75 to 90 minutes.
3. The Provider states that the services described in this Agreement are not available from the Provider without charge.
4. The Provider agrees that the client or any member of the client's family will not be charged in addition to the rate paid by the Buyer during the period authorized under the Short Term Behavioral Health Service Purchase Order.
5. The Provider shall not charge or accept from the Buyer compensation for services which is more than the Provider charges other similar buyers of equivalent services in equivalent volumes.
6. The Provider retains the option to bill the client/client's parent for no shows and late cancellations.

K. PURCHASE OF SERVICE ORDERS: This Agreement contains the entire terms for purchase of services contemplated hereby but does not obligate the actual purchase of any services. A Purchase of Service Order (PO) setting forth a description of the services and the duration thereof will be presented to the Provider on a child specific basis when the Buyer chooses to purchase services. The Provider shall charge the Buyer only when and as authorized by the PO. The Provider shall charge only for actual services rendered. The charge shall not exceed the authorized amount on the PO. Such POs are incorporated into this Agreement by reference. The Provider has the right to refuse the Buyer's PO. The PO will be mailed to the Provider for review, acceptance and signature indicating approval with the child specific terms.

If the Provider does not receive the PO within fifteen (15) business days after initiation of service to the child/youth, the Provider shall notify Healthy Minds Fairfax at ***(703) 324-8111***.

L. TERMINATION OF PURCHASE OF SERVICE ORDERS: The PO may be modified,

amended, or terminated at any time for child-related causes to include, but not limited to, changes in client eligibility and client progress, and inadequate or inappropriate services for the client. The Buyer may not terminate or adjust the PO arbitrarily or without cause. If the Buyer becomes unable to honor the approved PO for causes beyond the Buyer's reasonable control, including but not limited to, failure to receive sufficient federal, state, or local government funds, the Buyer may terminate, amend, or modify any or all POs pursuant to this Agreement as necessary to avoid delivery of service for which the Buyer cannot make payment. The Buyer shall notify the Provider immediately in writing of any cause for termination hereunder. The Buyer shall pay the Provider for any authorized services rendered prior to the Provider's receipt of notice of termination hereunder.

After accepting the PO, the Provider may request the Buyer to terminate service provision to the client for child/youth-related causes, including but not limited to, the Provider determining that the Buyer required services are not sufficient for the needs of the child/youth. The Provider may not request the Buyer to terminate or adjust the PO arbitrarily or without cause. In any event that the Provider becomes unable to honor the approved PO for causes beyond the Provider's reasonable control, the Provider may request the Buyer to terminate or modify any or all POs pursuant to this Agreement. The Provider must give thirty (30) calendar days written notice to the Buyer of any request for termination.

M. INVOICES: Each month the Provider shall submit a separate invoice for each child/youth served using the required template (Attachment D) for units of services authorized by the Buyer and delivered by the Provider during the preceding month.

1. **Each invoice must be submitted by the 10th day of the month following the month of service.**
   Mail all invoices to:
   Healthy Minds Fairfax
   Short Term Behavioral Health Service
   12011 Government Center, Suite 404
   Fairfax, VA 22035-3406

2. The Provider will submit an individual invoice for each clinician providing services under this agreement who completes the GAINS-SS on-line training. The invoice must be for no more than one hour of the clinician's time at the agreed upon rate. All invoices must contain the following information:
   a. Legal name of the Provider;
   b. Name of the clinician;
   c. Purchase order number;
   d. The provided service as defined on the APOS;
   e. Contract unit price;
   f. Number of units; and

g. Specific service dates.

3. The Provider will use Healthy Minds Fairfax provided invoices and submit a separate invoice for each child served. The invoice template will be provided by the HMF program (Attachment D). A fillable invoice document will be provided by HMF upon request.
4. If the invoice does not contain the required information as outlined in Attachment D, then that invoice will be returned for correction.
5. The Buyer shall not be obligated to pay for services when the Provider fails to submit an invoice within thirty (30) calendar days following the month in which the services were rendered.
6. The Buyer shall pay within forty-five (45) days after Buyer's receipt of approved invoices which have been submitted by the Provider within ten (10) days after the end of the month to which the invoice relates.

N. BILLING ERRORS: If payment received for services is incorrect, then it is the Provider's responsibility to notify the Buyer in writing of the questionable payment within forty-five (45) calendar days after receipt of payment. Supporting evidence describing in detail the nature of the payment error must accompany such notification. The Buyer will correct any error or respond in writing as to why no error exists within ninety (90) calendar days after receipt of the Provider's notification. If the Provider's notification and supporting evidence are not received by the Buyer within the forty-five (45) calendar day limit, then the Buyer is not obligated to make any adjustment to the questioned payment. Should the payment received for services be an overpayment, the Provider must notify the Buyer immediately, and at Buyer's election, issue a refund payment or credit memorandum within seven (7) business days. Where the determination of overpayment is made initially by the Buyer, then at Buyer's sole election, the Provider shall issue a refund payment within ten (10) business days after Buyer's request or Buyer shall offset the overpayment amount against amounts due or to become due hereunder.

O. INSURANCE: The Provider shall be responsible for its work and every part thereof, and for all materials, tools, equipment, and property of any and all description used in connection therewith.

The Provider assumes all risk of direct and indirect damage or injury to the property or persons used or employed on or in connection with, the work contracted for, and of all damage or injury to any person or property, wherever located, resulting from any action, omission, commission, or operation under the Agreement.

1. The Provider agrees to maintain commercial general liability insurance in the amount of $500,000 per occurrence aggregate, to protect the Provider, the Board of Supervisors, the Buyer, its officers, and

employees against any and all injuries to third parties, including bodily injury and personal injury, wherever located, resulting from any action or operation under the Agreement, or in connection with the agreed work.

2. If applicable, the Provider agrees to maintain owned and hired Automobile Liability insurance, in the amount of $500,000 per occurrence, including property damage, covering all owned, borrowed, leased, or rented vehicles operated by the Provider.
3. If applicable, the Provider agrees to maintain professional liability or medical malpractice insurance in the limits of $500,000 per occurrence/aggregate.
4. Rating Requirements: The Provider agrees to provide insurance issued by companies admitted within the Commonwealth of Virginia, with the Best's Key Rating of at least A:VI. European markets including those based in London, and the domestic surplus lines markets that operate on a non-admitted basis are exempt from this requirement provided that the Provider's broker can provide financial data to establish that a market is equal to or exceeds the financial strengths associated with the A.M. Best's rating of A:VI or better.
5. The Provider shall provide a copy of Certificate of Insurance, evidencing such insurance and such endorsements as prescribed herein, and shall have it filed with the Contract Analyst of the Buyer prior to the signing of this Agreement. The Provider shall provide, on demand, certified copies of all insurance coverage as required by this Agreement within ten (10) business days of such demand. These certified copies shall be sent to the Contract Analyst by the Provider's insurance agent or representative.
6. No change, cancellation or non-renewal shall be made in any insurance coverage without a forty-five (45) day written notice to the Contract Analyst. The failure of the Provider to deliver a new and valid certificate shall result in suspension of all payments until the new certificate is furnished.
7. Insurance coverage required in these specifications shall be in force throughout the Agreement term. Should the Provider fail to provide acceptable evidence of the current insurance, the Buyer shall have the absolute right to terminate the Agreement without any further obligation to the Provider.
8. If an "ACORD" Insurance Certificate form is used by the Provider's insurance agent, the words, "endeavor to" and "...but failure to mail such notice shall impose no obligation or liability of any kind upon the company ..." in the "Cancellation" paragraph of the form shall be deleted or marked out.

P. LICENSURE: The Provider certifies that he/she possesses a valid professional license in the

area of the contracted service as required by the State in which the Provider practices. All services will be provided by the licensed professional in the same state as the Provider holds his or her license to practice.

The Provider shall furnish to the Contract Analyst satisfactory proof of the necessary licenses required by State and Federal regulations prior to the Provider signing this Agreement. The Provider agrees that it will maintain its required licensed status with the appropriate Boards and will immediately contact the Buyer in the event that such licensing is withdrawn or revoked. The Provider agrees that such a revocation or withdrawal shall immediately terminate this Agreement. Misrepresentation of possession of such license shall constitute a breach of contract and terminate this Agreement without written notice. Further, the Provider agrees that should the Provider or any of its employees be named in the Child Protective Service Central Registry (or its equivalent in states other than Virginia), then this information shall be made available to the appropriate child placement and regulatory personnel of the Virginia Department(s) of: Youth and Family Services; Education; Behavioral Health and Developmental Services; and Social Services, as well as the Buyer.

Q. DISPUTES: Except as otherwise provided in this Agreement, any dispute concerning a question of fact arising under this Agreement which cannot be disposed of by negotiation or agreement can be presented by the Provider to the Fairfax-Falls Church Community & Policy Management Team (CPMT). The CPMT, or its designee, shall be responsible for making the final decision and notifying the Provider in writing of the decision. This provision shall not preclude the Provider from exercising any rights under law for the failure of the Buyer to comply with the terms of this Agreement.

R. AGREEMENT TERMINATION: Except as otherwise provided herein, should any of the terms of this Agreement be breached by one of the parties, the other party shall have the right to terminate its obligations hereunder if the aforesaid breach is not cured within five (5) days after notice of the breach is given to the breaching party.

S. TERMINATION FOR CONVENIENCE: This Agreement may be terminated in whole or in part by the Buyer in accordance with this clause whenever the Buyer shall determine that such a termination is in its best interest. Any such termination shall be effected by delivery to the Provider at least thirty (30) working days prior to the termination date of a Notice of Termination specifying the extent to which performance shall be terminated and the date upon which termination becomes effective.

T. NOTICE: Any notice expressly provided for in this Agreement shall be given in writing, shall be given manually, by mail, or by overnight delivery service, and shall be deemed sufficiently given when actually received by the party to be notified. (FAX may be used by the Provider to give notice to the Buyer followed by the mailing of the original to the Buyer.) The notice shall be sent to the address set forth below:

BUYER: ***Healthy Minds Fairfax Contract Analyst***
Department of Procurement and Material Management
12000 Government Center Parkway
Suite 427
Fairfax, VA 22035-1102
(703) 324-7853

PROVIDER: To the address as it appears on the first page of this Agreement.

Any party by written notice to the other, given in the manner prescribed herein, may change its address for receiving notice.

U. TERM OF CONTRACT: The term of this contract shall be from the date of signature of this document through June 30, 2024. ***This contract may be renewed at the expiration of its term by agreement of both parties. Such renewal may be one (1) three (3) year period, or less, if agreeable, to all parties.***

V. AGREEMENT EXTENSION: In the event the Provider has not submitted the Agreement to the Buyer per the Healthy Minds Fairfax Program schedule or the parties to this Agreement have not reached mutual agreement as to the terms for the next contracting period, this Agreement may be extended on a month-to-month basis until mutual agreement is reached. The Provider will continue providing services for current and new clients at the current terms until agreement for the new contracting period is reached. ***The County will continue to pay for services at the current rates until agreement is reached.*** If applicable, no retroactive increases on rate payments will be made by the Buyer.

W. BINDING AGREEMENT: The terms of this Agreement and any PO issued hereunder
1. shall be enforceable and binding upon and inure to the benefit of the parties hereto;
2. may not be modified or amended except by written agreement signed by the parties hereto; and
3. constitute the entire agreement of the parties with respect to its subject matter.

No provisions of this Agreement shall be deemed to inure to the benefit of any third party.

Fairfax County System of Care Office
Short Term Behavioral Health Service for Youth

Clinical Assessment
Attachment A

CLIENT NAME: Click here to enter text. **DOB:** Click here to enter text.
ASSESSMENT DATE: Click here to enter a date.
PRESENTING CONCERN: Click here to enter text.

MENTAL STATUS EXAMINATION

Appearance/Behavior:	☐ oriented	☐ person	☐ place	☐ time		
Mood/Predominant Emotion Status:	☐elation	☐fearful	☐ sad	☐angry	☐ anxious	☐ shame
	☐ curious	☐ euthymic				
Thought Process:	☐ WNL	☐ linear	☐circumstantial	☐ tangential	☐loose	☐slowed
Perception:	☐ unremarkable		☐ hallucinations	☐ flashbacks	☐disassociation	
Insight/Self Awareness:	☐ unremarkable	☐ fair	☐ poor	☐ developmentally appropriate	☐ other	
Psychomotor:	☐ unremarkable	☐ hyperactivity	☐ agitated	☐ hypoactive	☐ tics	☐ tremor
	☐ abnormal movements		☐ repetitive behavior	☐ stereotyped behavior	☐ gross motor	
	☐ impaired coordination		☐ fine motor			
Affect:	☐ WNL	☐dysphoric	☐ labile	☐ intense	☐ flat	☐ restricted
	☐ situationally inappropriate					
Thought Content:	☐ unable to assess	☐ developmentally appropriate		☐ fears	☐guilty	☐ dreams/nightmares
	☐ inadequate	☐ hopeless	☐ worthless	☐ delusions	☐ obsessions	
Judgment/Reason:	☐ unremarkable	☐ fair	☐ poor	☐ developmentally appropriate		
Speech/Language:	☐ unremarkable	☐ pressured	☐ limited expression	☐ loud	☐soft	☐ mute
	☐ hypo talkative	☐ hyper talkative		☐ limited comprehension	☐ incoherent	
	☐nonverbal	☐ articulate				
Emotion Regulation:	☐ WNL	☐ over controlled		☐ under controlled		
Attention:	☐ WNL	☐ easily distracted	☐ poor focus	☐ poor sustained attention		
	☐hyper-vigilance					
Suicidal Ideation:	☐ none	☐ passive thoughts	☐ active thoughts	☐ plan	☐ intent	
	☐ means	☐ attempt				
Homicidal Ideation:	☐ none	☐ passive thoughts	☐ active thoughts	☐plan	☐ intent	
	☐ means	☐ attempt				

Additional Comments: Click here to enter text.

RISK AND SAFETY ASSESSMENT

BEHAVIORS	No Hx	Active	Past Hx	DESCRIBE
Suicidal ideation/gestures	☐	☐	☐	Click here to enter text.
Homicidal ideation/gestures	☐	☐	☐	Click here to enter text.
Self-injurious behavior	☐	☐	☐	Click here to enter text.
Assaultive (identify targets)	☐	☐	☐	Click here to enter text.
Sexualized behavior	☐	☐	☐	Click here to enter text.
Elopement	☐	☐	☐	Click here to enter text.
Fire Setting	☐	☐	☐	Click here to enter text.
Substance use/abuse	☐	☐	☐	*Substances, amount, last use, consequences, etc.* Click here to enter text.
Other risk behaviors	☐	☐	☐	Click here to enter text.

Fairfax County System of Care Office
Short Term Behavioral Health Service for Youth

Clinical Assessment
Attachment A

SOMATIC FUNCTIONING

Sleep	☐ unremarkable	☐ hypersomnia	☐ insomnia	☐ initial	☐ middle
	☐ early awakening	☐ other			
Weight	☐ unremarkable	☐ loss 1-10 lbs.	☐ loss 10+ lbs.	☐ gain 1-10 lbs.	☐ gain 10+ lbs.
	☐ other				
Appetite	☐ developmentally appropriate		☐ increased	☐ decreased	☐ other
Energy Libido	☐ developmentally appropriate		☐ increased	☐ decreased	☐ other

Comments: Click here to enter text.

TRAUMA/ABUSE/TREATMENT HISTORY

None ☐

Type	No	Yes	Time Frame/Duration		
Sexual abuse	☐	☐	Click here to enter text.	to	Click here to enter text.
Description:	Click here to enter text.				
Physical abuse	☐	☐	Click here to enter text.	to	Click here to enter text.
Description:	Click here to enter text.				
Neglect	☐	☐	Click here to enter text.	to	Click here to enter text.
Description:	Click here to enter text.				
Domestic violence	☐	☐	Click here to enter text.	to	Click here to enter text.
Dating/Relationship Violence	☐	☐	Click here to enter text.	to	Click here to enter text.

Trauma Associated Symptoms Present: ☐ none ☐ nightmares ☐ intrusive thoughts ☐ avoidance
☐numbness ☐ detachment ☐ hyper-vigilance ☐ starting ☐ other

PREVIOUS TREATMENT HISTORY: Click here to enter text.

Family History of Substance Use ☐ Yes ☐ No Mental Illness ☐ Yes ☐ No
Click here to enter text.

MEDICAL/SOCIAL

Last Visit to MD: Click here to enter a date. Physicians Name: Click here to enter text.

Current Medical Conditions: ☐ None Click here to enter text.

Current Medications: Click here to enter text.

Environmental, Home, School, Social and Peer Supports: Click here to enter text.

Relevant Social History: ☐ None Click here to enter text.

SCHOOL INFORMATION

School: Click here to enter text. Grade: Choose an item. School Status: Choose an item.

Special Education: ☐ Yes ☐ No IEP: ☐ Yes ☐ No Academic Status: Choose an item.

Decline in Academic Performance: ☐ Yes ☐ No

Reason: ☐ school attendance ☐ conflict with peers ☐ accidents/safety violations ☐ bullying
☐recipient of threat(s) ☐ discipline problems at school ☐ conflict with authority figures

Fairfax County System of Care Office
Short Term Behavioral Health Service for Youth

Clinical Assessment
Attachment A

CLIENT STRENGTHS/LIMITATIONS

	Present	Absent	Notes:
Bright, learns quickly	☐	☐	Click here to enter text.
Insightful/self-aware	☐	☐	Click here to enter text.
Relates well to others	☐	☐	Click here to enter text.
Good social support system	☐	☐	Click here to enter text.
Satisfied with school	☐	☐	Click here to enter text.
Satisfied with school performance	☐	☐	Click here to enter text.
Hobbies or recreation activity	☐	☐	Click here to enter text.
Positive peer relationships	☐	☐	Click here to enter text.
Motived to change	☐	☐	Click here to enter text.
Cultural/community involvement	☐	☐	Click here to enter text.
Spiritual focus	☐	☐	Click here to enter text.
Special Needs	☐	☐	Click here to enter text.
Other	☐	☐	Click here to enter text.

PRELIMINARY DIAGNOSIS (ICD 10) Click here for ICD 10 Codes

1st Problem: Click here to enter text.
2nd Problem: Click here to enter text.
3rd Problem: Click here to enter text.

Treatment Goals: Click here to enter text.

Youth & Family can benefit from STBH Service ☐ Yes ☐ No If no, please explain: **Click here to enter text.**

Clinician Signature/Credentials Date Phone Number

Clinical Supervisor Signature/Credentials Date Phone Number

HEALTHY MINDS FAIRFAX
Short Term Behavioral Health Service for Youth
ATTACHMENT B

Statement of Understanding

You have chosen to receive Short-Term Behavioral Health (STBH) Services for Youth funded through the Fairfax County System of Care Office and provided by their approved providers. STBH services may include assessment and referral or brief counseling. The STBH provider will work with you to clarify the problem, identify choices, and develop an action plan. You may receive up to eight sessions total, to include an assessment, counseling sessions, and wrap-up closing session. System of Care staff are available to answer any questions you may have about the program and STBH providers are available to respond to your calls and will advise you of their after-hours contact policy.

FEES

These services are provided at no direct cost to you or your family. The System of Care Office pays for these services. However, if you need longer-term counseling or a specialized service, your STBH provider will assist in locating a resource or service in the community. **It is your responsibility to pay for services provided by any resources outside the STBH program.** (If you have health insurance, your insurance benefit plan may cover some of the cost. **Check with your benefits representative before services are provided by outside resources.**) **Failure to attend appointments without prior notification may result in you being charged a fee** (at the discretion of the provider).

CONFIDENTIALITY

The STBH Services program will maintain confidential records of your contact.

No one will reveal information concerning your use of this service to anyone outside the program except as follows: 1) you consent in writing; 2) life or safety is seriously threatened; 3) disclosure is required by law; or 4) your STBH provider refers you to benefits-covered treatment and the claims payer requires information. In addition, your STBH provider will disclose information and records to the System of Care Office as needed for coordination of STBH services, quality assurance, or payment.

I, (**print parent name**) _____, understand this form, including the confidentiality of the STBH Service and the limitations to confidentiality, and accept it as the terms of my participation in the program. As an STBH Service for Youth consumer, I also understand that I may request written information describing the System of Care Office's confidentiality policy and the STBH Service provider's confidentiality policy.

I UNDERSTAND THAT THERE MAY BE A NO-SHOW FEE CHARGED BY THE STBH SERVICE PROVIDER.

Parent/Guardian Signature_____ **Date**_____

Youth Signature_____ **Date**_____

STBH Provider Signature_____ **Date**_____

Fairfax County System of Care Office
Short Term Behavioral Health Service for Youth
ATTACHMENT C
DISCHARGE SUMMARY

Client Name:	**Final Diagnosis and ICD 10 Code:**
Click here to enter text.	Click here to enter text.

STBH Service Start Date: Click here to enter a date. **STBH Service End Date:** Click here to enter a date.

Number of STBH sessions attended by youth: **Choose an item.**

STATUS OF PROGRESS:

Targeted Problems:

- ☐ Deteriorated
- ☐ No Change
- ☐ Minimal Improvement
- ☐ Moderate Improvement
- ☐ Significant Improvement
- ☐ Not Addressed/Plan Changed
- ☐ Unknown: Click here to enter text.

REASON CASE CLOSED:

- ☐ Goals met/Client satisfied
- ☐ Client dropped out against advice
- ☐ Client referred
- ☐ Client utilized all available sessions
- ☐ Other: Click here to enter text.

Clinical Summary/Comments (Please provide detailed comments)

Click here to enter text.

FOLLOW UP SERVICES RECOMMENDED: ***(check all that apply)***

Client referred to:

- ☐ Substance use treatment
- ☐ Mental health treatment
- ☐ Provider within insurance plan
- ☐ Community Services Board
- ☐ Private non-profit behavioral health provider
- ☐ Other private provider
- ☐ No referral
- ☐ Other: Click here to enter text.

REFERRED LEVEL OF CARE

- ☐ Community resources
- ☐ Outpatient
- ☐ Intensive inpatient
- ☐ Inpatient
- ☐ Other: Click here to enter text.

Referred Provider Information:

Name:	Click here to enter text.
Address:	Click here to enter text.
Phone:	Click here to enter text.

Did client receive follow up services for which they were referred? ☐ Yes ☐ No ☐ Do Not Know

Provider Name (Print)	Provider Signature/Date

Revised: 8/2019

STBH INVOICE FOR OUTPATIENT SERVICES

Attachment D

[Enter Agency's Name Here]
Address:
City/State
[Phone] [Fax]

TODAY'S DATE:
PURCHASE ORDER #
INVOICE FOR:

Client's Name: [Enter Client's Name Here]

Therapist Name: [Enter therapist's name here]

Email or fax invoices to: **Hilda Calvo**
Healthy Minds Fairfax
FAX# 703/653-7052
Hilda.CalvoPerez@fairfaxcounty.gov

DATE(S) OF SERVICE(S)	DESCRIPTION OF SERVICE(S)	Session # (1-10)	# OF SERVICE HOURS/UNITS	CONTRACTED UNIT PRICE	LINE TOTAL
	Outpatient-Individual	1			$0
	Outpatient-Individual	2			$0
	Outpatient-Individual	3			$0
	Outpatient-Individual				$0
	Outpatient-Individual				$0
	Outpatient-Individual				$0
				TOTAL	**$0.00**

Comments/Notes:
*** To ensure proper payment invoices should be submitted monthly by the 10th of the following month.**
*** Please do not include services for multiple months on any one invoice.**